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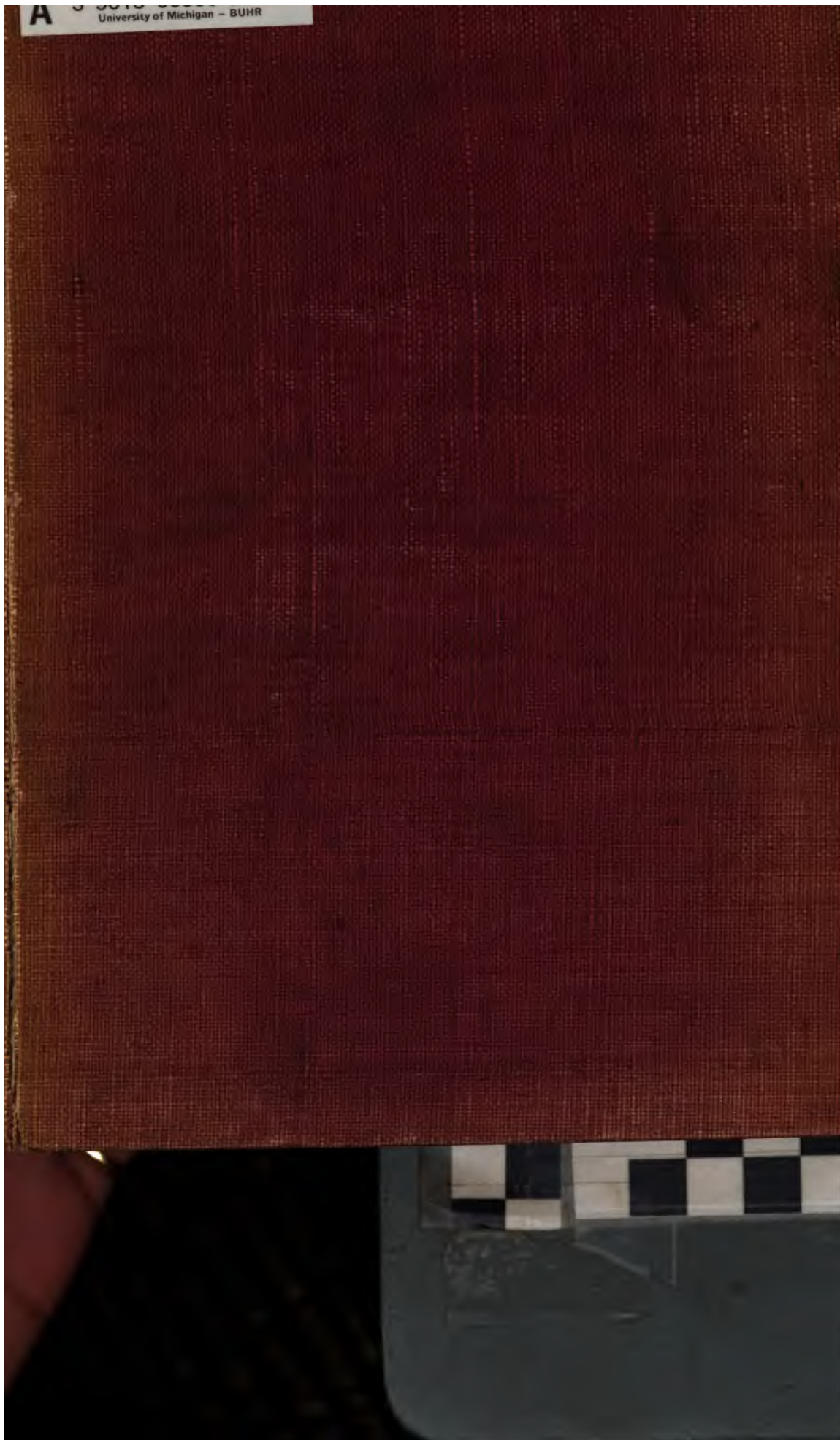
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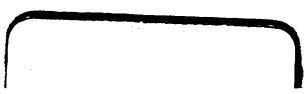
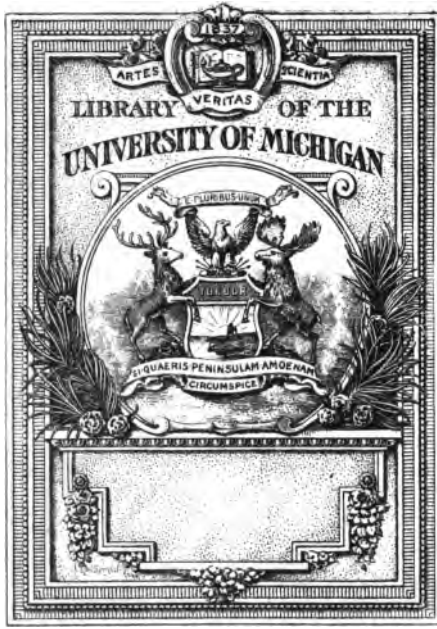
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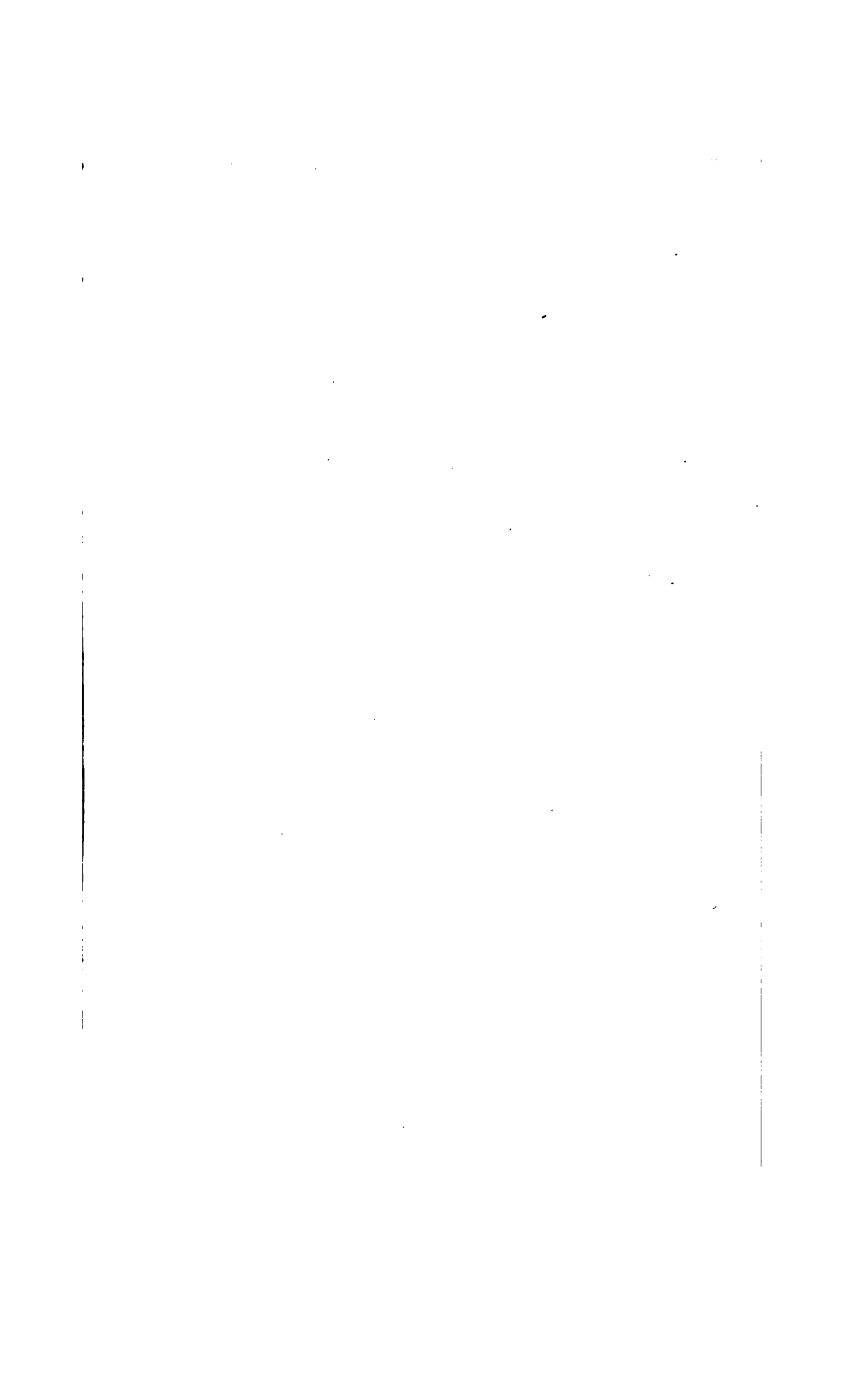
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The Journal
OF THE
British Homeopathic Society

1892-1893

NEW SERIES

VOL. I.

SESSION 1892-1893

EDITED BY

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1893

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NOTICE.

This volume comprises the proceedings of the BRITISH HOMŒOPATHIC SOCIETY during its Forty-ninth Session, 1892-93.

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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OF THE
British Homœopathic Society

No. 1.

JANUARY, 1893.

Vol. I.

All communications and exchanges to be sent to DR. HUGHES,
36, Sillwood Road, Brighton.

EDITORIAL PREFACE.

THE British Homœopathic Society was founded in 1844. It was not till 1860, however, that it began to issue a periodical record of its proceedings. This publication was styled "Annals and Transactions of the British Homœopathic Society and of the London Homœopathic Hospital." It has continued to appear ever since; for though its contents first saw light, from 1870 to 1876 inclusive, in *The British Journal of Homœopathy*, and from 1885 to 1892 in *The Monthly Homœopathic Review*, they were always reprinted in separate form and sent to the members, who thus have a complete set of the journal to the present time, forming twelve volumes of 600-700 pages each.

Our present publication is the avowed and direct continuation of its predecessor, though under a different name. It has assumed its altered title for several reasons. In the first place, the London Homœopathic Hospital has now acquired such strength and individual life that it has begun, and intends to continue, to publish its own "Reports" after

the fashion of other metropolitan institutions of the same kind. Its name, therefore, disappears from our title-page. Again, the phrase "Annals and Transactions" was chosen (we apprehend) in order to warrant the use of past as well as current proceedings of the Society. Of such liberty we have no need at present to avail ourselves. We might then have called our present issue simply "Transactions of the British Homœopathic Society." But, in the first place, we propose to give, in addition to the papers read before, and the discussions held by, the Society, a summary of the pharmacodynamics and the therapeutics of each quarter's journalism; so that "Transactions" simply will not cover our matter. And then, secondly, we want to indicate the fact that in substance as well as in form we are making a new departure; that the present series of the Society's publication is the fruit of a renewed life and energy on its part, which it trusts will be felt by its members far and wide.

We have, accordingly, assumed the title of THE JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, following thereby more than one well-known precedent. But we would have it distinctly understood that we in no way seek to rival *The Monthly Homœopathic Review* and *The Homœopathic World*. We occupy different ground from these our contemporaries; we give no news (save of the Society itself), review no books, take no part in medical politics or controversies. We aim only at providing the members of the Society with a record of its work, and a series of excerpts from the journals which lie on its table. If we can perform this task to their satisfaction, our aim will be attained.

ON STAMMERING HEART.¹

BY R. E. DUDGEON, M.D.

Consulting Physician to the London Homœopathic Hospital.

THE cardiac affections I am going to bring under your notice to-night are not very interesting because not dangerous. I have lumped them together under the name of "Stammering Heart," for I think that title best indicates their character and importance. Though as a rule they are not dangerous they are extremely disagreeable, and often cause a great deal of anxiety and alarm to the patient and the doctor.

What constitutes a stammering heart is irregular action, without ascertainable organic disease, valvular or muscular. I am not aware that the name "stammering" has been applied to these affections, but they have been described under other appellations. Thus Dr. Latham: "What can be said of palpitations of the heart, and intermissions and irregularities of its beats which come and go during a man's whole existence, neither originating in any known disease, nor terminating in any, nor abridging in any measure the duration of life? They must mean something, but we know not what. We may call them sympathetic, but it must be in a very lax sense." (Latham's *Works*, Syd. Soc., ii., 519.)

Probably modern pathology would not be content with such an inconclusive statement. In place of talking vaguely about sympathy, the up-to-date pathologist would have to speak about the sympathetic and the vagus nerves as factors of the phenomenon, or say something pleasant about the increase or diminution of the inhibitory power of the cardiac ganglia, or vaso-motor nerves. But after all, when we come to consider the matter curiously, we shall have to confess that the modern pathological explanation is hardly more satisfactory than Dr. Latham's no-explanation, and does not afford the slightest hint that could be of use for therapeutical purposes.

¹ Read before the Society, October 6th, 1892.

Irregularity of the heart's action is not always without a perceptible pathological cause. Pneumonia is frequently attended by a very palpable irregularity, a fit of asthma almost invariably shows it, an accumulation of flatulence in the stomach is a frequent cause of it, various valvular diseases are known to be accompanied by it, and some kidney diseases are seldom without it, but the stammering heart differs from all these.

As the analogous affections of the voice muscles are divided by pathologists into two classes, *stammering* and *stuttering*, so the irregularity of the heart's action I am speaking of may be said to be of two kinds, *stammering* and *stuttering*. Intermittence, regular or irregular, may be termed *stammering*; other irregularities in which, so far from there being fewer beats per minute, there are often many more beats than in the normal state, I would call *stuttering*. However, not to refine too much, I will call all the irregularities of the heart's action, without demonstrable pathological cause, "stammering heart."

The common typical variety of this affection is seen in the intermittent pulse.

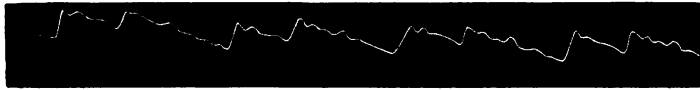


FIG. 1.

This is sometimes congenital. I will show now one of a series of sphygmograms I possess taken from a young lady at different periods of her life. When I first noticed her irregular pulse she was about two years old; she is now fifteen, and she has never lost the stammer I first observed in her. It changes its rhythm now and then, but never by any chance becomes what may be called regular, except transiently, when the circulation is hurried by great exertion or a febrile condition. When I first observed it it was of the character seen in fig. 1—a normal beat followed by a bigeminous beat—quite regular in its irregularity. Some days after this the little girl had an attack of jaundice, the pulse then became

entirely bigeminous, *i.e.*, the systole of the heart was succeeded before the pulse had attained its full length by an abortive systolic action, causing the slight curve seen in the middle of what appears to be a beat of double the normal length. It is thirteen years since then, but the pulse during all that period never deviated into a normal character, and never, as far as I am aware, showed three successive normal beats, with the exception to be presently noticed. I took a sphygmographic tracing in April of this year when she was in perfect health, and was nearly grown up to woman's estate, and it was still irregular, though the irregularity differs

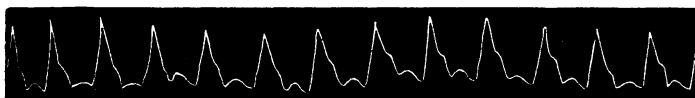


FIG. 2.

slightly from what it used to be. The latest sphygmograms I have of her were taken in September last, when she was evidently sickening for measles, with a cough and temperature of 103° . The regular intermittence is very obvious. When the fever attained its height two days afterwards, temperature 104.2° , the intermissions became rarer, usually every fifth or sixth beat, but occasionally the pulse would beat quite regularly for a much longer period, as shown in fig. 2. Here the pulse, which in the normal state ranged



FIG. 3.

from 70 to 80, was quickened to 126 beats per minute. Next day the fever having subsided, the temperature became normal, and the pulse went down to 70, its normal abnormality was restored, as shown in fig. 3.

Such cases, where there is never any return to a regular normal action except in morbid conditions in a heart otherwise presenting no sign of disease, are rare. On the other

OF STAMMERING TALK

THE CASE OF STAMMERING INTERMITTENT OF SCHOOL BOY.
I HAVE BEEN THE GUEST OF VARIOUS DISTINGUISHED GENTS. CON-
SULTING WITH THEM ON THE SUBJECT OF THE CASE OF THE BOY
WHICH I HAVE HERE DESCRIBED. THESE GENTLEMEN HAVE BEEN
VERY KINDLY AND GENEROUSLY ASSISTING ME IN MY
STUDY OF THE CASE. I AM LATE FROM A VISIT TO
THE GENTLEMEN TO WHOM I AM REFERRED AND WHOSE
NAME I HAVE TO CONCEAL TO THE BEST ADVANTAGE IN



FIG. 1

THE CASE WAS MY OWN. HE WAS SUFFERING FROM
DYSPEPSIA WITH DISTURBED SLEEP, CONSTIPATION, AND
ALL THE SYMPTOMS OF THE CASE. IT WILL BE OBSERVED THAT THE
INTERMISSIONS ARE INTERMITTENT IN THE MORNINGS, AND IN THE
AFTERNOON A PROLONGED INTERVAL AND AT TIMES INTER-
MITS WITH A STAMMERING CHARACTER AND SOMETIMES WITH
A STAMMERING CHARACTER OF THE SAME DAY IN WHICH TWO
DIFFERENT INTERMISSIONS ARE SEEN OCCURRING TOGETHER. NEARLY
THE SAME ACTION WAS QUITE REGULAR FOR 5. MONTHS THERE



FIG. 2

HE HAD NO IMPROVEMENT IN THE DYSPEPSIA SYMPTOMS. THE
DYSPEPSIA ACTION CONTINUED TO BE NEARLY QUITE REGULAR WITH
ONLY AN OCCASIONAL INTERMISSION FOR SEVERAL MONTHS, AFTER
WHICH IT BECAME AGAIN IRREGULAR, CONCURRENTLY WITH A FRESH
OUTBREAK OF THE DYSPEPSIA, WHICH THIS TIME WAS ATTENDED BY
THE PRODUCTION OF MUCH URIC ACID IN THE URINE. THE
CASE BEING I TOOK OF HIS PULSE SHOWS THE STAMMER ASSUMING
THE STAMMER CHARACTER. AFTER THIS I LOST SIGHT OF THE PATIENT,
WHO WENT OVER TO ALIOPATHIC TREATMENT. HE DIED SOME YEARS
AFTERWARDS, BUT OF WHAT I AM UNABLE TO SAY.

STAMMERING HEARD OF THIS CHARACTER USUALLY BECOMES

regular if the circulation is hurried by exertion, wine or any febrile attack. In this it differs from the irregularity attending heart disease, as that is usually unaltered when it is not increased by such causes. An intermittency of the heart's beats—though it is occasionally met with in cases of acute disease, and then may indicate a partial failure of power requiring some cardiac tonic—when it is an habitual state and especially when it preserves a sort of rhythmic regularity and is not attended by weakness of the heart's action generally, is not to be looked upon as a morbid or even as an important symptom. It is recorded of Talleyrand, whose pulse intermitted regularly every fourth beat, that he ascribed his longevity and good health to the circumstance that his heart had a rest every fourth beat which gave it a decided advantage over hearts which went on pumping the blood continuously and without pause. The idea that the

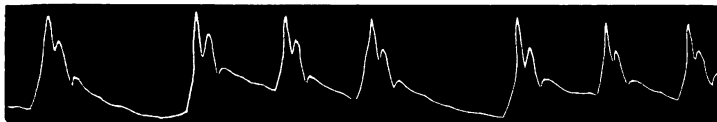


FIG. 6.

intermission is a rest during which the heart acquires fresh vigour derives some countenance from the circumstance that the next beat after an intermission is generally stronger than the other. I submit one among many examples in my possession which illustrates this: (fig. 6).

The same thing is observed even when the intermission is not perfect, when indeed the abnormal pulse consists of a normal beat followed by a weak or imperfect pulsation. Still the next beat will be found to be stronger than the strongest part of the abnormal beat.

Intermissions are usually not perceptible to the subject of them, but this is not always the case. Sometimes a more or less distinct momentary obstruction is felt during the intermission. It is not pain, but a kind of stoppage is felt. Sometimes the feeling is much more intense. Patients have complained to me that it seemed as though the heart were for an instant squeezed by a vice.

The more irregular variety of stammering heart, which I have called *stuttering*, is often accompanied by disagreeable sensations, described by the subjects of it as palpitation, fluttering, holding back, squeezing of the heart, &c.

Fig. 7 is a sphygmogram from an old gentleman above 80, whose pulse I had opportunities of observing for several years, and during all that time it presented similar signs of



FIG. 7.

irregularity, as much so when he was quite well as when he was suffering from some slight attack of cold or dyspepsia. In this case no subjective symptoms connected with the heart's action were present.

Fig. 8 is a sphygmogram taken from a lady well on in the seventies. I have many more sphygmograms of this pulse exhibiting almost every kind of stammer. The extremely irregular character will be maintained for months and even years at a time, and then without ascertainable



FIG. 8.

cause the pulse will become quite regular and remain so, with an occasional but rare intermission, for as long a period. She has been under my observation for thirteen or fourteen years, and I have never noticed that the heart stammer was dependent on any particular indisposition, for though she was often under treatment for dyspepsia, bronchial catarrh, and pains in the back, the heart was often quite regular during these attacks, and irregular when she was comparatively well. As a rule she did not feel more difficulty in walking when her heart was irregular than when it beat quite normally.

It may be thought that I am occupying your time un-

necessarily in bringing before you an abnormal state of the circulation that has little pathological significance, and therefore must be destitute of practical importance. But that is not quite the case. Patients are often alarmed to find that their heart is acting so eccentrically, and doctors who have not made a study of the phenomenon sometimes confirm the patients' fears. Several striking instances of this I have met with in practice. I will relate one of these *instar omnium*. A retired colonel, aged 60, who had served for some years in India, and since his retirement lived on his estate and devoted himself to country sports and public speaking, used to come up to town and consult me. He was a fine healthy-looking, I may say robust, man, and his chief complaint was that he would be occasionally seized with what he called palpitation of the heart, which would last for several hours, and frightened him very much. I first saw him in 1884, and he told me that he had been affected in a similar way for four years, but that the frequency and duration of his fits of palpitation had latterly increased very much, so that he now had them on an average every three days, and they would last for thirty-six hours at a stretch. He had consulted many physicians, but to no effect. With the exception of some slight gouty symptoms, such as enlarged finger-joints and the occasional passage of uric acid concretions, varying in size from a pin's head to a small pea, his health seemed to be good. I examined his heart several times when free from "palpitation," but could find no signs of valvular or other disease. After two years the "palpitation" became permanent, and on his next visit to London he went to consult an eminent and titled allopathic specialist, who gave a very unfavourable prognosis and told him that it was absolutely necessary he should give up all those amusements and occupations in which he delighted. He was to ride no more to hounds, to give up shooting, never to indulge in platform oratory, to live most carefully and to take only carriage exercise or a slow walk on level ground. After this consultation he came to see me and told me what the great man had said. I said I was of an entirely different opinion, and assured him that

he had only a stammering heart, which though disagreeable was not dangerous ; that, though it would be unadvisable to take any very violent exercise, he might still ride to hounds, walk briskly up hill, shoot partridges and pheasants and occasionally speak at public meetings on unexciting subjects. Fig. 9 will give you a good idea of what was the apparently permanent condition of his heart's action at this time. Two years later it was not improved. He acted on my advice and continued to go about his usual employments and sports



FIG. 9.

without giving any heed to the stammer in his heart, which he scarcely noticed since I had assured him, in the words of Mr. Fooks, it was "of no consequence." After this the heart seemed gradually to right itself, and when I examined him in the beginning of 1891 the sphygmogram I obtained was perfectly normal (fig. 10). That this return to normal action was not due to any improved state of the health was



FIG. 10.

evident from the circumstance that it occurred while he was suffering from a rather severe attack of bronchial and tracheal irritation with harassing cough, and he was also passing the small calculi before mentioned in considerable quantities.

This case illustrates the value of a knowledge of this not rare condition of the heart's action, for it is well known that nearly anything has a more disastrous effect on the comfort of a patient than a belief that his heart is diseased. If we are able to assure him that

the irregular action which so distresses him is of hardly any greater pathological importance than a stammer in the apparatus of speech, we shall often succeed in changing a life of misery and dread into one of cheerfulness and comfort. It has more than once happened to me to find a poor creature living in perpetual fear of making any exertion or undergoing any excitement, whether pleasurable or painful, lest some fatal catastrophe should occur. If we can convince him that his fears have no foundation, and that he may do pretty much as others do without fear of any bad consequences, we shall have acted the part of a good physician quite as well as if we had cured him of a serious disease by "drap or pill."

The most extraordinary case of cardiac stammer that I have met with in practice was that of a gentleman at the head of his profession in the musical world whose heart, though to all appearance perfectly sound, would take fits



FIG. 11.

of stopping for from four to twelve and more seconds at a time. In its normal state the sphygmogram showed a slow but pretty strong pulse of 42 in the minute, but without warning the pulse would suddenly stop for a longer or shorter time. On my first applying the instrument there was not the faintest indication of a pulse, during the short time (ten seconds) the paper took to pass through. A few minutes afterwards the sphygmogram showed a strong, regular pulse of normal character. Fig. 11 shows the same pulse four years afterwards. There are two rather weak beats, and then comes a pause which ran to the end of the paper, and was prolonged a good way beyond. On taking the sphygmogram two years later there was but one beat on the whole length of the paper, the rest of it being occupied with the pause. The instrument applied a few minutes later showed a perfectly regular and normal pulse.

I could not discover that this remarkable stammer was connected with any particular condition of the health. It was not worse during some severe attacks of bronchial catarrh than when he was apparently in good health. This peculiarity of heart's action did not hinder him [from performing with ease the very onerous duties of his profession, and I see that up to the present time he is as actively employed as ever, though in age he must be considerably far on in the sixties.

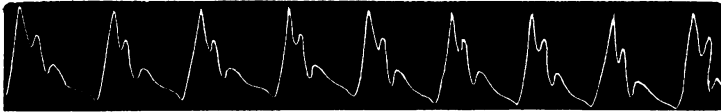


FIG. 12.

Wreden (Ziemssen's *Cyc.* xii., 784) relates a case of nearly equal retardation of pulse, but that was in a man dying of cerebral abscess.

The fluttering pulse met with in certain febrile affections and in some indispositions not distinctly febrile is essentially a stuttering pulse. In some cases the stutter will go on for days, and the heart will then right itself quite suddenly. As long as it lasts it greatly alarms the patient and his friends, and the ordinary mode of treating it by pouring in enormous quantities of alcoholic stimulants is often followed by disastrous consequences.

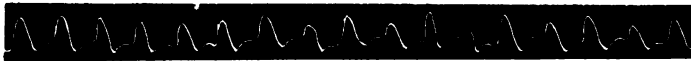


FIG. 13.

Fig. 12 is a tracing of the pulse of a gentleman in his usual state of health. It is tolerably strong and perfectly normal in character; 77 per minute. Under the influence of an attack of undeveloped gout (the gout did not appear until some days after the pulse had regained its normal character), the pulse took on the fluttering or stuttering character (fig. 13), which it maintained (the tracing it will be observed is utterly abnormal, and the velocity 168 beats per minute) un-

interruptedly for a fortnight and then suddenly resumed its normal character and speed. I do not give this as an example of stuttering heart pure and simple, for it no doubt was caused by the latent gout which broke out later.

Ordinary attacks of palpitation are nothing more than stuttering cardiac action. I have given a tracing of the pulse in such an attack in the *London Homœopathic Hospital Reports*, vol. i.

The action of the heart in attacks of asthma is often of the stuttering or fluttering character, but as these, though they may not be dependent on any organic heart disease, are caused by an obvious morbid condition, they do not properly belong to my subject.

Exciting causes of stammering or stuttering heart seem sometimes to be tobacco smoking or tea and coffee drinking.

As the affection appears to be more a habit than a disease, it is not very amenable to medicinal treatment. Smart exercise, a glass or two of wine, digitalis, strophanthus, cactus and especially that much advertised preparation of cactus called "cactina pillets," will sometimes rapidly restore the regular action of the heart, but as often it pursues the uneven tenor of its way without heeding the remedies administered. The best thing the doctor can do after ascertaining that the irregularity is unconnected with any obvious disease of the heart or other organs, is to assure the patient that the stammer or stutter of his heart is not dangerous, and that he need not lay himself aside as an invalid obliged to take precautions to avoid sudden death. The cases I have brought before you prove that the cardiac stammer may occur in the earliest infancy and the most advanced age, that it may be continued or intermitting, and that it is not dependent on any ascertainable condition of health.

Dr. BYRES MOIR thought the writer had mixed up a great many different conditions and classified them under "stammering heart." He wished he could accept the statement that none of them were due to organic changes, though he certainly agreed in the suggestion that these irregular conditions were frequently due to states that were only functional. But in later life when this

irregular action occurred he was sure, from many cases he had watched, that it was due to organic changes chiefly in the heart's wall. It would be interesting if they could get the full history of many of the cases which had been mentioned, as he felt sure many of them would die from heart failure. That day he had seen a man in a dying condition, who for four years had suffered from palpitations such as Dr. Dudgeon had described. For a few hours he would have an irregular action of the heart, and it would pass off, and perhaps for a month he would have no further attack. Gradually it got worse and worse, and he was now dying—a condition due to fatty degeneration of the walls. He was quite sure, in cases in advanced life, when there had been no irregular action before, some organic change was the cause. The treatment Dr. Dudgeon recommended in the case of the colonel was quite right. There was great danger in telling such patients to lie up. It was the worst treatment they could get. The more such persons could be encouraged to keep up a healthy exercise of their full powers the better they would be. The last tracing of the sporting colonel was a perfectly regular one, but that was taken during an attack of bronchitis, and if there was any febrile condition at all that would probably account for the regular action. Another case was apparently what was now called a case of tachycardia, and that was entirely due to stammering heart, because it was a paroxysmal condition, and was not due to any cardiac lesion so far as had been discovered, but was due undoubtedly to the paralysis of the vagus. He saw a case some time ago in which, by evacuating the stomach by a mustard emetic, the attack was at once checked and the pulse fell from 200 to 72 in an instant. Those cases were the most difficult to treat. There were, no doubt, many things which caused the intermittency, as excess of wine or tobacco. One of his fellow students, by smoking a certain number of pipes, could produce intermittency. With children the case was different. He had constantly seen children of all ages with irregular action from which they got quite free. But when it came on later in life he felt quite sure organic changes would show themselves sooner or later.

Dr. DYCE BROWN quite thought with Dr. Moir that in many cases of irregular heart there was organic disease. Still, there were no doubt an enormous number of cases which were simply functional, and it would be generally found in such cases there was some decidedly neurotic history—either the patient, when examined carefully, would show a neurotic temperament, or it

would be found that other members of the family had suffered from neurotic disease. No doubt many of the cases due to irregular action of the heart were perfectly curable, and did get perfectly well, yet, if they persisted for years with hardly any alteration, they indicated a very feeble nerve supply to the heart, and such patients, if not cautioned against over exertion and over-strain, might show serious symptoms of heart failure. There was another extremely interesting class of cases of irregular nervous action of the heart which Dr. Dudgeon had not noticed, and which did not perhaps come within the scope of his paper—those where there were very marked bruits, but where there was no disease of the heart whatever. He had observed cases, where through some nervous disturbance the heart had begun to be irregular, and at the same time showed very marked bruits, sometimes at the base, sometimes at the apex, and sometimes at both, and after treatment these symptoms would entirely disappear, showing that the production of the bruits was functional and nervous, and of the same character as the irregular action of the heart. He generally made it a rule, if he saw a patient of this kind for the first time, and found no history of rheumatic fever or probable existence of organic disease of the heart, to give a cautious diagnosis until he had seen the results of a few weeks' treatment; and in many cases this had been justified by finding that not only the irregularity disappeared, but the bruit entirely disappeared also. He might mention one medicine exceedingly useful in nervous affections of the heart—lycopus.

Dr. ARTHUR CLIFTON said he was the more pleased with Dr. Dudgeon's paper, because he had been in the habit of taking sphygmographic tracings every week of patients. He had had many cases similar to those brought forward to-night to which he could give no name. He had merely called it by the name of heart failure or want of nervous power. But whilst he used the sphygmograph he was sometimes much confused by the indications given, but they served his purpose, not so much for diagnosis as for reference from time to time to see how the patient was doing. From one of the tracings he should certainly have thought that the man had aortic mischief, whereas Dr. Dudgeon does not appear to have done so; and there were two or three other of the tracings which he should have set down to valvular disease, where he had not. Of course, however, Dr. Dudgeon was a far greater master of the subject than himself. He had seen many cases similar to those brought forward which had

been materially and permanently improved by medicines—and medicines different from those usually indicated by Dr. Dudgeon—in heart disease; and such medicines too, from the fact of their doing so much good, rather confirmed him in his diagnosis. The medicines he referred to were phosphorus and ignatia, and these two medicines had done more good to such cases than he had found from any medicine he knew of.

Dr. CARFRAE thought with Dr. Moir it would have been more interesting if Dr. Dudgeon, in reciting the cases, had also told them exactly what was the result of the physical examination of the heart by the stethoscope, and this would have confirmed or otherwise the suspicion entertained by Dr. Moir that some organic lesion would have been found.

Dr. R. HUGHES said the discussion they had heard showed that this question was one which constantly came before their minds when they were examining cardiac cases: Is the trouble in the substance of the heart or in its nervous supply? He thought that almost every set of symptoms for which patients came to them were referable to one or other of those categories, and very often might be assigned to either, and the question must really be determined by the concomitant symptoms, the history of the patient, and things of that kind. There was no doubt the vagus did exert upon the heart a controlling influence, which if stimulated would make the heart slow, and when cut off, as by division or paralysis, would set the heart off beating as fast as it could go, and which if stimulated irregularly would cause an irregular pulse, that would nevertheless have no significance, and, as Dr. Dudgeon said, would neither shorten life nor hinder one from activity. On the other hand, it was quite certain that if the muscular substance of the heart itself failed from fatty degeneration or any cause that weakens it, that too might show itself by irregularity of the heart's action before there was any evidence, to the ear, of organic disease. So that it might have a very evil significance or a very harmless one, and one must look at the concomitant symptoms. Such things as œdema of the feet (to which he attached great importance in all cardiac cases) must help to guide them in their conclusions. He would like to ask Dr. Dudgeon a question with regard to a remark which had impressed him very much. It had been said that where patients were conscious of intermission of their hearts' beat the intermission was functional only, and was due to some extraneous cause, while in true intermission in heart disease the patients were not conscious of the failure of

the heart. If that were a true distinction it was a very valuable one, and would aid much in determining the question which always confronted them in these cardiac cases.

Dr. MADDEN thought there could be no doubt whatever, that intermittent action, *per se*, was essentially an affection of the nervous system. It might arise in the brain, in the vagus or in the sympathetic system, whether accompanied or not by organic lesion. If accompanied by organic lesion, it might be secondary to that, in consequence of the ill-nourished nervous system, and not in consequence of the irregular state of the heart. They constantly found organic disease of the heart without the symptom of irregularity, and they constantly found irregularity without organic disease. They were not necessarily connected, and the important point for them to determine was whether there were both or only one. His experience had certainly taught him that irregularity was the least important of all heart symptoms as regarded serious prognosis, and in a general way he had come to the conclusion that heart symptoms of which patients were conscious were probably not due to heart disease, but to functional derangement. The more this was impressed upon them the more successful they would be in practice, especially in the way Dr. Dudgeon had pointed out—in not frightening patients unnecessarily. But even when there was slight—especially chronic—cardiac weakness he must confess that entire rest and non-use of the heart, or rather not exciting it to a little extra use, seemed to him to be bad treatment, as the exercise of the heart as a muscle was most important in strengthening it, just as it was in any other muscular portion of the system. He felt sure that Dr. Dudgeon's paper would be useful to himself and to others in the treatment of heart cases.

Dr. GOLDSBROUGH could not help thinking that the cases of purely functional affection of the heart, such as Dr. Dudgeon had described, were extremely rare. There must be some organic disturbance not observable by their ordinary diagnostic methods, which was the exciting cause of the irregularity spoken of. Were they not too apt to think of the heart as simply a muscle? whereas its innervation was a most complicated piece of mechanism, and indeed the muscular structure itself could only be kept in working order by the help of the nervous mechanism. But was not this particularly the case with regard to the cardiac ganglia themselves? If these were not kept in a good condition, the heart muscle was likely to fail, and soon they found thin walls and a very deficient and irregular action. He was in-

terested in Dr. Dyce Brown's remark with regard to the presence of a bruit where no positive disease could be discovered. He had seen one such case—that of a lady who was subject to severe attacks of angina pectoris. She had never suffered from rheumatism or gout, but was of a highly neurotic temperament, which he believed she inherited from her father, who died in the street from an attack of heart spasm. As a rule no organic mischief could be detected by an examination of her heart, but he had repeatedly noticed a bruit which he had attributed to a deficient closure of the aortic valves on account of insufficient innervation, and sometimes he had also noticed a mitral systolic which he had attributed to the same cause. At other times these signs were entirely absent. This lady suffered very much from intense pain across the chest, from the attacks of angina, which seemed almost to paralyse her for the time being. This pain had been relieved frequently by the medicine which has been referred to as a poison—namely, tobacco. It had been used several times with very great benefit. One could go on talking about medicines for a good while. There were several that had not been mentioned—particularly one, lachesis, which was very valuable in attacks of irregular heart.

Surgeon-Captain DEANE (a visitor) said that Dr. Dudgeon's paper had reference to a subject which for many long years had puzzled army surgeons. Palpitation of the heart had caused, and was still causing, an enormous amount of invaliding from the British Army; and when they had eliminated those cases which were due to something palpable and tangible in the way of anæmia, the results of rheumatic fever, and the cases of young and badly developed soldiers being overworked and overstraining themselves at drill, there was still a large proportion—more so than the last speaker would perhaps think—of cases where there was palpitation without any obvious cause. The men were in health; they were not anæmic, they had nothing the matter with them; they ate well. They went into hospital, and in hospital they got worse. But if their tobacco was knocked off, the palpitation stopped. Let the man get out of bed, and put on his tunic, and back came the palpitation as bad as ever. The case of the Colonel, referred to by Dr. Dudgeon, interested him greatly, because the disability passed off, and he would like to know to what extent civil practitioners met with the cases turned out of the army. They could not get rid of that stammering of the heart in the soldier. He became useless and was invalided. What became of such men? He believed with Dr. Moir that

many of them developed organic disease of the heart, and before they left the service they frequently showed signs of it in enlargement of the heart, and perhaps a little murmuring sound. The man who could give them a line of treatment which would enable them to keep those stammering hearts in the army had a great future before him. One of the first cases of stammering heart which he ever had to treat on his own responsibility was a soldier in Nepal, who had been invalided for this condition, though when examined (and he had over and over again examined his heart most carefully), there was not a sign of organic disease in it. All of a sudden, without any rhyme or reason, his heart went off at a gallop, and so it would be for hours. He was then young and enthusiastic, and gave a half drop of aconite in an ounce of water. A small dose always brought that man's pulse down to its normal beat. In India he had certainly benefited that condition of stammering heart with small doses of ordinary tincture of aconite. Still he confessed, as he was brought face to face with stammering heart in the soldier, he was nonplussed, and the custom in the army—he did not know what civil practitioners did—was to pass them on to somebody else. There was no doubt that the stammering heart of the soldier was caused by the unhygienic conditions under which he lived, and by the foul tobacco he smoked—often on an empty stomach. But when they had eliminated those cases which were aggravated by tobacco, there was still a very considerable proportion of cases where tobacco played no part, and of which, as Dr. Dudgeon had said, there was no explanation.

Dr. J. R. DAY remarked that the palpitation of puberty had not yet been mentioned. Some years ago he met with a case of that kind. The girl, about the age of puberty, had an extremely rapid pulse. He did not know whether it would come under the head of stammering heart—probably rather under the head of tachycardia—but this girl's pulse continued for many days at a rate of 120 to 130. There was no pyrexia, and there were no other symptoms except this extremely frequent pulse. He took no sphygmographic tracing, but the action apparently was regular though very frequent. Were they justified in regarding an intermittent pulse as of pathological significance? Considering that men, all their lives through, might have this intermittent pulse, and yet attain to extreme longevity, as was the case with the late Professor Sharpey, he thought it was not necessarily so by any means. With regard to remedies, he had lately had very satisfactory results with strophanthus, the first decimal dilution, in

cases of irregular heart, where dependant upon alteration in the circulation brought about by an alteration in the position of the body, resuming the vertical position from the horizontal, or again assuming the horizontal from the vertical.

The PRESIDENT said that they could all of them probably call to mind cases of irregularities of the kind spoken of by Dr. Dudgeon, which had gone on for many years. In some cases the patients might be still living, and in others they might have died of something quite irrelevant. He had one or two such cases in his mind at the moment. He thought they were all pretty well agreed that the heart was a good deal more of a nervous than a muscular organ, and that these irregularities depended upon disturbances of the nerves of the heart and must be attacked from that side. He had not heard any of the speakers refer to that kind of irregularity of the heart which was observable sometimes in cases of advanced nervous disease, such as when the patient had paralysis agitans. He had himself seen one or two cases of the kind, and in fact he had shown a tracing at one of the meetings of the Society a few years ago. The man had paralysis agitans which was of such a character that the voluntary muscles were in a state of constant fine tremor, in fact there were very often clonic spasms of the voluntary muscles, and the heart appeared to share in this, because, when the tracing was examined, it was seen to be not the usual thing at all ; but the up stroke and the down stroke of the tracing consisted of a very marked wavy line, as if the heart muscle itself shared in the clonic spasm. The bruit, to which Dr. Dyce Brown referred as being frequently present without obvious organic lesion, had come under his (the President's) observation several times, especially in cases of chorea, and he had put it down to an abnormal kind of susurrus of the heart muscle. Under ordinary circumstances the heart sound is tolerably uniform ; the susurrus of the heart muscle takes place in a regular manner, but where that regularity was disturbed they might have something very like a valvular bruit. Certain it was that it passed away, and no valvular mischief of any kind was found ; and frequently, where the opportunity for *post-mortem* examination had occurred, nothing had been found amiss with the valves of the heart in chorea, and cases, too, of an aggravated kind. There could be no question but that Surgeon Captain Deane was entirely right in what he had said about the abuse of tobacco in the army. He was quite certain, from several cases he had seen in hospital practice of old soldiers who had come with irregularity of the heart, that their troubles had been originated and kept up by the use of tobacco,

smoked the first thing in the morning on an empty stomach. Dr. Day's reference to the rapid pulse of puberty was also very interesting. That phase of disturbed innervation had doubtless occurred in the practice of most of them.

Dr. DUDGEON, in reply, said he was very much pleased with the manner in which his paper had been received. He thought, however, that a good many of those who had spoken had mistaken what the affection was of which he had spoken. They had spoken of palpitation, and a good many had confounded this with stammering heart. But palpitation of the heart was generally an increased action of the heart without any stammering. He had taken many tracings of patients suffering under palpitation, and, as a rule, the palpitation consisted of an increased jerky action of the heart without the stammering which had formed the subject of his paper. Dr. Moir seemed to think that if he had pursued the cases to the bitter end he would have found in cases of stammering heart a fatty degeneration, or something of that sort. But, unfortunately, his patients had not had the kindness to put themselves upon the *post-mortem* table, because in regard to none of the cases of stammering heart which he had related had he had an opportunity of being in at the death. Only one of those mentioned by him had died; and that person did not die under his treatment, but had, in fact, left his care for several years. Dr. Moir remarked that the Colonel's regular heart occurred during bronchitis when there might have been febrile action. But it was not so; because the heart remained regular both before he had the attack of bronchitis and after the attack of bronchitis was gone: so that he had an interval of perfectly regular action. Therefore he could not say that the regularity was caused by the disease from which he was suffering when he saw him last, which was only an ordinary cold with some cough.

With regard to bruit. This he had not alluded to at all. There was no question in any of the cases he had brought forward of any bruit. In fact, as he had said, in all those cases when he had the opportunity of examining them when the heart was not stammering there were no physical signs whatever on auscultation. He was perfectly aware that bruits would occur in the heart without any existent disease, either valvular or otherwise; but at the same time it occurred in a pathological state. As far as his experience went, either anæmia or something of the sort would produce that bruit; but then one could not say that the patient was not suffering from disease. He was afraid the cases he had brought before them were destitute of interest because they

were not accompanied by disease, as far as he could make out. He had not mentioned all the medicines that had proved useful in irregular heart, because as a fact he had never found any medicine of any particular advantage in the particular affection which he had described. Sometimes the patients would seem to be a little better for a glass of wine, or a dose of digitalis or glonoin, or some medicine of that kind, but at other times the medicines given did not produce the slightest effect. It had been suggested as a diagnostic point between irregularities of the heart due to organic disease, and those due to nervous affection, that the irregularity of the organic affection was not felt, while the irregularity of the nervous affection was felt. Now that was not at all the case with the stammering heart. It was sometimes felt very acutely, and sometimes was not felt at all. The ordinary stammer of intermission might be felt, but it also might not be felt. He was himself a victim of the disease—if it could be called a disease, and sometimes his heart took a fit of intermittency every third beat for months at a time. Yet he never noticed it except when he put his head down on his pillow and heard his heart beat, or, of course, when he put his finger on his pulse; and on many occasions he had been quite surprised at other people telling him that his heart was intermittent, as he had not felt it. Perhaps those present would say that was not a nervous affection, but that, as he had, as Dr. Hughes knew, very well-marked arcus senilis, it was a sign of fatty degeneration. However, it certainly did not prevent his doing anything he wished to do. Dr. Goldsbrough had said that there might be organic disease which the physician could not detect, for the physical signs were unknown, or of so slight a character that they could not be detected. It might be so; there might be organic disease, but it was not perceptible, and so he must say *de non apparentibus et non existentibus eadem est ratio*. Their very honoured visitor had given them his experience of palpitation in the army, and palpitation might be a very common affection among the soldiers. Probably a good deal of the palpitation of the soldier was due to anæmia, while a good deal was most likely caused by the excessive use of tobacco and of stimulants, because all those things rendered the heart very irritable and easily excited. But that was *not* the stammering heart that he alluded to, which would not prevent the soldier doing his duty. The palpitation of puberty was of the same character—a palpitation, not a stammering. The sphygmograms in paralysis agitans, alluded to by Dr. Blackley, he had himself observed several

times. There were various irregularities caused by diseases of the kidney, diseases of the lungs, and various other diseases; but the irregularities he had brought before them were not, as far as he could discover, attended with any morbid symptoms, and even although morbid symptoms might occur in other parts of the body or other organs, these did not seem to affect the irregularity one way or the other. He had already shown how a conspicuous example of the febrile state would completely annihilate the irregularities or the intermissions for a time.

ON THE MEDICAL TREATMENT OF PLEURISY.¹

BY MIDGLEY CASH, M.D.

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WHEN our Secretary invited me to contribute towards the discussion on the treatment of pleurisy, and when I had looked over my note books for the last sixteen years to see what available material I had to draw upon, I confess I felt somewhat dismayed to find that I had nothing either original or particularly interesting to bring before you, and had it not been for the desire to do what I could, however little, to support the movement for these discussions, I should have felt constrained to have excused myself from the task.

Amongst the *predisposing causes of pleurisy*, probably the first is a tuberculous habit of body. Pulmonary tubercle is a fertile source of pleurisy, and a non-inflammatory attack in a young person is often of sinister significance.

Dr. Wurmb, of Vienna, has suggested that this has probably to do with a pathological change in the blood, caused, as we now suppose, by the tubercle bacillus. Similarly, gout, syphilis, influenza and pyæmia may all act as general causes for the disease.

Exciting causes may be traumatic, as in rib fracture, or by the check of cutaneous perspiration in a chill, or by the

¹ Read before the Society, November 3rd, 1892.

spread of inflammation by contiguity, as in pneumonia and tubercle of the lungs—the latter thus being both a general and an exciting cause.

Remedies for pleurisy may be divided into these:—

- (1) To abort an attack.
- (2) To relieve pain and cough, and to control effusion.
- (3) To remove accumulation of fluid—serous and purulent.
- (4) To promote convalescence and to keep up the patient's strength.

1. *To abort an attack.*—For this purpose we have several remedies, pre-eminent amongst which is aconite. Aconite will frequently cut short an attack of simple inflammatory pleurisy if used early enough in the disease. But it requires to be given early. If after using it for a few hours the fever still keeps up, it is useless to persevere with it; some other remedy must be chosen. It will probably be of less use, as also it is less indicated, in pleurisy of tuberculous origin. It failed with me in a case where pleurisy was secondary to influenza, and yet was apparently induced by the patient getting a chill when over-heated—the blood being clearly in a deteriorated condition. Dr. Wurmb says (*British Journal of Homœopathy*, vol. i.), he never saw aconite directly promote the absorption of fluid, but as this absorption does not occur while fever is maintained, then by cutting short the fever, aconite gives indirectly most valuable assistance in this direction. It is the great specific against inflammatory fever and inflammatory pleurisy. What other abortifacients can we reckon upon besides aconite?

Belladonna.—In Hahnemann's "Materia Medica Pura," translated by Drs. Dudgeon and Hughes, many well-marked pleurisy symptoms are brought out under this drug. Trinks thought well of it where aconite failed, and where the pain, fever, and dyspnoea announced the still unchecked progress of the malady, and he specially instances those constitutions disposed to tuberculosis, and where therefore aconite may not be sufficient. This is illustrated by the following case. Aconite was given by me to a young man, but it failed to relieve a small dry pleurisy near the apex of his right lung.

This disappeared under belladonna and spigelia. The failure of aconite was accounted for when, eight months later, tubercular arthritis manifested itself in the ankle, a younger brother shortly afterwards falling victim to a similar attack.

Arnica comes in for traumatic cases. We may not get, and must not expect always to find, the bruised feeling which is given in the text books, but when injury has preceded and caused inflammation, this drug may be of much service.

After the initial stage is over, and the disease fairly established, we require remedies to conduct it along mildly, to relieve pain and cough, and above all, to control the amount of fluid effused into the pleural cavity. These stages, though adapted for classification of remedies, are often ill-marked clinically. The first stage runs imperceptibly into the second. Often when called in we find effusion has already occurred, and our efforts must be directed to limit it.

Now, for this purpose, probably no medicine is so useful as bryonia. While aconite comes in for the initial dry inflammatory condition, its sphere, as we have seen, is largely confined to this, but in bryonia we have a drug which, while useful for the early stitch and dyspnoea, is specially potent when inflammation has gone on to fibrino-serous exudation, for it effects its absorption with the least possible delay. Dr. Trinks' evidence is strong here (*British Journal of Homœopathy*, vol. viii.), and I suppose when called in first to a case of pleurisy, by far the most frequent prescription in our school would be found to be aconite and bryonia in alternation. For myself, I may say this is, in the main, my usual practice, and many are the cases I have seen beginning with a rigor or shiveriness followed by fever, dyspnoea, pleural pain and cough, in which these two medicines have wiped out the trouble, and restored the patient to health within a few days. And whatever may be said against the practice of alternating remedies as a rule, we have in the setting-in of pleural inflammation such a running together and overlapping of the first and second stages that in many instances, as we cannot watch our

patients from hour to hour, we shall, I believe, do the best for them by giving aconite and bryonia alternately at frequent intervals. When, however, the dulness on percussion and decrease of pain evidence the separation of the inflamed pleuræ by the effusion of fluid, the time for aconite has passed by, bryonia only may be sufficient to compass its absorption, but sulphur is the remedy in which I have most confidence for the removal of fluid in the chest. It seems to be well spoken of by homœopathic writers in general, not only in the fibrino-plastic pleurisies, but also in the serous effusions of hydrothorax, whether this term be used for a chronic collection of fluid remaining after acute pleurisy or for dropsy gradually thrown out from a failing heart, or due to a deteriorated state of the blood as induced by kidney disease.

Speaking of sulphur, Dr. Wurmb says: "Sulphur penetrates the entire organism, even in its finest and most recondite portions. It increases the activity of vegetative life generally, and of the processes of secretion and absorption in particular. It accelerates the interchange of elements, and makes it more pervading; in a word, it fulfils all the demands upon which the removal of an abnormal product is conditional. Upon these grounds we apply sulphur to the removal of pneumonic infiltration, or serous exudations, and of old as well as recent deposits in the skin, the parenchyma, the joints and the bones." (Wurmb's "Studies of Pneumonia," 1857.)

As illustrative of the resolvent action of the drug, I cite the following case which occurred to me some years ago.

T. C., aged 14, from Plymouth, staying at Hele Cross, near Torquay, came to my dispensary May 24th, 1881.

History.—Always been a healthy boy, but last winter caught a cold, which resulted in an obstinate chronic cough.

Lifting a block of stone about three weeks ago, when working in his uncle's stone yard, he strained himself. Dyspnœa came on, which has increased ever since, but he has no pain.

(The late Mr. J. H. Nankivell, when in Cornwall, has shown (*British Journal of Homœopathy*, vol. xxiii.) how

often attacks of pleurisy are set up amongst the miners by the intense muscular exertion of straining at their work.)

T. C. was seen by a well-known doctor in Plymouth, who sent him to Torquay as the best place he could come to, but told his mother he was sure to die—nothing could save him.

Present Condition.—Appears to be in great distress; there is an extreme appearance of illness, with rapid panting breathing. Percussion over the whole of the left lung absolutely dull. No vocal thrill or resonance. Side of chest feels very hot to the hand, perceptibly more than the right. Auscultation over the left lung: Breath sounds are very faintly heard, and there is well-marked ægophony. Over the right lung respiration is harsh and exaggerated. The heart beats with its maximum apical intensity in the epigastrium, and a little to the right of this. There is no visible pulsation in the usual apex area, and the sounds are heard feebly there, while loud in the epigastrium. Pulse 112, temp. 102.9°. He sweats freely. Has a cough and expectorates mucus, no blood. There is no external bulging of the chest walls. Appetite and functions good, considering his condition, which is grave, and he feels himself to be very ill. I ordered him one drop of aconite 1x, and arsen. alb. 3x, alternately every two hours, and to go home and to bed at once. The next day I saw him at his house and found him lying on his left side; respiration 32 per minute. Further examination confirmed above report. He had slept well, and felt better, since he came to this house, where the air is good. On the 26th he was lying easily, and had slept well. Pulse 104; respiration, 32 per minute. On percussion I thought the upper part of the left lung posteriorly not quite so dull. Ordered a linseed and mustard poultice to the chest, and aconite 1x and sulphur 3x to be taken alternately every two hours. By the 28th he could breathe better. Sweats heavily in his sleep. Respiration 32, and pulse 96 per minute. I thought there was more vocal resonance over left lung, though no vocal thrill was to be detected. On examining him on May 30th, I found the dulness in *statu quo*. There was copious sweating, vocal resonance

louder, but fremitus poor. Breathing weak. The following day I put a Southey's trocar through the seventh costal interspace below left scapular angle, but no fluid came.

On June 6th, I found, breathing better, and his face a better colour. Slight improvement in percussion note. He now got sulphur 3x, and digitalis θ , alternately every two hours. The next day the pulse was a little over 80. Respiration 24 per minute. Heart resuming normal position. Percussion note still further improved. Finds himself less breathless on exertion. He looked better and was cheerful. Appetite good; functions regular.

By the 13th, apex beat was about normal position. Sweats much less. Stronger, and able to walk a little out of doors.

On July 5th, he walked two miles down to dispensary to see me, looking well and strong. A little dulness remained over left base, where also breathing was slightly deficient, otherwise air entered lung well; he had no dyspnoea, and scarcely any cough.

He came to see me at the dispensary on September 13th, looking very well and strong. Can walk for eight miles without effort. No cough, no dyspnoea, and altogether healthy; pulse 84. Ordered to work in moderation.

In April, 1883, he came down again about some little matter, and I really did not know him. He had grown into a strong, broad-shouldered, muscular young man, enjoying excellent health, and working as a monument mason. He had called on his former doctor to report himself cured, but when the latter heard what treatment he had been under, he turned rusty, and showed him out of the house. Under sulphur taken steadily for about three weeks, the effusion in this case all but disappeared, though it could not be said that the lung had completely cleared up for some time after he had apparently quite recovered his general health. I should like to have tried the effect of arnica had I seen the case shortly after the strain to the chest, which probably excited the inflammation in this boy, whose system was predisposed to the complaint by a lingering cold. The time for aconite was—as I now think—passed. And should I

meet with such a condition in such a stage again, I should feel inclined to give sulphur at once. The time also for bryonia had passed. Earlier it might have controlled the large effusion; so also had there been pain to indicate it, it might have been useful; when I saw him, there was no pain.

And this reminds me of a very different case. I once was called to treat a tall delicate girl of 16, who had exposed herself to cold one chilly night in March. She had a small dry pleurisy in the right lung, with friction sound; high pulse and temperature, which at the third day of my attendance still kept up to 103°. There was never any effusion, but she had a harsh, gruff cough, and the pain was so acute she was in terror to breathe, and held her breath with such success that I could hardly hear any respiratory murmur. She began to wander, got flushed, and the skin was bathed in perspiration. During four days I gave her aconite, bryonia, and belladonna, with hot linseed poultices to the side, but did not seem to myself to effect much till I gave her *drosera*. ("Severe stitches in chest when sneezing or coughing; must press on chest with hands for relief."—Hering) ("Stitching in muscles on coughing and breathing. . . . almost arresting breath."—Allen.) This acted quickly, so as to quiet the cough and much relieve her pain. She got a critical epistaxis, and very shortly the cough, which had been severe on waking, almost disappeared; the pain left, and she became convalescent.

For the relief of acute stitching pain—not necessarily only neuralgic or myalgic—I have given *ranunculus bulbosus* and *sceleratus*.

Farrington in his "Materia Medica," says:—"We may think of *ranunculus bulbosus* in inflammation of serous membrane, particularly of the pleura or peritoneum; when there are acute stabbing pains in the chest, in the case of pleuritis, and accompanied by the effusion of serum into one or the other cavity. Accompanying this effusion we find great anxiety, dyspnoea and distress, caused partly by the accumulation of fluid, and partly by the anxiety from the pains themselves."

Again, arnica has served me well for the removal of acute pleural pain.

Under the head, "*The Relief of Pain*," the use of *local applications* falls naturally to be considered. I may say shortly for myself, that along with internal remedies I use external applications, and should be sorry to be without them in treating pleurisies. Not only for the alleviation of the acute side stitch, allowing increase of power and comfort in breathing; for the lessening of the fever which severe pain and dyspnoea alone will account for; for a sedative action, therefore, upon the irritated nerves of the system, both locally and generally, resulting in better sleep and more ability to take food—for all this at the commencement of a painful feverish complaint we must be often indebted to the use of the hot linseed poultice, with or without a judicious admixture of mustard. And when the stage of severe pain is passed, when the presence of fluid or of plastic membranes in the pleural sacs calls for removal, we may do much to aid their absorption, and at the same time tone up and supple the rigid uneasy muscles by gentle frictions of rhus, bryonia or arnica liniments, and by supporting and protecting the thorax with applications of oil on fir wool or flannel.

As a case in point I may mention a case now under treatment where bryonia liniment has been of striking benefit. Its use aided convalescence from a right-sided pleurisy, causing perceptible increase in the respiratory action, and removing the sensation of a stiff wall in the side.

When, unfortunately, we have to do with a collection of pus in the pleural cavity, we shall, I believe, be consulting the best interest of our patient by removing it as quickly as possible, and for this we must have recourse to paracentesis thoracis.

Hepar sulph. has been credited as a useful remedy in this condition. I should, however, prefer, first, to withdraw the pus as by pneumatic aspiration, and then give some medicine such as this or silicea to prevent its re-formation.

To promote convalescence and keep up the patient's strength I have recourse to arsenic, especially the iodide and the chininum arsenicosum, to china tincture and to chininum

sulphuricum, which, besides their general strengthening or tonic properties, have special curative action on the lungs; a generous diet, as by red wine and meat; a pure, mild, bracing air, by moor and sea; the use of cod liver oil and some of the maltine preparations, especially for the young and tubercular. Of the prepared animal essences I have found Bovinine useful, and Carnrick's peptonoids given in hot milk, both to the young and to the old and feeble.

Cases of pleurisy must be considered as to their *ultimate probability of developing phthisis*, when lingering on in a state of partial unsatisfactory convalescence. These cases do extremely well, as a rule, at Torquay. The mild yet gently bracing atmosphere of our sunny hills sloping to the south, the shelter afforded from the cutting E. and N.E. winds, the very large average of sunshine all the year round—all these surroundings greatly favour the removal of old pleural adhesions and deposits, and by stimulating the respiration and benefiting the general health, help to put a definite end to long-continued danger of ultimate tubercular formation.

NOTES ON PLEURISY AND ITS TREATMENT.¹

BY HERBERT NANKIVELL, M.D.

Physician to the Hahnemann Convalescent Home, Bournemouth.

WHEN our Secretary asked me to read a short paper on the treatment of pleurisy and empyema, I felt that I was at a certain disadvantage in complying with his request. The cases of pneumonia or pleurisy which have occurred, in previously healthy people, in my practice during the past twenty-five years have been very few indeed—only five or six in all before influenza began to

¹ Read before the Society, November 3rd, 1892.

increase the liability to this class of disease. I suppose that this is really due to the same qualities of climate which tend to produce amelioration in more chronic diseases of the chest, for which Bournemouth and its neighbourhood have long been a resort.

The relation of pleurisy to phthisis is a well marked one.

(1) Pleurisy with effusion has long been recognised as a cause of phthisis; this is due to (α) the general interference with the lung function when that organ has been compressed for any length of time by the presence of fluid in the pleural sac, or tied down more permanently by bands of lymph, the result of pleural inflammation; (β) and further to the more or less direct infection of the lung by contiguous inflammatory processes, or by absorption of depraved effusions, or by the irritation set up by imperfectly organised false membranes, themselves liable to degeneration of structure; (γ) by the depression to the general health ensuing in the course of slow recovery from a debilitating and incapacitating disease. According to circumstances, the lung trouble may be primarily pneumonic, becoming caseous; or it may be primarily tubercular; or it may assume the slower fibroid degeneration.

CASE 1.—Miss H., aged 25, tall, delicate looking, had been under medical care (allopathic) in 1876 for pain in the left side. There was no fever. On examination, well-marked dulness and *œgophony* were noticed on the left side of the chest posteriorly. There was no marked cardiac displacement, and slight dyspnoea occurred only on exertion.

Bryonia was exhibited; absolute rest in bed and a dry diet ordered; the effusion steadily decreased, and in fourteen days the physical signs had disappeared, including the friction *redux*. She still remains in excellent health.

CASE 2.—Mrs. L. had a severe attack of pleurisy with serous effusion in 1871, at the age of 39. The serous fluid was on several occasions aspirated; the illness lasted nearly twelve months. Four years afterwards a severe hæmoptysis occurred, and she was sent to Bournemouth.

I found a contracted right lung with dryish crepitus in the upper third; there was a suspicion of crepitation in the apex of the left. General health was greatly restored; the lungs became drier, but there was always dyspnoea on exertion. With variations in health, specially caused by the approach of the menopause, this condition was maintained for seven years, and her life was enabled to be one of considerable bodily and mental activity. In the autumn of 1882 at her own home, her health began seriously to deteriorate, and a renewed attack of hæmoptysis (from which she had been free for seven years) was the immediate precursor of a fatal issue.

CASE 3.—G. W., aged 18, returning from an ocean trip took cold off the Azores. He walked into my consulting room one day in 1874, looking thin, but bronzed and healthy. On examination the left thorax was found intensely dull, the intercostal spaces bulging, and the heart pushed to the right side of the sternum. I was glad when he got safely into his own bed. After a few days, aspiration was performed and seven measured pints of pus were withdrawn: the pus was healthy. In about a month a recollection had taken place; an incision was made in the axillary line and a tube inserted. After a time I wished to make a posterior opening, but on passing a long probe into the pleural cavity I found the false membranes so dense and thick that I desisted. His health improved much, notwithstanding that he belonged to a "tuberculous" family; after three years he went to Australia still wearing a tube in the side. After two years' residence there, disease of a phthisical character was set up in the right lung, and he died.

I have related these three cases as illustrating some different tendencies, and results of pleural effusions in relation to normal recovery or the future production of pneumonic trouble as the case may be. There is, however, another well established connection between pleurisy and phthisis, and that is, where an intercurrent pleurisy is established in the course of a phthisis. I have never known an effusion to take place in these cases, the pleurisy is always "dry," and generally obtains in the lower thirds of

the lungs posteriorly or laterally. It is almost always of grave import, is accompanied by increased fever, and the dry sounds are generally in the course of a few days or weeks reinforced by moist crepitations, having their origin in the lung tissue. I think it is Powell who remarks that the causes of these intercurrent pleurises are due to the deposit of caseous or tubercular matter in the peripheries of the lung substance; a slight roughness is thereby induced first of all in the lung pleuron, and after a time as the deposit softens, the moist sounds become established. I believe bryonia is still the best remedy we have for controlling this double condition.

In speaking of treatment, I have chosen to narrow my subject somewhat; others will speak more directly of the treatment of the disease in its initial stages, but the best treated case of pleurisy may leave in the patient conditions which more or less inevitably lead up to a termination of life through the induction of fatal chronic disease.

1. The absolute removal of liquid effusions of any character must be accomplished, and unless these be purely serous, they should be removed by surgical means.

2. The absorption, or organisation of false membrane is a most important desideratum. Medically, much may be done by steady courses of *hepar sulphuris*, *merc. corros.*, and *ars. iod.* These courses must be reinforced by careful hygiene and diet, building up the patient's physique, and strengthening skin and nerves against "taking cold." Physiological rest should be for a considerable time most strictly enforced, and the patient absolutely forbidden to get fatigued or "out of breath," and true physiological exercise must also be enjoined by massage of the thoracic muscles, by careful lung drill, and by the discriminating use of very light dumb-bells and bar-bells, so that the damaged and contracted lung may have every opportunity of expanding. The question of climate, and especially of alpine climate, will have to be considered at this point.

3. Care should be taken that the very first indications of true lung mischief be treated promptly and energetically;

every day of their existence must be fraught with the greatest danger to the patient's welfare.

Before closing this very imperfect paper, I will relate shortly a case of diaphragmatic pleurisy that was under my care last February. A severe attack of influenza had quite prostrated a lady, aged 40; there were no complications, but the debility was great. After ten days she was allowed to walk to the sofa one evening, but soon after intense pain set in, deep in the right thorax above the liver. No morbid sounds could be heard either in front or behind; the pain, which was very intense, yielded to bryonia and gelseminum in a few hours, and convalescence was apparently re-established. In a week's time, in consequence of a slight imprudence, the same pain recurred on the other side of the thorax, and though at first no physical signs could be detected, in forty-eight hours friction sounds, followed by dulness on percussion, and oegophony were established anteriorly and posteriorly, as well as on the axillary border. The pleurisy was of a very curious character, and for several days slowly increased in extent, involving fresh spots of about two inches in diameter every two or three days till it reached a full half of the thorax. The debility was extreme, and painful dyspnoea considerable, but there was never much compression of the lung, and the patient made an excellent though tardy recovery, and there is now no indication of dulness, and the lung expansion is excellent.

I shall be glad if the relation of this case educes from members of the Society an account of their own experience in similar ones.

THE SURGICAL TREATMENT OF PLEURAL EFFUSIONS.¹

BY E. WYNNE THOMAS, M.D.

Surgeon to the Birmingham Homœopathic Hospital.

YOU have already heard the subject of pleurisy treated from a physician's point of view. It occasionally happens, as you know, that inflammation of the pleura is followed by the effusion into the pleural cavity of more or less fluid. This is Nature's way of relieving the inflammation when the disease has passed a certain point of intensity, but if the case is seen early, and the constitution is sound, it is not likely to happen often, because medicines, such as aconite and bryonia, will generally cut short the inflammation. When a considerable quantity of fluid has, however, been poured into the pleural cavity, the question arises whether this should be let out by a surgical operation, and it is my part now to place before you the rules which experience has led surgeons to lay down on this matter.

Let me tell you frankly that my experience, in such operation, is very limited. I have performed a certain number and variety of operations, enough perhaps to make me judge of their comparative advantages, but I shall lay before you the opinions of our chief authorities. I was house-surgeon at University College Hospital, under Mr. Erichsen, a good many years ago. Anæsthesia had been in use about ten years, but the second great discovery, that of antisepticism, was not to be made for another decade. Those were evil days, and I look back with a shudder when I think of the results of operations simply from surgeons not knowing the importance of cleanliness. Those educated in the last twenty years can little realise the change. At that time surgeons shrank from opening the great cavities of the body, such as the peritoneum, pleura, skull—and rightly so, so great was the mortality. Now these operations are performed daily with confidence, knowing that if

¹ Read before the Society, November 3rd, 1892.

rigid care is taken to introduce no dirt, all will go well; moreover, many of our best surgeons have abandoned the antiseptics of Lister as unnecessary.

Let me say a word about effusions in general. When a membrane or other part is inflamed, the inflammation is relieved by the transudation through the walls of the blood vessels of a portion of some of the elements of the blood. In the case of a mucous membrane it is thrown off from its surface, and passes immediately out of the body. If a solid part is inflamed, the effusion is into the tissues around, and in the case of serous membranes, the fluid is thrown into the cavity of the particular serous membrane affected. These effusions, then, do not constitute the original disease, but are its effects; and when these fluids are retained in the body they are often much more dangerous than the original disease. Thus in relieving a pleuritis, Nature fills the pleura with fluid which she cannot rid herself of, except at much cost and risk—like firemen who, in extinguishing a conflagration, drown the premises. We may say it is an accident that there happens to be no outlet for the fluid. Now great progress has been made in the last fifteen years in the successful treatment, by drainage, of effusions. For instance, it has been applied to collections of fluid in the peritoneum or its neighbourhood, as well as to parts after operation or accident, numerous instances of which will readily occur to your minds. We should, I think, ask ourselves whether, even if we could effect the absorption of the fluid by medicine, we ought to do so. Formerly patients were poisoned and invalided for years by the retention of pus, who are now quickly restored to health by operation, and I ask whether pleuritic effusions are to be treated on general principles or regarded as requiring special rules. Probably, we might say, certainly, no good to the constitution can result from the re-absorption of an effusion which has been stagnant outside the circulation for days or weeks. If taken up by the lymphatics and poured into the blood it cannot be utilised in the nutritive processes, but must be excreted by the various organs—kidneys, bowels, skin and lungs; and I feel sure that if we could obtain reports of 100

cases in which a considerable effusion had been absorbed, we should see that the health was impaired for months or years.

Pleuritic effusions are of various kinds, ranging from serous to purulent, but even in those chiefly serous there are pus cells, and often bacteria, and although the so-called serous fluids may remain in that state for many weeks, there is always a tendency in them to become more and more purulent or even septic. In proportion as they are purulent, so is the danger to the constitution of blood poisoning, if absorbed, and it is impossible to make a rigid division, although practically we distinguish them into serous effusions and empyemata.

We begin, then, with the serous effusions. To determine, in any given case, which we have to deal with, the safest plan is to use the aspirator, and if the fluid is found to be chiefly serous, we may, if we think well, proceed to draw it off. In this, the closed method, it is essential that extreme care be taken to ensure that while the fluid is removed, no air is admitted into the pleura.

When we ask, at what period shall the operation be done? we find great differences of opinion. (1) A very large majority advise that no operation should be done (i.) if the inflammation of the pleura is still active; (ii.) if the effusion is small in amount. Now Castiaux advocates a very early puncture even during the acute stage of the pleurisy, and even if the fluid is small in quantity. He maintains that this cuts short the inflammation. He operated thirty-seven times, in all successfully, and says the convalescence was in all the cases completed in a few days. Such a plan, if safe, as it appears to be, has great advantages: (i.) you withdraw the fluid before it has time to deposit its fibrin on the pleura; (ii.) you prevent increasing compression of the lung; (iii.) you at once restore to the lung its function, and (iv.) by preventing the absorption of the fluid you avoid the risk of poisoning the blood. Supposing there was a valve, by opening which we could at once drain off the fluid, it would be obviously the right thing to do. The operation as now done amounts to little more. Why, then, lose these obvious.

advantages by trying to promote absorption? This is a point I particularly ask you to discuss. Porritt warns us against rashly proceeding to operate. He further says "a recent effusion may give rise to urgent symptoms, even commencing cyanosis, which may become less urgent after further effusion, and tapping would in such a case only add to the danger." Why should it, I ask? Suppose, too, the further effusion did not relieve. The large majority of writers are for following the happy mean; they wish to give Nature a chance of re-absorbing the fluid herself with the aid of diuretics, diaphoretics, purgatives, &c. Just think of all these exhausting processes! Apparently they do not fear the consequences of interfering with the lung for several weeks, and getting it possibly permanently bound down by adhesions. All advise us to operate if the pleura is nearly full, or if there are signs of distress, such as cyanosis, syncope, &c. Bowditch says, if the effusion is stationary from two to four weeks, and the pleura half full, he would then operate; also if the fluid reached to the angle of the scapula he would operate after four weeks. He would wait for subsidence of fever in acute cases. Clifford Albutt says if the fluid rises above the angle of the scapula he would tap after two or three weeks. Anstey in the same cases would wait four weeks. Bowditch was very successful. Out of 386 operations, he did not lose one. Contrast this with Dupuytren's results, who only saved two cases out of fifty.

Toussaint gives the following statistics:—

4	deaths	out of	176	cases,	operated	upon	between	1	and	20	days.
6	"	"	80	"	"	"	"	20	"	60	"
1	"	"	7	"	"	"	"	60	"	120	"

showing that mortality rises in proportion as the operation is deferred.

These statistics, combined with Castiaux', clearly show that the operation is nearly free from danger, and seem to point to the advantage of operating early. Now I am quite willing to admit that practically we are almost compelled by our patients to adopt the waiting course, and I am not prepared to urge operation when the effusion is a very small

one, because I fancy the chances of wounding the lung hardly warrant the risk.

Where should the puncture be made? Considerable discussion has arisen on this point, but the balance of opinion is in favour of the eighth. intercostal space in the back. The really important matter is to do it above the line of the diaphragm.

There is a general belief that it is dangerous to draw off too much fluid at one time, the rule being to watch the patient, and instantly stop if any distress is produced; further, not to remove more than sixteen ounces in a child, and twenty-four in an adult. It must be drawn off slowly. The operation has to be repeated several times if absorption does not go on. Should the fluid become offensive, it must be treated by the open method.

It hardly seems worth while to discuss the various methods of performing the closed plan. As I have already said whether we use the aspirator or the trocar with a tube dipping into an antiseptic solution, the essential points are that the instruments shall be absolutely clean, the chest wall thoroughly cleansed, and no air admitted.

We next come to the purulent effusions.

Having ascertained by the exploring trocar that the fluid is purulent, there is only one course to pursue, and that is, at once to evacuate it, the only exception being in the case of phthisical empyemata. It is generally agreed that operations in such cases are out of the question, and only hasten the end. It makes no difference whether the case was originally purulent, or has become so, nor whether the case is recent or chronic. Clifford Albutt, who is slow to operate in serous cases, says, "I, therefore, dislike and reprobate all tampering with an empyema."

As to the method of operating, there are, as we may expect, differences of opinion; a certain number, apparently wishing to pursue what seems a milder plan, advocate the closed plan. The majority are for thorough and open drainage. There are three plans mostly in vogue: (1) Evacuation by an aspirator or trocar, on the closed plan; this seems to have answered frequently in the case of children.

The operation may have to be repeated. (2) The open plan—that is, incision and the insertion of tubes, the orifice being carefully covered with layers of antiseptic gauze on Lister's plan. Good results have often been obtained in this way, and no objection can, I suppose, be made to it in the case of children and young persons. But the safest, most scientific plan, and that adopted by the great majority of surgeons, is *pleurotomy*, that is, an incision of two inches to four inches through an intercostal membrane so made as to allow of thorough evacuation of all the fluid, and then kept open with free admission of air. By this plan even shreds of membrane can be extracted, the one and only point for care being that no fluid shall remain to become putrid. In doing this an incision must be made down to the pleura, and then, instead of incising with a knife, the closed points of Hilton's forceps must be thrust through, and the blades opened so that the pleura may be torn freely. By this plan one is less likely to injure lung and artery, and also the wound is less liable to heal too soon. Surgeons who have often operated inform me that they do not adopt strict Listerism. The air does no harm as long as the drainage is free.

One plan, viz., that of Dr. Morgan, I have seen remarkably effective. He passes a full-sized soft tube, the larger the better, through the chest from the fifth space in front to, say, the eighth behind.

Are ribs to be resected? I know a surgeon who treats his cases in children by always resecting the upper two-thirds of a rib; others prefer to cut out one to one and a-half inches of a rib, but others, as Porritt, object to the proceeding as being unnecessarily severe, and as barbarous. Porritt says, "It is a barbarous procedure, whose effects will tell upon the patient as long as he lives." Marshall, on the contrary, says, "It adds but little to the gravity of the operation, for the bone is soon renewed and the chest wall will be as strong as ever."

How are we to decide? It seems best to be guided by the local conditions, and to resect if sufficient room cannot be got without it. The operation is a very easy one, and is shown to have been very successful. I may add here that

as a later operation done for the purpose of allowing the chest wall to fall in when the lung does not expand, resection of several inches of several ribs has been found useful. In such cases an incision is made down in the mid-axillary region, and another nearer the sternum; the ribs are cut across and drawn out, and then the periosteum removed by scissors, otherwise the bone is not renewed.

At what point in the chest wall is pleurotomy to be done? Here, again, we meet with differences of opinion, one party selecting the fifth interspace below the nipple (on right), others choosing some part in the back—seventh, eighth, or even ninth space.

Mr. Marshall strongly advised tapping in the fifth interspace in front below the nipple, and gave the following reasons for his choice, but it is not quite clear to me that he was speaking of pleurotomy. He speaks of puncturing, not incising. If the chest be opened near its inferior limit, when the distended pleura is being emptied the chest walls fall in and the diaphragm ascends, and its inflamed surface covered with organised lymph will cohere with the costal pleura. The opening, if in the seventh, eighth, or ninth space, will often be closed by the diaphragm. A longer tube will be required, and will keep up irritation. He adds that adhesion between the pleural surfaces of the ribs, lung, and diaphragm will be prevented. I suppose he means that these adhesions are to be desired if the lung does not expand.

The usual point of selection is the seventh or eighth space in the back outside the angle of the scapula, on the ground that the thicker portion of the fluid gravitates there, and shreds of membrane can be most easily removed. If there be bulging of any part of the chest wall it is advisable to open it there, but if the drainage is not effectual an incision should be made in the usual place as well. The free opening of a pleurotomy is less dangerous than paracentesis; œdema of lung never follows it; the strain upon the lung is less severe.

Should injections be used? Not until there is some evidence of putridity or retention. The best is pure water,

or if more active measures become necessary, a little alcohol or salicylic acid may be added by means of a fountain syringe. Alarming symptoms have occasionally followed their use.

I have now brought before your notice what seem to me the most important points relating to the surgery of pleuritic effusions. I have said nothing about the concomitant use of medicines, because my time was limited, but I none the less urge you to work at the same time with both hands. While advocating the withdrawal of the fluid effused, I recognise that the diseased pleura and lung must be restored to their healthy state by the natural powers of the constitution, which can be greatly aided by medicine. I will now conclude with a couplet of Porritt's—

When in doubt,
Let it out,

and to this I add—

To keep it in
Would be a sin.

Dr. DUDGEON said that he had practised in the pre-historic days, when opening the thorax was never thought of, or was at least, looked upon as a hazardous operation which must be left to the mightiest of surgeons. He remembered a case of pleurisy, with great effusion in the left side of the chest and great dyspnoea. This was more than thirty years ago. Now no one would hesitate to employ a drainage-tube; but as a disciple of Hahnemann he had perfect confidence that the medicine would relieve the effusion. But he was mistaken. The lady he was attending had a violent attack of vomiting, and ejected two or three pints of pus, and thus the empyema discharged itself. In another case he attended thirty years ago, the effusion was discharged between the fourth and fifth ribs, and the child made a rapid recovery. In dry pleurisy, he had heard no mention that evening of a medicine which he had found very successful; viz., cantharis. He was called to a lady a few days since, suffering from violent pleurisy in the right side. She could scarcely draw a breath without screaming. Temperature 102°; pulse 120 and upwards. He gave aconite, but found she had had a bad night; fever and pulse still high. He then gave cantharis and aconite alternately. Next morning the pulse was about 70. She had perspired profusely during the night.

Dr. CLARKE thought Dr. Dudgeon's experiences showed the efficiency of medicines given in assisting the operations of nature in getting rid of the pus. Dr. Hilbers had told him of a remarkable case of pleurisy with effusion, which filled one side of the chest. Arsenicum was given, and the effusion was absorbed. He was glad to hear Dr. Cash speak of belladonna. About seven years ago he was called upon to attend a lady, about 35, who was exposed to a chill and was seized with violent pains in the side which had lasted two days. Temperature 104° . Dulness at the base with ægophony. He gave her aconite and bryonia 1, but the pain and temperature continued the same, and she now had violent headache and throbbing arteries. He then gave belladonna, and the next day the pain had almost gone, and from that time she became almost convalescent. One indication of belladonna was the inability to lie on one side. It caused, usually, great sensitiveness. He had also found sulphur of immense benefit in many cases. He had used it with one lady who had hæmoptysis. She had attacks of catarrhal pneumonia; violent influenza of the old sort; bronchitis; violent pain in the left side, and desire to cough. He gave her a few doses of sulphur, which acted like magic, and the pleuritic trouble disappeared.

Dr. CLIFTON was glad surgeons could apply remedies when physicians were in vain. The main purpose of physicians was to prevent the effusion. He should not hesitate to call in the surgeon to aid in the evacuation of the serous fluid, but by the aid of three or four medicines he had been able to "abort" or control pleurisy. The medicines were belladonna, bryonia, and veratrum viride; the last when the temperature reached 104° , and the tongue showed the characteristics of this medicine. By the aid of these remedies he had generally been able to control pleurisy. He had known hepar sulphuris, iodide of sulphur, iodide of calcium, and arsenic used with effect.

Mr. HABOLD THOMAS instanced two cases which illustrated the surgical treatment of pleuritic effusion—one, a young man, aged 24, who contracted simple pleurisy in June, 1890. In three weeks pus had formed, and the chest was aspirated; in two days a small portion of the eighth rib was removed and chest drained. After nine days the pleural cavity was washed out with iodine lotion. The patient was much troubled with profuse night sweats, which were controlled by meals of rump steak and Bass's ale at midnight and 3 a.m. He laid great stress on the usefulness of the midnight meals. The next patient, aged 49, was cured after two aspirations with Potain's aspirator. Carefully compiled charts were exhibited.

Dr. HUGHES referred to Dr. Jousset's excellent clinical lectures, in which it was shown that good recoveries were made where cantharis was used. The same results might be obtained from the use of similarly-acting medicines as seemed to be achieved by the aspirator, the drainage-tube and other active measures; though he agreed with Dr. Thomas that if there were purulent matter it would be a sin to keep it in. Jousset cited a series of experiments made on dogs by M. Laborde, which showed that the action of blisters had in many instances been really homœopathic to the case. He had also found sulphur effectual where there was effusion.

Dr. DYCE BROWN said they were all agreed as to the value of aconite. But when aconite failed he had found baptisia answer, though he could not explain why it was so. Arsen. iod. had also been mentioned, but it was hardly efficient when the patient was in a weak condition; but when the temperature was not high, arsenic acted beautifully. Belladonna sometimes operated wonderfully. He agreed with Dr. Cash as to the value of sulphur. He did not think he should begin with it so early in the case as Dr. Cash did. When there were any signs of absorption he should go on with medicines.

Dr. MOIR said that it was impossible to separate pathology from treatment. Some cases were tubercular. There was a striking article by Dr. Barrs, of Leeds, in which it was said that out of seventy-four cases treated, there had been thirty-two deaths; but thirteen of these were cases of phthisis. When the disease was tubercular half the patients died within five years. Was the tubercle the result of pleurisy? In many children's cases pleurisy was overlooked. With regard to the treatment, they had to abort it when they could. In hospitals there were many instances in which the chest, on the admission of the patient, was full of fluid. If there were urgent symptoms—if within fourteen days there was too rapid an accumulation—he used the aspirator. In chronic cases, when it was not urgent to make a large aspiration it was quite enough to see what the effusion was, and try the effect of apis and other medicines. Out of seven or eight hospital cases of empyema he had lost two. One was tubercular—in another there was a septicæmic condition on admission. He agreed with Dr. Thomas that when a tube could not be retained resection was the best.

Mr. WRIGHT thought in a child of tender years it was not necessary to resect the rib. There was ample space between the ribs. In the more rigid chests of older people resection of the rib

was more often necessary. One of Marrant Baker's india-rubber tracheotomy tubes might sometimes be used for drainage, and the flange end of it prevented its slipping in. He thought the chest should be washed out as soon as possible. Fluid should not be injected, but simply allowed to enter by hydrostatic pressure. In some cases withdrawing a small quantity of fluid by an exploring syringe has been followed by rapid absorption of fluid.

Dr. NEATBY had found good results from apis, by which he had succeeded in emptying the chest of fluid. Another remedy was Koch's tuberculinum, which had been successful when the fluid was sero-purulent and of scrofulous origin. Cases ought to be watched after recovery for twelve months, particularly if there was a suspicious tuberculous history. He had found a cyrtometer made by Maw, Son, and Thompson useful in determining the development of the chest physique. The patient ought to be watched, and the effect of hill climbing observed. Care should be taken to see whether there is diminution or alteration in the size of the chest.

Dr. JAGIELSKI gave his experiences of chronic and complicated cases in dispensaries. There was great variation in the elasticity of the thorax. Up to the age of 24 the expansiveness reached three to three and a-half inches; but after that age it went down by one or one and a-half inches. The spirometer would indicate the increase of cubic inches. As to chronic cases, massage had been mentioned by Dr. Nankivell, but its effect depended upon how it was administered.

Dr. GOLDSBROUGH had found kali carb. very useful, and also tincture of iodine. Pleurisy had been controlled in less than twelve hours by bryonia. If there were no risks in an operation, surely it was our bounden duty to recommend a patient to submit to it.

Dr. NANKIVELL, in reply, observed that each of the readers of papers, though they had been separated from each other by hundreds of miles, had fortunately taken up different parts of the same question. He could have wished, however, that Dr. Cash had read his paper first, and that he had been sandwiched between Dr. Cash and Dr. Thomas. He agreed that cantharis was a valuable medicine, either by itself or with aconite or bryonia. The severe pain of pleurisy was apt to disappear a few hours after the slightest effusion had taken place. But it would not do to jump to the conclusion that it had then been controlled. Local applications were also valuable. He recommended the application of cotton wool covered with oil silk, and left on for twenty-four or

forty-eight hours, or even longer. It acted speedily as a poultice, and saved the patient a great deal of trouble.

Dr. CASH said that his object was to prevent effusion, and at the same time prevent excessive inflammation. Dr. Dyce Brown had recommended sulphur. He himself used aconite, which he employed until the pulse indicated subsidence of the fever. Belladonna was very useful, especially in tuberculous cases. It was preferable even to aconite. Dr. Wright had spoken of the benefit of withdrawing small amounts of fluid. He would go even further; a small puncture would stimulate the vital powers and set up absorption.

Dr. WYNNE THOMAS said the more he thought of it the more he believed that effusion was not a disease. He would not consider (in the same way) expectoration as a disease. The earlier the pleurisy was cut short the better. But when effusion is established relief should be given at once, instead of waiting week after week. He never used the spirometer.

ON THE SUCCESSFUL REMOVAL OF A LARGE OVARIAN TUMOUR, KNOWN TO HAVE EXISTED FOR AT LEAST EIGHT YEARS.¹

BY GEORGE BURFORD, M.B.

Physician to the Gynæcological Department, London Homœopathic Hospital.

DR. ARTHUR CLIFTON, of Northampton, brought up to town in September, 1892, a lady aged 52, for consultation, with a view to determine the propriety of removing a large ovarian tumour, which now was causing considerable sickness and no little pain. I say advisedly the propriety of removal, for, some eight years ago, the patient had consulted Sir Spencer Wells on exactly the same point, when the tumour was much smaller, and received from him the advice to undergo no operative treatment, but to allow matters to remain as they were. This advice was followed, until the embarrassing distension, the acute attacks of pain, the recurring crises of vomiting

¹ Read before the Society, November 3rd, 1892.

and the general impairment of the patient's health made it desirable to review the situation, to determine whether now operation were legitimate and desirable.

I found the lady with a large polycystic tumour occupying the pelvis and lower abdomen, and chiefly developed on the right side. There were some solid elements plainly to be made out in the right iliac fossa; but the major part of the tumour was fluctuant. As it was rapidly increasing in size, I advised operation with a view of relieving her of the more conspicuous symptoms, which were becoming more and more intolerable.

The following week I performed ovariectomy, finding, exactly as had been diagnosed, several cystic loculi, each containing some pints of fluid, and a large doughy mass, the inspissated contents of which refused to flow through the ovarian trocar. I therefore turned it out whole and entire, and with it the attached but emptied cysts which had been dealt with earlier in the operation. Fortunately there were no adhesions, and no bleeding. The pedicle was tied—an ordinary ovarian pedicle springing from the right broad ligament—the serous cavity flushed, a glass drainage tube inserted, and the operation concluded in the usual way.

Arnica had been regularly administered for a week anterior to operation; but immediately thereafter, its place was taken by bell. and merc. corr., given alternately each half hour for twenty-four hours. A troublesome flatulence now called for special attention, and a course of nux vomica, with the use of the rectum tube, was instituted. These measures relieved to some extent, but not sufficiently, and an aperient was administered again and again, in order to unload the intestines of their gaseous accumulation, but no purgation was effected, although the distension gradually lessened. Nux was continued for some days, and afterward china, as the convalescence became more advanced. Piles were complained of during the later stages of the recovery, although there was no local evidence of their existence; but all unpleasant sensations subsided as the intestinal evacuations became more frequent and more regular. The patient was sent home five weeks after operation with the

abdominal incision well healed, and the general health much improved.

Examination of the removed tumour mass showed it to consist of a large dermoid cyst, with fatty fluid contents, and of some three or four thin-walled cysts, containing amber-coloured fluid. This condition is quite in keeping with the patient's statements as to the existence of a tumour for eight years, with its rapid increase during the latter part of the time. Dermoids are notably of slow growth, and the original tumour mass was doubtless the dermoid cyst, large and dense, the contents of which could not be evacuated by the trocar. The remaining cysts were broad ligament cysts, probably of a much more recent origin, and it was the rapid growth of these which caused the notable enlargement of the tumour mass so distressing to the patient. These cysts often grow with a rapidity as remarkable as the enlargement of a dermoid is slow and dilatory. Abdominal section effected the removal of the entire tumour mass, to the great relief of the patient and the restoration of her capacity for a useful and enjoyable life.

ON THE OVARY AND ENDOMETRIUM CONSIDERED AS GLANDS.¹

BY EDMUND ALLEYNE COOK, L.R.C.P., &C.

I propose in this paper to consider, 1st, how far diseases of the uterus and ovaries may be looked at as diseases of glandular structure; 2nd, what influence abnormal nerve action has upon them; and 3rd, whether by considering these diseases as nerve irritation acting through glandular structure we may not get light on treatment.

In his observations on the nature of the ovary Tait says (p. 275) "the ovary then is a gland, developed as other

¹ Read before the Society, December 1, 1892.

glands, and formed of similar elements. Its peculiarity is that its cell nuclei have special powers during a certain period of life." And Johnstone, quoted by Tait (p. 326) says "in the ordinary acceptation of the term the endometrium above the internal os is not mucous membrane, but belongs to the so-called adenoid tissue, and that menstruation is for it exactly what the lymph stream is for the lymph glands, or the blood current to the spleen."

Here, then, we have views of the ovary and endometrium which deserve consideration, for if these can be regarded as glands in their functions, then circumstances which affect the growth, well-being, and decay and disease of glands generally will affect these. Wherever we find bone in the human body its nourishment and diseases are the same; wherever we find involuntary muscle it will be controlled by similar nerves, its diseases amenable to similar treatment; thus when we find a medicine having an action on the muscular fibre of the heart we may expect it to have a similar power over the uterus so far as this latter is composed of similar tissue, and *vice versâ*, the action being varied by function; and observed facts tell us that whatever will affect one gland in the body will affect similar glandular structure generally. The difficulty crops up at once of defining what we mean by a gland. With grammarians the adverb was a sort of sink—any word they could not classify under other heads was an adverb. With chemists in old times any matter they could not classify was "extractive"; and with anatomists and physiologists any organ lacking a class home seems to be a gland—sometimes it secretes, sometimes it does not—all the same it is a gland, only more so if it secretes. With such an all-embracing faculty it is much more difficult to say an organ is not a gland than to say it is one; but there are several views in which we can regard an organ, and if we can in all of them say it has glandular properties our belief in that special organ being a gland becomes emphasized. If we find it secretes, if we find it has glandular structure, if we find that the organ we consider develops in the opposite sex into an organ which has all a gland's properties of function and structure, then our idea is

confirmed. The ovary certainly secretes ova (a gland is not necessarily bound to have a *liquid* secretion), and has its origin from the same structure which forms the testicle in the male, but that it has ordinary glandular structure would not, I think, be commonly accepted; nevertheless we may reasonably view it as a gland. With regard to the endometrium, it has evidently secreting power and ordinary glandular structure. The part from which it develops becomes in the male of no importance.

We find in almost all studies, that when facts are looked at in various lights, analogies drawn, and theories formed, the theories are found thoroughly to fit the facts from the theorist's point of view only, and to fail from other points of view—no one theory is perfect. This is especially so in chemistry; yet, there has scarcely been a chemical theory advanced during the last thirty years, but we find the consideration of it has brought out and emphasised facts which otherwise would have remained dark, and progress in the science has been derived from all: there has been no theory but has been useful, provided it has been rigidly tested by experiment and only adhered to so far as results warranted. The *bete noir* of medicine has been that views or theories have been adhered to when the facts reviled them. How can we test this view of the ovary being a gland? If it be affected by disease, by medicine, by poisons as are other glands; if when it is affected other glands show sympathetic affection, then we are strengthened in our idea; and if we find that medicines when applied to diseases of the ovary because of what is known of their action on glands are able to bring relief, then we add to our knowledge.

We well know there are certain diseases special to glands such as Hodgkin's disease; of the influence of these on the ovary and endometrium there is, so far as I can find, no record. But there are other blood diseases as mumps, or scarlet fever, or smallpox, which have a special influence on glands. This influence is most probably due to an animal poison in the blood which poison is arrested at the gland and causes swelling and inflammation. The curious influence of an attack of mumps on the testicle has its

counterpart in its influence on the ovary, and when scarlet fever spends its venom on the tonsils, it also affects other glands and very strongly the ovary, and the effect of small-pox or rheumatism is similar. It is certainly very suggestive that the reason these poisons act similarly on structures so widely apart, is because they are similar structures, the difference of final result between the action, say, on the lymphatics of the neck or the parotid, being explicable by difference of secretion. If the poisoning is intense we know the glands break down. Indeed, the inflammatory deposit in any gland changes in three ways, it is absorbed and leaves no trace, or it breaks down into pus and is discharged, or it takes on a plastic organisation and remains, being then not easily acted on by medicine. The tendency to absorption is greater, the greater the outlet; the salivary glands have an outlet in saliva, the ovary has none but in ova. The poisonous material can easily get away in a liquid but scarcely in an ovum; therefore it can be easily understood how the effects of the one poison remain in the ovary as a chronic tenderness and enlargement, while the salivary gland returns to its primal state; again, it is a curious fact that the gonorrhœal poison will sometimes apparently pass by the uterus and spend its effects on the ovary, but since the endometrium regarded as glandular structure secretes a liquid and is subject to denudation there is at once a reason for apparent difference of effect.

As an instance of the action of medicine on glands, pilocarpine or mercury may be taken. Either will cause salivation in consequence of their action on the nerve controlling the salivary glands; but the action does not end here, for the whole of the organs of the body known as glands are deeply affected by these medicines, from the liver to the smallest lymphatic gland, and if the ovary be a gland and the endometrium gland structure, we should expect these medicines to have a powerful action upon them. Regarding pilocarpine, there is no literature of its effects on ovarian tissue, but mercury is known to have a deep action on it, and to cause a leucorrhœal discharge from the endometrium which may well be comparable to that

from salivary glands. Again, the effects of chill or cold on well-known glands have their counterpart in the ovary, and on the other hand there are the effects of removal of the ovaries of cows during lactation. When this function is in full vigor, if the ovaries be removed, then the lacteal glands, instead of ceasing to secrete after a certain time as in unspayed animals, continue to give plentiful supplies of milk without cessation; and I have a strong conviction that the ovary does not suffer primarily from any cause without showing effects of sympathy (probably from similar nerve control) on the other glands; for instance, I have now had many cases in which ovarian disease was accompanied by swollen tonsils, the tonsils swelling more and getting more tender with every aggravation of the ovarian trouble. There are other circumstances besides the above showing the intimate sympathy between the mammary glands and the ovary, and Freund has shown that there is no more certain mode of producing abortion than cupping the mammae and passing an electric current through them. The lymphatic glands of the body swell under certain conditions; any irritation of the lymph channels will produce swelling, poisonous or non-nutritive material travels up them and then sets up irritation most easily, which subsides, becomes chronic, or causes them to break down and decay; and if we take the ovary as a gland simply, we can understand how the gonorrhoeal poisons, or the poisons of the puerperal states act in enlarging the gland and that permanently. Tait states that when the uterus is enlarged by gestation the ovary is so also, and refers to Henning's table of measurements of ovaries under several conditions, and points out, backed by this authority, how the puerperal woman has ovaries increased in size beyond all other healthy states, and that the left ovary is enlarged far beyond the right, and he says that he has "no doubt this is explained by the want of a valve in the left spermatic vein." "As the ovaries rise in the abdomen with the pregnant uterus, their ligaments, their tubes and everything connected with them rise in proportional degree"; "it is therefore not to be wondered at that any incident which interferes with the involution of

the uterus after parturition should also affect the ovary." "It is therefore practically a sub-involution of the ovary with which we have to deal, and as in the uterus we have hyperæmia of the organ, gradually passing into chronic metritis, so we have a similar process occurring in the ovary."

The facts stated I do not gainsay, but the deductions from these facts are singular. The gland is stated to be enlarged from blood congestion; the vein is the outlet for blood from the enlarged gland; there is no constriction in its calibre, not even a valve; it is enlarged in proportion to the other organs; the uterus and ovaries rise in the pelvis, and therefore their veins have a smaller weight of blood to overcome, and yet we are told gravely that these conditions are sufficient to explain an enlarged ovary. If it be so then the laws of hydrostatics and hydrodynamics are abrogated in this especial matter (not an uncommon thing when a theory has to be fitted). When we consider this matter without bias we must see that were the veins smaller or otherwise constricted that would be an unanswerable reason for the enlargement of the gland, we should say our remedy was to enlarge them, and nature does that—we are told that the result of this action of nature is to cause enlargement of the ovary!! Poor nature! The whole problem is in what way the uterus, tubes, ligaments, and ovaries enlarge, why they decrease in size, why the process sometimes stops at a given moment. Tait well sees that the reason of all this is one and not several, and could we fit any theory to the facts it must and should explain all. He inclines to the idea that the ultimate cause is some nerve control referable to a centre or ganglion, but he enunciates no reason why the process stops in one case, goes on to health in another, and to hyperinvolution in a third. With regard to the evolution and involution of the uterus we know very little about the matter; but we *do know* that once emptied of its foetal contents the healthy natural course is for it to return in due time to nearly its original bulk, and any departure from this course is a diseased condition whether it stops short or proceeds too far, and must have some cause. A remnant of placenta, a

nerve shock, a retention of natural discharges, exposure to cold, gonorrhœal inflammation, are all possible causes. In diminishing in bulk the material disappearing goes partly into the blood current and partly is discharged, and as the uterus diminishes so also does the ovary; but this latter has no possible means of discharging its surplus material save into the blood current. So long as this surplus material is healthy all will be well, but if it be poisonous it will act on the ovary in like manner as it would on any other gland and cause swelling, tenderness, and breaking down. So long as there is a free discharge from the uterus after parturition there is scarcely likely to be a stoppage in the involution of the organ, but any spasm or doubling on itself preventing free outlet will at once cause the putrefying poison-producing discharge to act on the nerve supply, it may be in a similar manner as does the poisonous material of a bruised wound which results in tetanus—it may kill the nerve supply, or cause a tetanoid condition of the nerve. In the one case you will have stoppage of involution, for if the nerve be killed how can it act; in the other an increased action which may result in hyper-involution. There are certain well-known discomforts of the sub-involuting state, but the pregnant uterus at two or three months is at least as heavy as the sub-involuting one, and as low in the pelvis, therefore, since it causes no discomfort or even consciousness of its presence, weight alone cannot be any element in the discomfort of the sub-involuting state.

The strong influence of nerve action on gland structure—no matter whether set up by muscular action of contiguous parts, or by thought or emotion—is well known. The dog standing in front of a butcher's shop, dwelling, doubtless, with ecstatic thought on the delicacies on view, has his salivary glands affected beyond control. The effects of anger, excitement or emotion in stopping the supply of milk in a nursing mother, the effects of anger in disordering the liver, are instances of the effects of abnormal nerve action on a gland; and if the ovary be a gland, and the endometrium glandular, we should expect that any nerve action affecting them abnormally would have large effects in

evidence. It is said a woman feels with her ovaries. The seat of the emotions has been variously placed. Heart rhymes with so many words that poets have placed it there. The Turk considers it to be in the liver, and addresses his intimates as, "O! friend of my liver, O corner of my liver." Old David devoutly believed it was in the bowels, and some of us who have had troubles in examinations think there is truth in that. The German thinks melancholy emotions connected with the spleen, and finally emotion has found a location in the ovary. Certain it is that a woman with tender ovaries is a creature vibratile, susceptible to much emotional influence, and if you can allay the ovarian disease you rehabilitate her nerves. We know that ovarian disease will have vast influence in promoting epilepsy; and a little time back, a patient, aged 22, suffering with enlarged and tender ovary, which gave trouble in peritonitic attacks at irregular times, had some few days recovered from one of these and had been for forty-eight hours absolutely free from pain. Her ear needed syringing on account of a discharge, and the opportunity of her freedom from pain and discomfort was taken to syringe it. The operation was done with the utmost gentleness, producing no pain in the ear but a giddiness (which usually accompanied it). But with the giddiness this time, there occurred first, a sudden feeling of constriction across the upper sternum; second, a fierce pain through the ovary which lasted twelve hours, with headache; there was some weeping, but no unconsciousness; as she expressed it, "it seemed as though the ear were connected with the ovary."

The intimate nearness of nerve action and sexual erethism is far too often overlooked. It can scarcely be needful for me to point out how the sexual organs are influenced by every variation of emotion. The way in which the catamenia will cease on nerve shock, how labour pains will cease on an even expected arrival, how far fear will cause a paralysis of the sphincter vesicæ, all these without a particle of sexual feeling, prove the subtle and delicate influence of even a slight emotion. We know these things, and yet it is not often we take into account as a cause of alteration and

disease of the sexual organ the subtle influence of sexual feeling which must have a daily influence infinitely greater than the other causes I have mentioned. A girl grows up from girlhood to womanhood—

“Standing with reluctant feet
Where the brook and river meet,
Womanhood and childhood sweet,”

absolutely unconscious of what is dawning within her, because of the absolutely abominable social pseudo-delicacy which prevents her guardians approaching the subject; and as Ruskin says, “She may fall and defile her head in the dust if you leave her without help at some moments of her life.” Yet the social custom is to leave her without help, often without fellowship; leave her to find out for herself or by the instruction of nasty people things that are essential to her health she should know—how the good God has made her. And then we wonder at the outcome, that we have swollen ovaries, distended tubes, painful catamenia and all the ills which civilised life makes women heir to. More than that, in treating her ailments we do not keep sufficiently, if at all, before our eyes those subtle overwhelmingly powerful causes of her defects of body; let us consider whether it is not the fact that at this time of waking womanhood, she is overpowered by natural animal instincts and mostly with no more knowledge than an animal of what they mean. Now, we know there are drugs which will rouse sexual erethism in both sexes, *origanum*, *ferrum mur.*, *damiana*, *saw palmetto*, *iodine* are examples. Surely among these, if there be any truth in the homœopathic law, we can find means to repress sexual instinct in obedience to civilised conventionalities and amenities for the good of the individual. I think evidence could be produced to prove that, unless the female be a sort of sexless individual, in 80 or 90 per cent. of the cases of gynæcological interest which come before us we have as a root cause of abnormalities of function and form past or present sexual erethism, and I do not think there is a gynæcologist who professes to have found the consideration of this a ground of treatment, and I do not think gynæcology can be called scientific without its students give these things

their due place, which is a large one. It would not become me to take up your time with cases, but this I can state that the drugs I have named are valuable aids in small doses in allaying irritation of nerve. Take the case of a woman having tumour of the breast, and bear in mind Freund's demonstration of the influences of irritation of this gland on the pregnant uterus; then ask yourself whether it is probable or possible any such irritation can exist in the mammæ and not have its reflex action on the uterus and ovaries and vulva, and although the woman will not complain (she has nothing definite she cares to state) yet you will not cure her except by chance unless you take it for granted such irritation exists, and give remedies for it; and if you give damiana or origanum in dilution you will, even if you don't cure the tumour, get an amelioration of the general health. This I know from practical experience.

The ovary and its treatment is the opprobrium of gynæcology. If its surgical treatment was absolutely sure and entirely satisfactory we should have less to regret; but in this organ, while operation frequently relieves, it as frequently leaves matters in their unameliorated condition so far as pain and discomfort are concerned, while it would be, to put it mildly, inaccurate to say that the relief by medicines fulfilled our expectations and desires. To look at the ovary as a gland, and from this position to study its treatment, may be imperfect, but already this point of view has in my experience opened up some prospect of relief and is therefore worth pursuing. If I could reasonably hope to get help by looking at the organ as a nerve centre I should readily consider its prospects, for while I admit that were the Homœopathic law perfectly applicable it might answer all purposes, yet I know in our present imperfect application of it there is something left to be desired.

Dr. HUGHES said that some French physiologist had observed that a woman was what her uterus made her. He agreed with Dr. Cook in thinking that it would be more correct to say that a woman was what her ovaries made her, because the uterus was very little more than the receptacle of the ovary, in which lay

the centre of sexual life. Undoubtedly, a woman for a long period of her life was what her sexual system made her—in most cases unconsciously. He agreed that the ovary was to be regarded as a gland—he had always thought so, and it had helped him to think so. Much help could be derived in the treatment of obscure diseases of single women by remembering the part which the ovary had to play, and applying remedies accordingly. Help was then often given, though the patient was ignorant of the way in which she was helped. His list of remedies for these troubles was somewhat different from Dr. Cook's. He had no experience of damiana. But he had often found origanum useful. Platina was also serviceable in checking morbid tendencies. Dr. Blake had told him that next to origanum, platina was the best medicine in these disorders. Another remedy was lilium. These three drugs were the most effective he knew.

Dr. NEATBY mentioned one case of the connexion between the parotid glands and the ovary. He had reported the case in the *Review*. It was one of mumps. It was on one side only, and was followed up by ovarian pain and miscarriage without any obvious cause. There was no departure in any other respect from the usual course.

Dr. DUDGEON said that the ovaries were undoubtedly glands; but a definition of "gland" was required. In one sense every organ might be said either to be a gland or to contain glands. The kidneys were glands—the intestines contained glands. There was a great analogy between the ovaries and the testicles in a man. The former secreted one thing—the latter another. This analogy assisted him once in curing diseased ovaries in a very striking way. A lady complained of abdominal swellings. He found both ovaries enlarged to the size of a fist. Not knowing of any medicine which acted directly upon the ovaries he fell back on the idea that graphites, which had a distinct action upon the testicles, might do good. He used it and the tumours disappeared. It was nearly a year before they finally vanished. He had recorded the case in the *British Journal of Homœopathy*. His notion was that the glandular structure of the testicles had a great analogy with the ovaries. Dr. Cook had referred to the danger of girls being brought up in ignorance of their sexual system. He knew of a striking example of this. A mother told him that her daughter was suffering from curious symptoms. The young lady was the daughter of a clergyman, and very strictly brought up. He gave the mother a hint and the girl con-

fessed that she regularly masturbated. The girl did not know it was wrong until her mother explained that it was—both morally and physically. The girl had brought herself into a condition of extreme nervousness, and suffered from extraordinary fits of passion and of sulkiness, and was not the least like the other children.

Dr. BURFORD said they must not depend wholly on text-books. It did not follow that because a man was a good operator he was a good pathologist, and *vice versa*. In looking at the book of a distinguished pathologist he found it stated that the ovaries conditioned the function of menstruation. They had, however, little to do with menstruation. Remove them and the patient will continue to menstruate. Mr. Lawson Tait said the ovary was a gland. It was so in a rough sense. So are the tonsils, the red marrow. But it was not a gland in the sense that its secretion was influenced by nerves or the blood supply, as in the case of the salivary gland. It was shewn by the researches of Polus that the ovaries contained all the glands which they ever contained at birth. The ova tended to diminish. Apart from the stroma's development the number of ova diminished. If the ovary and the uterus are glands much more so are the tubes, though they did not secrete anything. The tubes and their surroundings had far more influence on uterine functions than the ovaries. If you removed a woman's tubes with the adjacent structures the function of menstruation, in 99 cases out of 100, would be stopped beyond recall. The uterus and the vagina found their culmination in the tubes. Suppurative lesions and inflammatory lesions were really inflammations of the tubes. The ovary was sometimes free from trouble, while the tube had been the root of all the mischief. Compare the ovary considered as a gland with the undoubted glands, *e.g.*, the breast. A tumour of the ovary in a girl was, in 99 cases out of 100, a sarcoma. In the breast it was not a sarcoma. The two structures on the gland theory were similar structures, largely knit together by that nervous plexus which united all the sexual organs. So far as the endometrium was concerned it was a gland because it secreted. The theory advanced by Dr. Cook was still inchoate and embryonic, but it was an excellent working hypothesis, from which good results had followed. But he would not bind himself to the hard and fast theory that the ovary was a gland. Experience showed that we gained little by pathological observations, but a good deal from observations of symptoms.

Dr. MOIR thought the greatest triumphs were to be looked for

in the way of prevention. There was a great future before us in that respect, and Dr. Cook's paper was full of suggestion of what might be done in the future.

The PRESIDENT remembered Dr. Dudgeon's paragraph concerning the action of graphites in ovarian trouble, and had found it very useful, and had often prescribed it. But at the same time it had not been proved to his satisfaction that the ovary was a gland after all. As Dr. Burford had said, this was a subject which required more working out. There was clinical reason for thinking it was not a gland. It did not answer to the clinical test. If there was one medicine more than another which had an effect upon the glands it was iodine in its various forms; but iodine had no appreciable effect upon the ovary. He agreed with Dr. Cook that the endometrium was much more of a glandular structure. He concurred with what had been said about the importance of avoiding false delicacy with regard to young girls.

Dr. Cook in reply to Dr. Dudgeon admitted it was not easy to define "gland." An illustration might be drawn from the difference between the hands of a washerwoman, which are constantly in water, and those of ordinary persons. In the washerwoman's case the cuticle seemed always to have some secretion which kept it moist. There was a swelling of the epithelial tissue, and this illustrated a primary gland structure. The lining of the membrane of the tubes was glandular for the same reason. They secreted more because there was more mucous membrane in a small space. Dr. Burford had said that he could not understand why sarcoma occurred in the ovary and not in the breast. But irritation of the mammæ would set up irritation of the ovary, and what affected the ovary generally affected the mammæ. He put forward what he said as speculations only. It was the heretic who doubted received doctrines who often led the way to discovery.

OBSERVATIONS ON THE DIURETIC ACTION OF
"APOCYNUM CANNABINUM," OR AMERICAN-
INDIAN HEMP.¹

BY BYRES MOIR, M.D.

Physician to the London Homœopathic Hospital.

THE root is the medicinal part of the plant, and the preparations in use are :—

1. Tincture.

2. Triturations of the root.

3. An infusion (of 1 oz. of the fresh root to a quart of water).

4. Hunt's Decoction ; an American preparation.

5. Keith's Apocynin ; also an American preparation.

Apocynin and Apocynein, active principles, were separated by Schmiedeberg in 1883, and are said to resemble digitalis in their properties.

This drug was, I believe, first brought to our notice in Hale's "New Remedies," where it is mentioned that in America it had received the title of a "veritable vegetable trocar," and in the same article Dr. Griscomb is quoted as saying "that this agent has four different distinct operations upon the system—causing (1) nausea and vomiting ; (2) this is followed by increased alvine discharges, which are succeeded by (3) copious perspiration, and in many instances (4) by diuresis." In Dr. Peter's proving with half a wine glassful of Hunt's "Decoction" three times a day, the urine was diminished by a third. Dr. Marcy's provings were made with the third dilution. Some diminution of urine was noticed for two days, then decided increase with dull aching pains in the kidney. Many clinical cases are given with splendid results, but the cause of the dropsy is not often definitely recorded. Several were evidently due to heart failure ; no mention of Bright's disease, as a cause, is given.

In the *Cyclopædia of Drug Pathogenesis* several new provings are narrated, but the results on the quantity of

¹ Read before the Society, December 1, 1892.

urine passed are quite indefinite, the amount being sometimes increased, sometimes lessened. Its action on the heart is well shown in the proving of Mr. Chapin (page 329). He took the hot infusion in $\frac{1}{2}$ oz. doses, and after the fourth dose the pulse, which to begin with was 68 and regular, was described by a medical friend as "full, slow, irregular, intermittent, dicrotic; at times feeble and readily compressed:" slight darting pains in region of heart; had to breathe deeply from feeling of suffocation. The weakness of heart and pulse lasted for some days.

The next important observation on apocynum that I have found is Dr. Murray's "Graduation Thesis on Apocynum Cannabinum," published in the *Therapeutic Gazette*, Sept. 15th, 1889. After saying that in America it has been specially recommended as a diuretic in renal dropsy, he mentions that Dr. Ringer had tried it in Bright's disease without getting any result; and states that "so far as our experience goes in this country, apocynum does not act as a diuretic in the class of cases of dropsy in which American authors have found it useful." He goes on to quote some experiments, as to its physiological action, made by Dr. Rose Bradford, who shows that its principal action is on the heart, resembling on the whole strophanthus more than digitalis. He gives a case of mitral disease, under Dr. Sydney Ringer, at University Hospital, in which it was used.

CASE.—A woman, 38 years of age, with mitral regurgitant murmur, œdema of feet and hands, cyanosis of face, and great dyspnoea. The pulse on admission was 128: and 16 ounces of urine were passed in twenty-four hours. Five minims of the tincture was given every four hours; increased the next day but one to ten minims. On the fourth day of treatment the pulse had fallen to 94, and 179 ounces of urine had been passed in the twenty-four hours. The dropsical fluid having been got rid of, the quantity of urine began to diminish while the pulse maintained a normal average.

He also records a case of mitral constriction, in which the good results obtained by digitalis were repeated, when, digitalis having to be discontinued, apocynum was given in its place. He arrives at the conclusion that its action, as a

diuretic, is similar to digitalis—through the heart and not as a local renal diuretic.

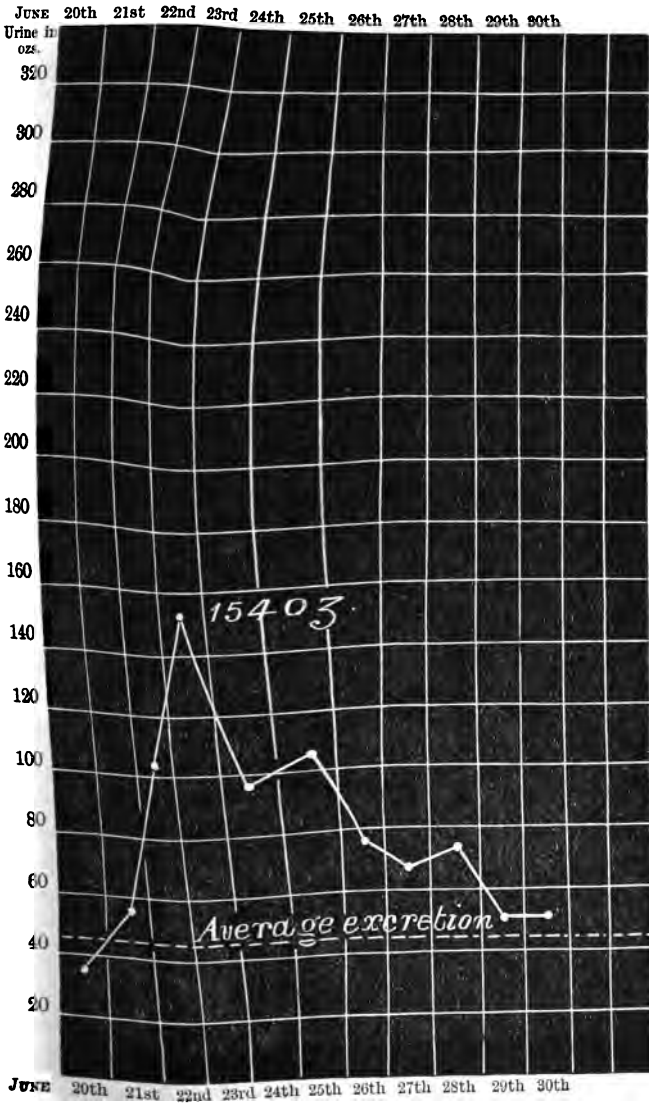
In our own literature on the subject I have found very few reports of the action of apocynum. In looking through the volumes of the *British Journal of Homœopathy* for the last twenty years, I only found two reports of cases treated by it. One was in vol. xxiii., 1865; an extract from the *American Homœopathic Observer* of a case of hydrothorax, reported by Mr. H. M. Warren as cured by apocynum cannabinum, five drops of the tincture every two hours. The other case was reported by the late Dr. Drysdale, in vol. xxxviii., 1880,—a case of ascites and anasarca, without heart disease, in which the diuretic action was most beneficial.

I will now record my own case, which shows the diuretic action of apocynum :—

The patient, a man, æt. 67, had for two years signs of heart failure, from fatty change, the pulse being quick, irregular, and feeble. The apex beat of the heart was two and a half inches below, and outside the nipple line; over this area a systolic bruit was subsequently developed, though it was not present at the beginning of the illness. Œdema of the legs came on gradually, with some swelling of the lower part of the abdomen and genitals and an effusion of fluid into the right pleural cavity. Under infusion of digitalis, strophanthus and mercurius, the quantity of water passed had varied from 23 to 50 ounces in the twenty-four hours. Once, under infusion of digitalis, it had reached 63 ounces, but the œdema had steadily increased.

On the 20th of June, 1892, the note was—pulse is so feeble and irregular that it cannot be counted; no dyspnoea. The œdema has steadily increased. Measurement round the calf of leg $18\frac{3}{4}$ inches. Bowels confined. Thirty-nine ounces of urine passed in twenty-four hours; it is loaded with lithates, and has a trace of albumen. Infusion of apocynum was ordered, one drachm three times a day. Only one dose had been taken before my visit on the 21st, but 57 ounces of urine had been passed, and after this a steady increase in its flow took place. 22nd, 107 ounces; 23rd, 154 ounces; 24th, 98 ounces; 25th, 102 ounces; 26th, 67 ounces; 27th, 65 ounces; 28th, 75 ounces; 29th, 50 ounces.

DR. MOIR'S CASE, SHOWING DIURETIC ACTION OF APOCYNUM CANNAB.



By the 15th of July the whole of the œdema had disappeared, and the calf measured twelve and a half inches (six and a quarter inches less). The apocynum was only given for ten days, and as soon as improvement began, only once a day.

On the 12th, after the apocynum had been discontinued for a week, the urine excreted fell to 34 ounces, but in three days again, when the medicine was repeated, the quantity rose to 72 ounces. After this the œdema was quite kept in check by the apocynum, but there was no great improvement in the heart or pulse, and the patient died three months later from heart failure.

I am indebted to Dr. Washington Epps for the following case showing the diuretic action of apocynum.

A girl, æt. twenty-one, was said to be suffering from a weak heart, but there was no bruit. Dr. Epps saw her for the first time on the 7th January, 1891, after an illness of ten days. She had then a pulse of 140, feeble and irregular, and was struggling for breath. He found double pneumonia, with effusion of fluid into the pericardium. Great œdema of abdomen and lower extremities, the abdomen being dull to the level of the umbilicus, and the skin of the legs stretched almost to bursting.

He tried tincture apocynum cannabinum ϕ , from one to four drops every four hours, without effect; also arsenic and phosphorus.

On the 20th January the condition was much the same, twenty ounces of urine having been passed in the last twenty-four hours. One drachm of fresh infusion of apocynum in one ounce of hot water was ordered every four hours. During the night three ounces of thick urine were passed.

At midday on January 21st, ten ounces of clear urine were passed, and from that time a steady improvement took place, the quantity of urine passed was as follows:—

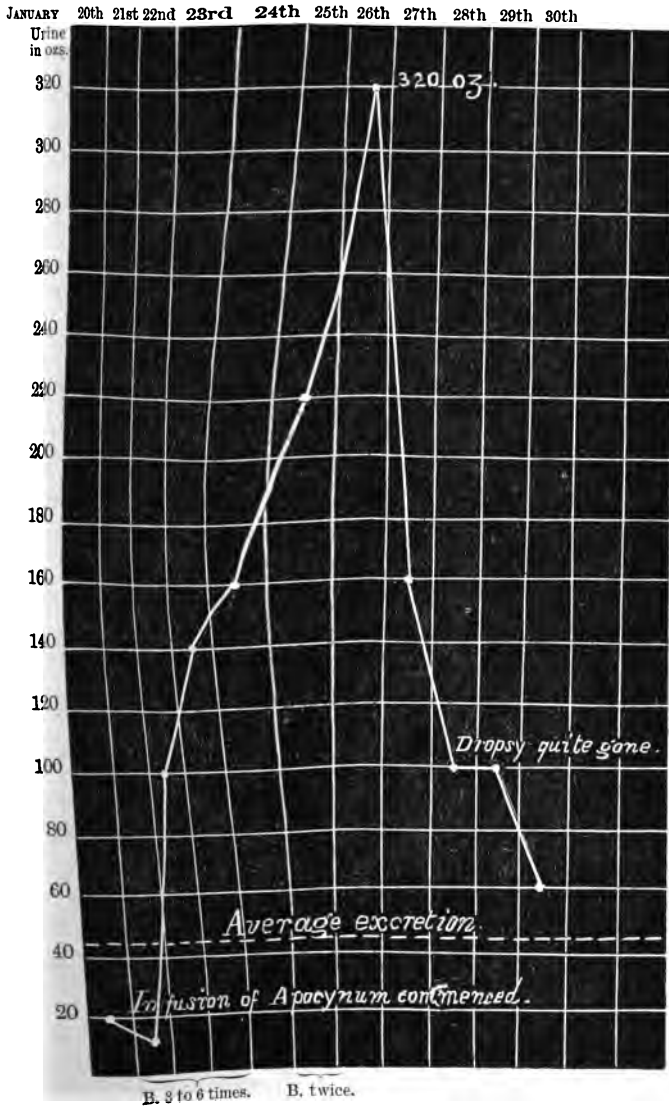
22nd, 100 ounces; 23rd, 140 ounces; 24th, 160 ounces.

25th, 220 ounces; 26th, 320 ounces; 27th, 160 ounces.

28th, 100 ounces; 29th, 100 ounces; 30th, 60 ounces.

By this time the dropsy had quite gone, and there had

DR. EPPS' CASE, SHOWING DIURETIC ACTION OF APOCYNUM CANNAB.



JANUARY 20th 21st 22nd 23rd 24th 25th 26th 27th 28th 29th 30th

been a corresponding improvement in the heart and pulse, and the patient made a rapid recovery. For the first three days the infusion was given the bowels acted from three to six times; then for two days twice a day, but were afterwards costive.

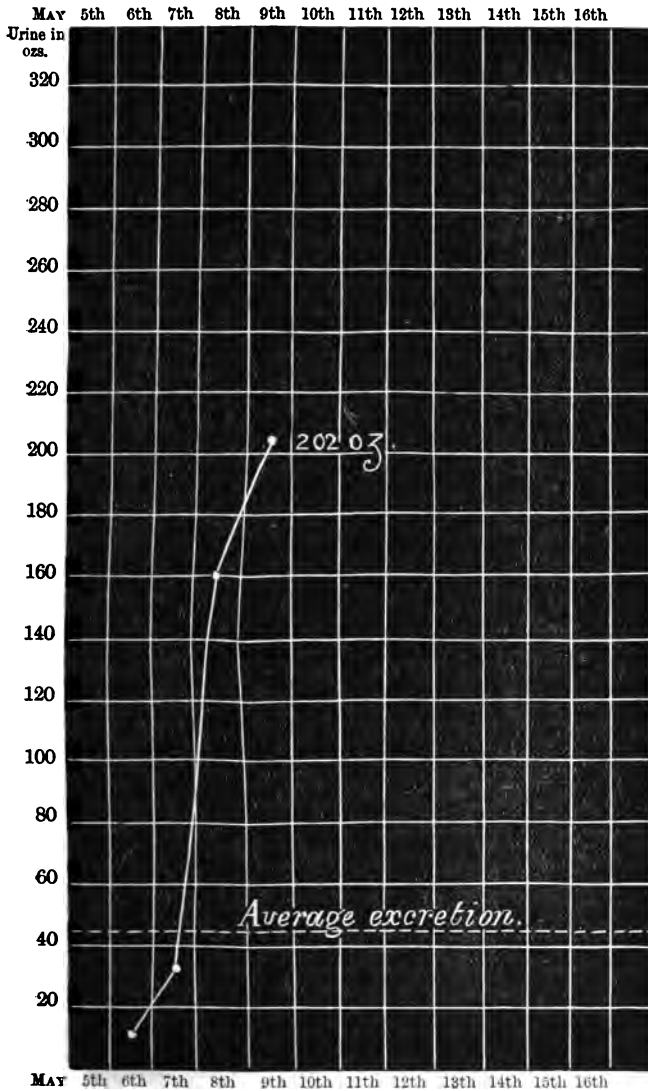
Dr. Blackley has kindly allowed me to make use of the following case exemplifying the action of apocynum as a diuretic.

A boy, *æt.* fifteen, was admitted into the London Homœopathic Hospital for heart disease and dropsy. There was a history of rheumatic fever seven months previously. The heart was enlarged, and there was loud mitral systolic bruit. He had ascites, and measured thirty-seven inches at the umbilicus. *Œ*dema of legs and genitals was very marked. On the day following admission, on account of the urgency of the symptoms, he was tapped, 192 ounces being withdrawn. In the last twenty-four hours ten and a half ounces of urine were passed. On the 7th May, he had passed twenty-six ounces of urine in twenty-four hours, free from albumen. He was ordered *ʒ*iii. of fresh infusion of apocynum three times a day. Next day he had passed 158 ounces of urine, and the swelling had gone down considerably. On the 9th May it was noted that he had passed 202 ounces of urine containing a trace of albumen. By the 13th, the urine had fallen to seventeen ounces, and the dropsy had nearly disappeared, with great improvement in the pulse and heart. By the 26th May he was out of bed and left the hospital on the 6th June, being free from dropsy and able to walk about. He was re-admitted on the 8th July, and died the next day from heart failure, but there was no return of the dropsy.

This case is not satisfactory with regard to the action of the medicine, as a great deal of the benefit was evidently due to the tapping, but both Dr. Blackley and Mr. Spencer Cox, who had charge of the case, were convinced of the undoubted diuretic action of the drug.

In addition to Drs. Blackley and Epps who kindly lent me the notes of the two cases I have just given, I wrote to twelve other medical men asking them for their experience

DR. BLACKLEY'S CASE, SHOWING DIURETIC ACTION OF APOCYNUM CANNAB.



of the use of this drug, especially as a diuretic and with regard to its action on the heart.

From these I had answers (with one exception). Seven state that they have had no satisfactory results. Four use the drug more or less largely, and from these I will first quote :—

Dr. Arthur Clifton, who sent me a valuable synopsis as the outcome of over fifteen years' experience of the drug, in a dozen cases of ascites and anasarca; mostly in patients over fifty years of age.

"In one-third of the cases, where the dropsy was dependent upon or caused by cardiac disease, or by kidney disease, *per se*, but associated with liver disease secondarily, the medicine did but little if any good, *i.e.*, did not reduce the dropsy,

"In the other two-thirds, passive congestion and enlargement of the liver were the primary causes of the ascites, leading to cardiac dilatation and kidney inaction,—the urine containing small amounts of albumen, but giving no evidence of true Bright's disease. In these the apocynum was all-sufficient in removing the water, stimulating the kidneys to pass as much as two quarts in the twenty-four hours. As well as the enlargement of the liver there was often more or less jaundice with pale stools, the bowels being sometimes constipated, but more often slightly relaxed; the urine being scanty, high coloured and loaded with lithates."

Though the kidneys have been so apparently over-stimulated, Dr. Clifton has never known the reverse condition on leaving off the medicine.

The drug was used in the form of Boerické and Tafel's concentrated decoction $\mathfrak{z}\text{i}$. to $\mathfrak{z}\text{iii}$. every four hours. He had tried the matrix tincture in doses of from five to ten drops without good results.

Dr. Alexander, of Plymouth, reports that he has used the drug for years with the greatest success in cases of œdema of the legs, and even of ascites, due to cardiac weakness. He divides his cases into two classes. (1) In cases with valvular lesions; in these the relief to cardiac distress

was very great, and was attended by a marked diuretic effect. The benefit was not always of long duration, recurrence taking place with more or less rapidity according to the gravity of the lesion. (2) In cases due to commencing dilatation of the heart from feebleness of muscular contraction, or perhaps fatty infiltration; the results here have been more permanent. He thinks that the drug has some specific action on the cardiac muscles, and though it may not be distinctly homœopathic, considers that it is a very useful and reliable medicine. He uses an infusion in ʒss. to ʒi. doses, which he finds acts better than the tincture.

Dr. Hardy, of Bournemouth, writes that apocynum "is a drug in which I have the greatest confidence, and as a diuretic in the anasarca of Bright's disease, and more especially of cardiac disease (mitral valvular disease with dilatation), it has no superior. For here, in addition to its power of diminishing dropsy, I am sure it is also a 'cardiac tonic,' like digitalis, steadying the pulse and increasing arterial pressure. (When digitalis is failing I turn to apocynum, and always with satisfaction). In pleural effusions it has several times helped me greatly." He uses the matrix tincture, five to ten drops three times a day, but whenever he has used the infusion in ʒj. doses he has been more pleased with it than with the tincture.

Dr. Percy Wilde, of Bath, states that he has never been able to arrive at any satisfactory conclusions with regard to apocynum, especially as to its action on the heart. He gave me the notes of two cases:—

(1). Ascites in a man, æt. 43, whose liver was enlarged, heart weak, and slightly dilated. Apocynum ϕ , \mathfrak{mij} ., was given four times a day, causing profuse watery evacuations. The dose was reduced to \mathfrak{mj} ., four times a day, but still produced watery stools, though less violently. There was no diuretic effect, but the whole symptoms improved, and the man was dismissed cured.

(2). A female, æt. 54, whose abdominal ascites was due probably to liver, which was enlarged. The urine was very scanty, but free from albumen. Apocynum had no effect; diuretin, no effect. Apis 3x relieved all the symptoms. He

has used the liquid extract, but with no particular advantages; it caused nausea, and he had a solid extract prepared, and gave it in the form of pills. He has also used the drug in tachycardia and nervous palpitation with slight benefit, but thinks that it is only under conditions of abdominal plethora that it does good in such cases.

I have given you one successful case occurring in my own practice, but my failures have been far greater than my successes. For several years I used the tincture, but never obtained any good from it. I then tried the fresh infusion in ʒj. doses, with better results; but I have just lately made a trial of the drug in the wards in four cases of anasarca and ascites for heart disease, and in not one of them was there the slightest improvement from the use of it. In all of them the failure of the heart was very advanced.

From the evidence I have brought before you to-night, there can be no question about the powerful diuretic action of apocynum, and also that it is very uncertain in its action. The two reasons for this uncertainty I would put down to (1) the unreliable preparations of the drug, (2) the selection of unsuitable cases.

This is only a short paper, and I hope in another one, before long, to be able to decide these points, and for the present would only say that the best preparation of the drug is the fresh infusion of the root: and that with regard to the suitable cases not much can be expected from it in the dropsy of an advanced case of Bright's disease or cardiac disease, but that Dr. Arthur Clifton has given us the key for the use of the drug, viz., "cases in which passive congestion and enlargement of the liver are the primary causes of the ascites, leading to cardiac dilatation and kidney inaction secondarily." In my own experience I have found little evidence of a direct action on the heart, but there is enough to show that it has a decided action, and I think that the source of its action must be looked for as well in the stomach and liver.

I will now only refer for one minute to the question, whether the use of apocynum in ascitès and anasarca is homœopathic?

In Dr. Drysdale's paper he says, "The action of the apocynum here may be fairly claimed as homœopathic, acting directly on the disordered capillaries and lymphatics, and not indirectly as a primary diuretic, for the dose, viz., four drops of the tincture *per diem*, was too small for a diuretic."

In 1870, the late Dr. Douglas Hale read a paper before this Society, entitled "The Drift of Modern Homœopathy," implying that the modern practice of homœopathy is drifting away from the early precepts of Hahnemann, and brought forward the use of apocynum in dropsy as an instance.

In the *British Journal of Homœopathy* for 1870 there is an answer to this charge by Dr. E. M. Hale, of Chicago, who maintains that apocynum is homœopathic to dropsy, arguing that apocynum is primarily homœopathic to profuse urine with excitement of the kidneys, and secondarily homœopathic to scanty urine with congestion of the kidneys; these two conditions having been produced respectively in persons from small and large doses. He appeals for the following law of dose, viz., "That opposite pathological conditions are caused by the primary and secondary effects of medicines; that their effects may alternate; and that a strict adherence to the law of similia should oblige us to take cognizance of this dual action, and select the dose in accordance with such action."

Dr. HUGHES was in favour of the soft "c" and the short "y." He had been disappointed with the drug in dropsy. He had only given it in tincture. Perhaps Dr. Moir would give the proper strength of the infusion.

Dr. MOIR: One ounce to one quart.

Dr. COOK had used the drug once or twice, and had come to the conclusion that it made all the difference whether or not it was a fresh infusion from the fresh root. In a meadow cattle would avoid buttercups, but in hay they ate the buttercups with the rest of the grass. The drying seemed to produce some alteration in the properties of the buttercup, and to effect the elimination of some active principle. A like result was observable with respect to cascara sagrada, which was very different according as it was old or not old. So fresh orange peel would not, but dried orange peel would, produce evacuations. So with burdock applied to the treatment of eczema.

Dr. BURFORD had only given the drug once, to a patient who had a large abdominal tumour with swelling of the legs. The dose was given in tincture, and the only effect was to double the amount of urine without affecting the total of albumen. She only passed more fluid through the kidneys, but the circumference of the legs was not altered. With regard to pronunciation he had asked a distinguished classical scholar, who told him everybody now pronounced *scybalæ* with a hard *c*, and the same would apply to *apocynum*. Dr. Moir's papers had struck out a new line, and he agreed with Dr. Cook that we are much too content to follow in the steps of our ancestors. There was every reason to believe that it made all the difference in what condition the drug was when it was administered.

Dr. DUDGEON said that Dr. Moir had asked whether the employment of *apocynum* as a diuretic was homœopathic. If an infusion of one drachm was given and a diuretic effect was produced it was decidedly allopathic. He did not suppose Dr. Moir had seen *apocynum* given in dilutions produce any diuretic effect. He had not had great success with it in any case of dropsy. He had seen violent purging produced which did no good to the patient. But diuretic action might be produced by homœopathic medicine in small doses. A gentleman had come to him with a large abdomen. He found that the patient must have had an attack of peritonitis. There was a fluctuation on every side except in one part, and he imagined that the peritonitis had caused some adhesions. Having had some experience of a dilated bladder he introduced a catheter, but found that the bladder was not distended. He gave him some *apis*, and the result was that the abdomen fell into its natural shape, and the patient said that he had passed an immense quantity of urine. This shewed the diuretic effect produced by a homœopathically acting medicine. Dr. Moir's large doses are allopathic. In one case he had given some doses of citrate of potash, and the dropsy disappeared. He gave 10 grains—two doses of 5 grains each. This was not homœopathic.

Dr. LOUGH, in a case of dropsy with albuminuria, had given 1 to 5 drops. He had never been able to report any result at all with it. He had never used the infusion, but would do so in future.

Mr. KNOX SHAW thought from what he had heard in Dr. Moir's papers that it was quite possible to ascribe a homœopathic action to *apocynum* in dropsy. Perhaps he might be allowed to refer to a paper he read at the Congress on the action of iodide of potash on tertiary syphilis. He had tried to show that the

medicine might be homœopathic to tertiary syphilitic nodes. In Dr. Peters' proving, after material doses of Hunt's decoction—a strong remedy—the urine was diminished; but with Dr. Marcy's proving with the third dilution, the amount of urine was increased. When proving with massive doses produced a given effect, moderate doses would relieve the corresponding symptom in the diseased state. But when a proving with a dilution revealed an opposite action to that induced by the large dose you must give a higher dilution if a curative action was desired. He had been accused by an American journal of leading homœopaths by a will-of-the-wisp for enunciating the theory. The basis of an admirable paper might be laid if the varying effects of provings with material and small doses of remedies known to be valuable were recorded. Some drugs appeared to produce two opposite actions. It would be interesting to know in each case in what dilutions it was proved. It was often difficult to judge whether a particular result was due to the drug administered. When he was House Physician at Guy's a man came with an enormous ascites. *Mistura cinchonæ* was given him, and whilst taking it he began to pass enormous quantities of water, and the ascites disappeared. It was impossible to say that this was due to the remedy.

Dr. JAGIELSKI would like to know whether any alkaloid had been discovered in apocynum. All analytical results were of great importance.

Dr. NEATBY had been much disappointed with the drug in renal dropsy; but he had much confidence in it in the cases described by Dr. Clifton when there was commencing heart failure, or a damaged heart due to diseased liver, or injury to the lungs through long bronchitis, asthma or emphysema.

Dr. Cox had had several cases during his long residence in the hospital, and the medicine struck him as of great value in most cases of dropsy due to the heart and not to the kidneys. But the infusion had to be given to get any result. The tincture produced no result.

Dr. EPPS said that in giving a drachm of the infusion not more than $1\frac{1}{2}$ grains of the root was administered.

The PRESIDENT said the short papers had been exceedingly interesting, and he wished they had them more frequently—everybody had something to tell about individual medicines, and much might be expected from collective investigation. It was important to distinguish cases from one another. The medicine did not act in all cases of dropsy. It was necessary to divide the cases into renal, cardiac, lymphatic, and other cases of dropsy, and old standing bronchitis and emphysema. Dr. Moir's case of

a woman was favourable to the supposition that the drug had a diuretic effect. But it was not always so. He had in the wards a woman *æt.* 45. For the last eight years she had had attacks of bronchitis resulting in emphysema. There was very extensive anasarca. The abdominal wall had increased in thickness from the amount of fluid. The urine was scanty, from about 15 to 25 ounces. Shortly after admission she was put upon an infusion of the drug. During the last 48 hours the amount of urine rose to about 22 to 26 ounces. She was now taking 3 drachms. She began on one—then two—then three; but there had been no material increase in the amount of urine, and there was still a trace of albumen. The woman's condition was desperate. He had given the tincture till he was tired, and he never saw the slightest effect.

Dr. MORR, in reply, said it was unfortunately not possible to get the drug fresh. Dr. Burford had said the drug had no effect on albumen, though it increased the quantity of water; this was the experience of others. Dr. Dudgeon had spoken of small doses being homœopathic, and large doses not homœopathic. That was not homœopathy—the essence of which was the similar action. High dilutions had been found to increase the amount of urine, and were homœopathic to such cases as diabetes insipidus. As to alkaloids two principles had been extracted, but most preferred infusions and tinctures to the alkaloids. In digitalis he found infusions acted better than the other forms of administering the drug.

LIVERPOOL BRANCH MEETING.

A MEETING was held in the Hahnemann Hospital, Liverpool, on December 1st, at which Dr. Hawkes (*President*), Drs. Hayward, Mahoney, J. D. Hayward, Gordon Smith, C. W. Hayward, Green, Murray Moore, B. Thomas, and Capper (*Hon. Sec.*) were present.

Some preliminary business, to which reference has been made in another part of the Journal, having been transacted:

Dr. CONRAD GREEN gave details of a case of continued fever which Dr. Hayward had attended with him in consultation. The patient, a young lady, had inhaled a bad smell while staying in the country. The early symptoms were

enlargement of the glands of the neck: then frontal headache, epistaxis and pain in the right side of the abdomen. The temperature kept at about 102° for some time: then fell to nearly normal: but afterwards began to rise very irregularly. There were continuous sweats throughout. During the last few days the temperature had been normal, after having been above the normal for eight or nine weeks. Baptisia was given for about three weeks at the outset, with other medicines in alternation according to symptoms: calcarea carb. 6 and sulph. 6 were prescribed for three or four days; then at Dr. Hayward's suggestion tuberc. 6 (Koch), for a week; latterly ars. 3 and calc. c. 6 were given for alternate weeks.

Dr. HAYWARD, commenting on the case, said that it appeared to him to be a case of incipient phthisis, cured with ars. 3 and calc. c. 6, and was specially interesting as it illustrated the good effect of prescribing symptomatically, when a prescription according to pathological changes had failed.

Dr. J. D. HAYWARD thought it was a case of typhoid with relapse. He questioned whether the treatment could be considered as prescribed only in accordance with subjective symptoms, since bapt. and ars. cause pathological symptoms similar to typhoid.

Dr. B. THOMAS described a case of gonorrhoeal rheumatism, which he had attended: and said that in obstinate cases of rheumatism, confined to one or two joints, it was often wise to enquire carefully as to the possibility of this cause of origin.

Dr. HAWKES exhibited a portion of the liver of a patient he had attended at the Hospital, and subsequently at her own home. Persistent vomiting; the passage of urine dark in colour manifesting the melanic reaction; and the light colour of the alvine evacuations, were the most marked peculiarities of the case. The whole of the abdomen was dull on percussion, and some difference of opinion existed as to the cause thereof. The patient, who eight years before had had her right eye removed for intra-ocular sar-

coma, gradually sank. At the *post-mortem* only a small incision was permitted, but this disclosed the fact that the liver almost filled the abdominal cavity. It was dark, nodulated, and hard, and microscopic sections made by Dr. Chas. Hayward established the view suggested by the urine, that the case was one of melanosis. The only helpful medicine was arsenicum, which seemed to mitigate the vomiting.

Dr. Hawkes also showed an ovary he had removed from the right inguinal canal. The patient had suffered much inconvenience since a confinement six years before, and ordinary appliances had not helped her. The ovary, which was oscillatory between the external ring and the upper portion of the labium majus, was reached by an incision similar to that practised in Alexander's operation. Adhesions were dealt with, and the ligament ligatured. The wound healed by first intention, save where a small drainage tube was inserted. The temperature, subsequent to the operation, did not exceed 99°F.

Dr. B. Thomas sent the patient into the Hospital, under Dr. John Hayward, who, having diagnosed the condition, transferred the patient to Dr. Hawkes' care.

The next specimen shown was a portion of an atheromatous aorta. Dr. Hawkes stated that he had recently lost the patient, whose malady had, *towards the end*, closely simulated aortic aneurism. Two or three observers had been misled by the physical signs, and he had incurred the displeasure of the patient and friends, in that he had not told them earlier of the existence of the alleged aneurism. During the last week or so the pulses were unequal, but not the pupils; there was dulness to the right of the sternum, and a systolic bruit was audible in the second intercostal space; and a peculiarly shrill cough was heard, not for the first time. These symptoms, together with dyspnoea, pain, and restlessness, led to another practitioner being called in, who, on hearing of a long standing pain in the chest, reflected somewhat on the diagnostic skill of the family attendant. A *post-mortem* revealed a greatly enlarged fatty heart. The

auricles were much dilated; their walls degenerated and thin. The right auricle was found to occupy the position assigned to the supposed aneurism, which was non-existent.

A discussion upon *Health Resorts* then took place, based upon Dr. Hayward's recent paper on "Grand Canary as a Health Resort."

Dr. HAYWARD, in opening the discussion, spoke of the fact, that patients of phthisical tendency could frequently overcome and eradicate such tendency by placing themselves under suitable atmospheric and climatic conditions.

Dr. F. MURRAY MOORE said that he had intended to compare the most favourable climate of New Zealand for consumptives with that of the Canaries, but had not yet had time to do justice to the subject. He feared that after hearing what Dr. Hayward had to say, there could be little comparison, but he had seen many cases do very well in New Zealand. The advantage of the Canary Islands was in the fact, that there was much less tendency to rain and storms than in New Zealand, where winds especially are very prevalent. He had had some doubt as to the water supply in Gran Canaria, but Dr. Hayward had satisfied him on that point. The advantages of New Zealand are that there is a long sea voyage, and that a patient is among his own countrymen, and can easily settle there. It appeared that a great deficiency in the Canary Isles was a lack of amusements, which is not the case in New Zealand. The temperatures of the latter place are, however, 4° or 5° colder in winter. There are great differences in the rainfall in New Zealand; the least is 25 inches per annum, and the highest 125 on the west coast. Thus in both groups of islands the west coast is the moister. The summer temperatures are about the same in the two places; but in New Zealand there is a breeze which makes it easier to bear the heat. Apart from the undoubted benefits of the sea voyage the Canaries have the advantage of being near. There is not so much to attract the eye in the Canaries, owing to the comparative absence of foliage. Dr. Moore also spoke of Tasmania.

Dr. J. D. HAYWARD quite endorsed the remarks of the previous speaker. He considered that it was absolutely necessary that phthysical patients should be placed amidst congenial surroundings, and there appeared to be a lack of facilities for amusement in the Canaries. He had understood from his reading that the climate of Guimar is really the best ; and made reference to Dr. Yeo's work on health resorts.

Dr. MAHONEY maintained that climate has far less to do with the cure of consumptives than is generally imagined, and that the essential feature was to attend to the manner of life, and general sanitation. He quoted cases, where an open air life with exercise, without change of climate, had proved very beneficial. If cases cannot stand the climate of England, and are sent away for a time, they frequently break down on their return. This is not a cure, and we must follow the Hahnemannian doctrine of ensuring a complete cure.

Dr. SMITH noticed the English health resorts, Ventnor, Torquay, and Penzance. He mentioned that Dr. Williams, who has had thousands of patients through his hands, advocates Ventnor as possessing far the best climate.

Dr. HAWKES mentioned the importance of early morning exercise in phthysical cases : but a respirator should be worn. He had sent one patient suffering from hæmoptysis to China, and he had never looked back since his return. One patient he sent to Crosby did very well ; and he also recommended Formby, but the house should be built upon piles. He had also sent patients to Australia, but had found indigenous fevers deleterious there. He spoke of Davos, Mentone, Bournemouth, and the Clyde ; and said he had been disappointed in West Kirby.

Dr. HAYWARD, in replying, said that there were many disadvantages, as well as advantages, in a sea voyage. Of our own climates that of Llandudno is a good example of a dry sea climate ; but it is at the same time far too moist ; and we cannot get a dry climate in England. The dampness of our warm climates puts them out of the sphere of health resorts for consumptives. In South Africa there are

many health resorts, but all suffer from heavy winds and heavy rains. In parts of Teneriffe there is plenty of foliage. With regard to amusements, there are theatres, public buildings, and even an English club. There are no cold winds in Gran Canaria. There is great advantage in our own coasts that are sandy, in the air being dried by blowing over the sandhills. Thus Southport has been highly spoken of. W. Kirby has been greatly overrated, as it has a damp cold air. He quite believed that the dry side of Teneriffe might be very good.

SOCIETY NEWS.

At the opening meeting of the session, held on Thursday, October 6th, the president (Dr. Galley Blackley) said that before passing to the business of the evening, he had to thank the Society for the honour done him in selecting him for the important office of President. He felt sure that the kindness and generosity which the members had always evinced to him in his capacity as Secretary would also help and support him in his arduous duties in the presidential chair. Members had received their notice papers, and would see that the Council which was appointed at the Annual Assembly had been far from idle. The Council had had two meetings, and the result of their deliberations had been two appointments, which he was sure would be received with approbation by every member of that Society. As to the appointment of the Hon. Secretary, his feeling was that if he (the President) had done well, it was in resigning the position of Hon. Sec., which he had held for the last seven years, in order to make way for so energetic and so evidently useful a man as their late President. He had had his eye upon Mr. Knox Shaw for some months before the end of last session, and came to the conclusion that here was the very man to carry on the work of the Society, not in the somewhat humdrum way in which it had been carried on recently, but so as to infuse new life and new spirit into the work. He felt that the time was come when they needed a little vigour infused into their proceedings.

The second appointment he was sure they would greet with equal satisfaction, which was that, acting upon the authority of the Annual Assembly, they had come to the conclusion to publish the Transactions of the Society quarterly, as a separate quarterly periodical, and Dr. Hughes had very kindly undertaken the duties of Editor of those Transactions. Dr. Hughes' name alone was one of the very best auguries for the future success of those Transactions, and he considered that success was already assured, and certainly, were any inducements necessary to outsiders to join the British Homœopathic Society they could now offer ample advantages. The Society he thought might feel quite comfortable on the score of expense, as he believed the outlay was not likely to be appreciably greater than it had been under the late arrangement.

Letters have been received and presented to the Society from Dr. Lambrechts, fils, and Dr. Boniface Schmitz, of Antwerp, acknowledging in courteous terms their election, at the last annual assembly, as corresponding members of the Society.

On Thursday, November 3rd, the following gentlemen, having been duly nominated as candidates, were elected by ballot:—G. Abbot, M.D., 11A, Standishgate, Wigan; E. Bellis, L.R.C.P.I., 4, Addison Terrace, W.; Ashley Bird, M.R.C.S., Stanwell Road, Penarth; H. d'Arnim Blumberg, L.R.C.P., Warley House, Southport; W. F. Blyth, L.R.C.P., 99, Approach Road, Victoria Park, E.; T. R. Brotchie, M.D., 102, Great Victoria Street, Belfast; F. W. Clifton, M.R.C.S., 348, Glossop Road, Sheffield; C. P. Collins, M.R.C.S., Norham Lodge, Leamington; H. E. Deane, M.R.C.S., Aldershot; J. Finlay, L.R.C.P., Greystone, Rawtenstall, near Manchester; J. Gordon, M.B., 70, Upper Parliament Street, Liverpool; C. T. Green, M.R.C.S., 33, Grange Mount, Birkenhead; Vincent Green, M.B., London Homœopathic Hospital, W.C.; J. Hamilton, L.R.C.P., 16, Eldon Square, Newcastle; J. D. Hayward, M.D., 15, Princes Avenue, Liverpool; J. C. Huxley, M.D., 91, Harborne Road, Edgbaston; J. McLachlan, M.D., 38, Beaumont Street, Oxford; D. Moir, M.D., 333, Oxford Road, Manchester; W. H. Rean, M.R.C.S., 36, Vernon Terrace, Brighton; W. Cash Reed, M.D., 8, Queen Anne Terrace, Plymouth; A. Roberts, M.D., Princes Square, Harrogate; W. Roche, M.R.C.S., 36, Berners Street, Ipswich; G. Scriven, M.D., 33, St. Stephen's Green, Dublin; A. G. Wilkinson, M.R.C.S., 28, Newland, Northampton; C. J. Wilkinson, M.R.C.S.,

112a, Chorley New Road, Bolton; Eubulus Williams, M.D., Beaufort Road, Clifton; J. Wingfield, L.R.C.P., Alcester Road, Moseley, Birmingham.

At a meeting of the Council, held on November 24th, the first branch of the Society was formed by the Council granting the petition of the Liverpool Homœopathic Medico-Chirurgical Society to become a branch of the British Homœopathic Society. It is to be hoped that this is merely the first of a series of influential and active branches being formed in other parts of the country. There is scope for the formation of local medical societies in two or three counties. The benefits of meeting for the interchange of thought and for the consideration of matters of interest in all branches of medical work is invaluable to the advance and elucidation of Homœopathic therapeutics and to the professional well-being of its exponents. The Liverpool Homœopathic Medico-Chirurgical Society has long been a power in the development and organisation of Homœopathy in the Lancashire district. It has already a membership numbering sixteen, and it will now probably increase its strength and position by drawing to its meetings those members of the parent Society who may be residing in neighbouring towns.

All members of branches are entitled to attend and take part in the meetings of the Society held in London, as well as those of the branch to which they are attached.

On Thursday, December 1st, the following gentlemen, having been duly nominated as candidates, were elected by ballot:—F. H. Bodman, M.D., Oakland Road, Clifton; J. Buchanan, M.D., 49, Stanhope Gardens, S.W.; J. P. Cavanagh, L.R.C.P., 57, The Tything, Worcester; R. P. Cox, M.D., 2, Lime Grove, Manchester; G. A. Craig, M.B., 63, Soho Road, Birmingham; J. Craig, L.R.C.P., Shelton House, Stoke-on-Trent; J. S. Craig, M.B., 137, Steelhouse Lane, Birmingham; J. Drummond, L.R.C.P., Shenstone, Great Malvern; F. Hall, L.R.C.P., Oak House, Bacup, Lancashire; J. J. Mitchell, L.R.C.P., 1, Howard Place, Stoke-on-Trent; T. D. Nicholson, M.D., 2, White Ladies Road, Clifton; A. J. Ockenden, M.R.C.S., 25, Regency Square, Brighton; A. Ross, L.R.C.S., Vernon Place, Scarborough; R. Gordon Smith, M.B., 164, Upper Parliament Street, Liverpool; W. O. Steinthal, L.R.C.P., 128, Tweedale Street, Rochdale.

The attention of members, especially those who have lately joined, is drawn to the Library of the Society which is at the London Homœopathic Hospital. It contains a very good selection of works bearing upon Homœopathy in all its departments, and has in the reading case a number of current Medical Journals of this country, of America, and of the Continent. Members are allowed to take books home to read, and it is hoped that arrangements will ere long be effected to make the contents of the library more accessible to country members.

The new additions to the library are the last editions of Norton's "Ophthalmic Therapeutics," Hughes' "Pharmacodynamics," and Ludlam's "Diseases of Women," as well as the *Therapeutic Gazette* and the *British Medical Journal*.

At a meeting of the Liverpool Homœopathic Medico-Chirurgical Society, held on December 1st, at the Hahnemann Hospital, it was resolved that in future the Society should be entitled the Liverpool Branch of the British Homœopathic Society, and that its meetings should take place on the second Thursday in each month. It was decided that a branch subscription of two shillings and sixpence be levied to meet local expenses. At the same meeting Dr. Hayward, senior, was elected as the Liverpool Branch representative on the Council of the Society.

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

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

SEPTEMBER—NOVEMBER, 1892.

In commencing a new series of the *Annals of the British Homœopathic Society*, the Council has thought it desirable that, out of the many journals taken by or supplied in exchange to the Society, excerpts should be made for the use of its members, embodying all observations pertinent to their specialty which have appeared during the three

months previous to the issue of each quarterly number. Homœopathy being a method of utilising the action of medicines in the treatment of disease, it is obvious that the facts which come within its sphere are those of pharmacodynamics and of drug-therapeutics. Our quarterly summary will, therefore, consist of these. They will be arranged in alphabetical order in one or other of these classes, according as drug or disease is the peg on which they hang, and will be indexed at the close of each volume.

This summary being compiled primarily for the use of members of the British Homœopathic Society, it should not, we think, include the British Homœopathic journals, which every practitioner of our school in the country ought to take and read. For the sake of completeness, however, we propose to give a reference to any noteworthy observations, pharmacodynamic or therapeutic, which have appeared in these journals during the quarter, leaving details to be followed up in their own pages.

PHARMACODYNAMICS.

Acidum aceticum.—Dr. Owens has had very favourable experience with this acid in cancer. In external forms of the disease he keeps the growth or ulcer moistened with the 2x dilution, giving the 1x internally; in cancer of the stomach he relies on the latter alone. He relates four cases, of which three seem undoubted instances of the disease.—*Medical Era*, September.

Acidum nitricum.—The virtues of this acid in menorrhagia (which the author—or editor—writes “hemorrhagia”), already exhibited by Drs. Ludlam and Claude, receive further confirmation in an article from Dr. S. O. Amerman in the *American Homœopathist* of Nov. 15th. The 1x dilution was given.

Arsenic.—A case of poisoning by this drug is recorded in the *Lancet* of Oct. 22, in which the sulphide was deposited over one-third of the endocardium of the left ventricle. The peritoneum was generally congested and of a rosy hue, especially over and in the region of the stomach.

Borax.—Lemoine has observed two cases of epilepsy in which, under the administration of borax, a bluish-grey line was observed on the gums resembling that produced by lead (there was no history of lead poisoning), and in both cases there was a

slight gingivitis, the gums being swollen and reddened; in one case they were also tender, and in the other there was salivation.—*Therapeutic Gazette*, September.

Cadmium iodatum.—Dr. F. O. Pease, in a proving of the 6x trituration of this salt, developed great itching of rectum and anus, felt during the day only. There was also constipation, frequent desire for stool without result, or only scanty discharge of dark brown offensive stools of clayey consistency. Tenesmus accompanied the stool and was also associated with the itching, which it felt as if it would relieve. There was much bloating of abdomen, with sense of fulness. Dr. Pease has verified these indications in practice.—*Homœopathic Physician*, November, p. 503.

Camphor.—In an article on the treatment of cholera in the *Artzliche Rundschau* (No. 34 of 1892), the following statements are made about camphor (without, of course, any reference to Hahnemann or homœopathy): “Camphor comes first among the older approved remedies. The spirit proved very effective in the frightful epidemic during the Bohemian campaign of 1866. Various persons who recovered stated that they could not sufficiently praise the extraordinarily warming and enlivening action of the camphor; whereas ‘schnapps,’ which had been given them before in lieu of a better remedy, in no way lessened the frightful algidity and dread of death, but rather increased the nausea and consciousness of danger. After an hour the camphor produced a comfortable sense of warmth, and after a day it enabled them to urinate.”—*Therapeutic Gazette*, September.

Cicuta.—A case of poisoning by this plant is recorded by Dr. Stonham in the *Monthly Homœopathic Review* of September.

Cocculus.—Dr. E. P. Colby contributes a short study of this drug to the *New England Medical Gazette* of September. He thinks that many of its symptoms point to Menière’s disease, and are better explained by a labyrinthine influence than one exerted on the crura cerebri. (His symptomatology, however, is of so mixed a character that it seems to us impossible to draw sound inferences from it). He describes, as conditions in which the remedy is useful, one of “deathly sickness” with vertigo, the face being pale, pulse slow and weak, and skin clammy; and the occipital pain of “tired spine.”

Colchicum.—In the *New England Medical Gazette* of November, Dr. Sutherland has an interesting study of colchicum in relation to cholera, to which—from a review of its pathogenesis—he shows it to be more truly homœopathic than any of our standard remedies for the disease.

Ficus indica.—Dr. Banerjee, of Calcutta, communicates to the *Southern Journal of Homœopathy* of September (which journal is now edited by Dr. Eldridge C. Price, of Baltimore), a proving on himself and nine others of the fruit of this tree. In eight out of the nine it seems to have caused phosphatic urine, and in five spermatorrhœa.

Hamamelis.—Dr. Lauder Brunton has a paper on the treatment of hæmorrhoids in the *British Medical Journal* of March, 1892, in which the sole medicinal treatment recommended is the local use of hamamelis, of which he prefers the proprietary to the pharmacopœial preparations.—*Therapeutic Gazette*, September.

Dr. Clarke contributes some new symptoms observed in a patient with varicosis, taking the first dilution of the drug.—*Homœopathic World*, October.

Hypericum.—Dr. McGilchrist, reporting the surgical work of the year in the Homœopathic Medical Department of the State University of Iowa, writes: "After every operation the wound is covered with a compress of absorbent cotton, wet with hypericum (watery extract), a dry compress outside of this, and a bandage over all. This dressing is not removed for several days, unless soiled. Hypericum, ten drops in \mathfrak{z} i. of water, is given in teaspoonful doses once in fifteen or twenty minutes for four or five hours; then once an hour for twenty-four hours, when it is discontinued. . . In nearly every case there was entire absence of pain, due to the hypericum, and primary union."—*Hahnemannian Monthly*, September.

Kali bromatum.—A case of acute poisoning in an infant appears in *L'Art Médical* for November. The chief symptom was general urticaria. It was preceded by great agitation.

Lithium.—Dr. Brant writes:—"I once had a case with the following symptom, and only this one, as the lady was enjoying good health with this exception; 'on inspiring, the air feels cold down into the lungs.' I recollected having noticed that symptom, so I went to work to find it. I spent several hours and found it under lithium carb. One dose of the 30x relieved her entirely."—*Monthly Homœopathic Review*, September, p. 550. [It is a curious satire on repertory making, that no such symptom appears in the pathogenesis of lithium. Who was Dr. Brant's authority? ED.]

Natrum sulphuricum.—Dr. Dahlke states that a bitter taste in the mouth is characteristic of natrum sulphuricum. A woman who, besides such a taste, complained of nothing abnormal, received the second dilution, three drops per diem. The taste disap-

peared after a few days, but as long as she took the drops she suffered from a morning diarrhoea, with rumbling in the bowels.—*Hahnemannian Monthly*, September, p. 655.

Nux moschata.—A case of nutmeg-poisoning is reported in the *Therapeutic Gazette* of September.—“The condition was one of low muttering delirium, with occasional silly laughter, the most constant hallucination being that she had two heads. From this condition she could be aroused momentarily by shaking her or speaking to her sharply, but she immediately relapsed into the same state. There was also a sense of impending dissolution, for she besought me piteously not to allow her to die. Her pulse was 120, of good strength and volume.” Vomiting had preceded this condition. She had taken about three nutmegs in powder to produce abortion. No uterine action was manifested. The reporter compares the action of the drug to that of *cannabis indica*.

Oleander.—V. Oefele, from the use of oleander in seventy-three cases of cardiac disease, concludes that the leaves, cortex and fruit have a therapeutic action which places the drug in the *digitalis* group. Its effect is prompt and lasting. The pulse becomes slower, more regular, and more powerful. Diuresis, with increase of the urinary solids, is brought about, and the stools are more abundant. The palpitation, œdema and dyspnoea of valvular disease disappear. The diuresis is more marked than with any other member of the group. Oleander has no such action on the vessels as *strophanthus*, and may thus be given in atheroma. A small daily dose is from 0.05 to 0.5 grm. of the crude drug.—*British Medical Journal*, October 22.

Phytolacca in Rheumatism.—Rheumatism of the right deltoid, of twenty-seven years' standing, in a man of 62, was removed by four doses of *phytolacca*, 3x, and there had been no return of the trouble six months afterwards.—*North American Journal of Homœopathy*, September, p. 631.

Plumbum.—A case of lead poisoning, in which death occurred from cerebral hæmorrhage, is given from an Italian journal in the *Hahnemannian Monthly* for October. Besides the arteritis it causes, lead is said to set up a chronic diffuse meningo-encephalitis.

Podophyllum.—Drs. Wilson and Harper have both had a case in which, under *podophyllum* prescribed for liver symptoms, old cataracts have cleared away. The former gave a high, the latter a low, dilution of the drug.—*Hahnemannian Monthly*, September.

Santonine.—A case of poisoning by a 5-grain dose in a boy of 9 is reported in the *Lancet* of October 29th. The symptoms

were those of collapse with cyanosis, loss of consciousness, and convulsive twitching of the limbs. Recovery ensued under stimulants.

Silicea.—A serious case of vomiting cured by this drug—to which repertory-searching led him—is related by Dr. Wolston in the *Monthly Homœopathic Review* of November (p. 662.)

Stannum.—Observations of effects of vapour in workers with tin are to be found in the *Homœopathic World* for September.

Succinum.—Dr. Morris Wiener reports that a proving of amber on himself developed symptoms of hay fever, and that he finds a 3x trituration remedial in the idiopathic disorder.—*Homœopathic World*, September.

Tarentula cubensis.—Dr. W. J. Martin some time ago reported great success with *T. cubensis* in diphtheria where the initial symptoms are febrile and inflammatory, such as in less toxæmic states would indicate belladonna. He now, after eight years, renews his testimony to its value. "So great is my confidence," he writes, "in the power of this drug to cure diphtheria of the variety I have tried to describe, that I feel as though there should be no deaths from this much dreaded disease, if recognised at once, and *T. cubensis*, in the 6th, 12th or 30th potency, immediately prescribed."—*Hahnemannian Monthly*, September.

Tuberculinum.—Dr. Jousset is using Koch's preparation; internally, in the third to the sixth dilution, where albuminuria persists after the other symptoms of renal mischief have been removed. He reports very good results.—*L'Art Médical*, Aug.—Nov.

Dr. Bernard Arnulphy, who for some years past has been practising at Chicago, relates his experience with this substance in tuberculosis. In chronic cases he has had but indifferent success. In acute tuberculosis, however, he describes it as having "the most wonderful remedial action he has ever seen," and relates three cases which bear out his praise. He gives the 6x—8x trituration, and advises the preparation to be freshly made.—*Medical Era*, October.

THERAPEUTICS.

Alopecia areata.—Dr. H. M. Bunting relates a case of this disease in which much itching of the scalp was present, cured in three weeks by *vinca minor* 200.—*Hahnemannian Monthly*, September.

(Dr. Bunting states that he cured this case in a, to him, "thoroughly Hahnemannian manner." How this should be does not clearly appear; for the itching of the scalp is a generic symptom common to hundreds of medicines, while the specific condition of baldness in patches does not occur even in the somewhat apocryphal pathogenesis of the plant supplied by Rosenberg—*Cyclopædia of Drug Pathogenesis*, iv., 419.—ED.)

Aortitis, Chronic.—Dr. Elias C. Price (*Southern Journal of Homœopathy*, September) records a case presenting the features of this disease as described by Tessier and Jousset. Great benefit resulted from a course of phosphorus 3x and convallaria ϕ , while a drop of glonoin 1 would arrest the paroxysms ("choking," as he called them) in a few minutes. The patient, who was 67 years old, was carried off by influenza and pneumonia, and no autopsy was made.

Aphonia.—Dr. Alex. Villers states that from a large experience with professional singers he finds arnica the best remedy for vocal fatigue of untrained voices, argentum nitricum for that of trained ones, and nuxvomica where the inability to exert the voice is part of a general "laziness."—*Homœopathic Physician*, September.

Bright's disease.—A case of plumbism is recorded in the *Hahnemannian Monthly* for October, 1892, where, in addition to colic, the patient showed great prostration, marked nausea, oppression of breathing, waxy pallor of face, frequent and copious urination. The urine was of low specific gravity, and by analysis yielded much albumen. On giving up his trade he became well, and remained so till his death by accident. The reporter cites several observations of curative results following the administration of plumbum in interstitial nephritis.—*Hahnemannian Monthly*, October.

Chorea.—Dr. Marc Jousset relates a case of chorea, in which antimonium crudum (3x trituration), given for anorexia and disgust at food, caused such marked improvement in the movements of the limbs that it was persevered with, and rapid recovery ensued.—*L'Art Médical*, November.

Cornea, Ulcer of.—In a case of superficial ulceration of the cornea, with intense photophobia, ulcer appearing as if covered with a layer of gray pus, silicea 3 and 30 cured in a very short time.—Deady, in *North American Journal of Homœopathy*, September, p. 632.

Diphtheria.—In *L'Art Médical* for September, Dr. Jousset relates a case of laryngeal diphtheria, with albuminuria, which

made a good recovery under *spongia*, which was given in the 1x trituration every hour.

Dropsy, General.—In a case of this disease, of six weeks' standing, *lycopodium* 15 induced diuresis within twenty-four hours, also diarrhœa; and in three weeks effected a cure.—Terry, *North American Journal of Homœopathy*, November, p. 759.

Enteritis membranosa.—Dr. J. R. Cocke relates a case of this rare disease, where the presence of the false membrane was established by microscopical examination by Dr. Sutherland. Before passing it, severe attacks of colic were experienced, which colocynth relieved (2x). The curative treatment consisted of *merc. corr.* 3x and *nux vom.* 2x. Under these remedies the attacks became fewer and slighter, and soon ceased altogether.—*New England Medical Gazette*, November.

Epididymitis.—Dr. Allison Clokey reports a chronic case of this affection, showing an enlargement almost hard as bone, with pains shooting up the cord. Under *aurum* 6x this disappeared in six weeks.—*North American Journal of Homœopathy*, October, p. 656.

Erysipelas.—In a case of this disease, appearing in the abdominal parietes, and involving the scrotum, the latter was found enormously swollen, dark, and superficially ulcerated. Delirium, high fever, rigors, and dry blackish tongue, were present. *Arsenicum* 3x arrested the gangrenous process, and completed the cure in four weeks.—Terry, *North American Journal of Homœopathy*, November, p. 757.

Glycosuria.—*L' Art Médical* for November gives an account of a thesis by Dr. Cartier on the toxic glycosurias, and especially on that produced by uranium. He studies the glycosuria of phloridzine (a glycoside found in the bark of the roots of various fruit trees), of the acids (which cause also the diabetic coma), of the narcotics (*morphia*, &c.), of the "agents stéatogènes" (*arsenic*, *phosphorus*, &c.), and, finally, of uranium. It has, he writes, for a constant property the production of glycosuria, though the sugar is not very abundant; there is always albuminuria also. It kills the animals experimented on in a few days, after having induced torpor, paralysis, somnolence, and actual coma; all these symptoms are accompanied by emaciation, slowing of respiration, and diminution of temperature. The liver and kidneys are the seat, first of congestion, then of fatty change. There is also gastro-enteritis, with ulceration of stomach (as observed by our own E. Blake), and predominating proctitis.

Goitre, Exophthalmic.—Dr. E. H. Linnell contributes a

paper on this disease to the *North American Journal of Homœopathy* for November, with three cured cases. In the first, *lycopus 4x—6x* was the chief remedy; in the second, it relieved the symptoms, but had to be supplemented by *ferrum* and *digitalis*; in the third, *iodine 30*, with *ignatia*, did all that was required.

Hiccup.—In a case of this affection, combined with pleurodynia, *ranunculus bulbosus 1x*, prescribed on account of the latter, cured both.—*Monthly Homœopathic Review*, September.

Laparotomy.—The value of medicines in aid of the success of these operations is appraised by Dr. Burford in the *Monthly Homœopathic Review* of November.

Madarosis.—Dr. John H. Payne relates a case of this affection, in which the eyelashes had been absent since infancy (patient being now 18). The edges of the lids were thickened, rounded and glazed, and itched much. There was eczema behind the auricles, and a chronic nasal catarrh; also, after washing face in morning, a stiff glazed feeling remained in the skin. These symptoms suggested petroleum, which was given (dilution not mentioned) three times daily. After two months, itching had gone; in another month the nasal catarrh was nearly well, and the lashes had begun to grow, and this they continued to do till they, with all else about the face, were in a normal state.—*New England Medical Gazette*, October.

Myxœdema.—A typical case of this disease, of three years' standing, was admitted to the Royal Free Hospital, in July, to be treated by hypodermic injections of thyroid juice. In consequence of the difficulty experienced in obtaining the latter, Dr. Hector Mackenzie was induced to try the effect of feeding the patient on fresh thyroid glands. The result has been a very striking improvement. The myxœdematous swelling has entirely disappeared, the temperature has become steadily normal, the skin moist and the speech natural. At first the thyroids of two sheep were given every day, finely minced. This was probably more than was advisable, because a remarkable acceleration of the pulse ensued, which lasted until the thyroids were discontinued for a time.—*Lancet*, October 15. In a communication to the same journal, of October 29, Dr. Mackenzie gives details as to obtaining and preparing the thyroids, of which he thinks one every other day sufficient. His patient looks and feels perfectly well, and her previously bald crown is now covered with thick hair.—In the *British Medical Journal* of the same date, Dr. Mackenzie relates his case in detail, and another is communicated by Dr. Fox, of

Plymouth, showing similarly good results. "Small doses" of the minced gland are recommended by the latter physician.¹

Neuralgia.—Dr. Jousset relates in *L'Art Médical* of September two cases of this kind. One was sciatica of six weeks' standing, cured in one week by *nux vomica*, 1x trituration, which he considered indicated by lancinations of pain on movement. *Bryonia* 3, given for four days, had had no effect. The other was tic-douloureux affecting the infra-orbital nerve, and dating from far back. Under *Thuja* 6 and 3 and *Coccus cacti* 6 and 3, the attacks entirely subsided for the time. This was a favourite medication of Tessier's, and both the present case, and some experience reported of old by Dr. Escallier, seem to show that the *Thuja* was the active agent. (On what authority does Dr. Jousset state that the pathogenesis of *Thuja* shews "sharp lancinating pains on the level of the upper jaws and in the teeth; the face becomes suddenly purple with the exacerbations of pain"? These symptoms are not to be found in Allen's "Encyclopædia," even among the apocryphal contributions of Dr. Wolf.—ED.)

Perinæal Rigidity.—In a pleasant paper on "The Perinæum in Normal Labour" (*Medical Advance*, August), Dr. Winterburn speaks warmly from large experience of the value of the free use of lard for reducing rigidity of vagina and perinæum. It should be not only introduced, he says, but rubbed in. It will break down the rigidity of the most obstinate perinæum, and prevent rupture.

Pleurisy.—To the treatment of this disease Dr. Jousset devotes a clinical lecture in *L'Art Médical*, October. He continues to account *Cantharis* the leading drug in its treatment, and relates two hospital cases illustrating its efficacy. In the first, a copious effusion on the left side, of several days' standing, causing absolute dulness and absence of respiratory murmur, disappeared in three weeks under the third dilution. From the third day of treatment free diuresis occurred, and therewith the dulness began to diminish. In the second, the effusion was enormous, and it was not till the eighth day of the treatment, and the use of the mother tincture, that improvement set in, here again with diuresis. Symptoms of acute œdema of the sound lung now appearing, 400 grammes of fibrinous fluid were removed by thoracentesis from the other side, and the *Cantharis*

¹A history of the "Method of Treatment by Injecting Physiological Fluids" is given in *L'Art Médical* for September. See also *Therapeutic Gazette*, September, pp. 609, 621.

continued. The patient, who had been admitted on May 8th, went out entirely convalescent early in June. In illustration of the homœopathicity of the remedy, Dr. Jousset cites the experiments on dogs of a M. Galippe; cantharidine, injected into the veins, caused, besides its usual genito-urinary troubles, a "double sero-purulent pleurisy." A case is also related in which a diaphragmatic pleurisy came on during convalescence from typhoid. There were such violent paroxysms of pain that on one occasion morphia had to be injected hypodermically. Bryonia was given, ten drops of the mother tincture during the day, and the malady rapidly subsided.

Salpingitis.—Dr. Marc Jousset mentions a case of left salpingitis presenting a swelling as large as an orange. Homœopathic medication (actæa, apis, cantharis, colocynth), with antiseptic applications to the os uteri (why these?), caused the swelling to disappear almost entirely, and a season at Croisic completed the cure.—*L'Art Médical*, November, p. 377.

Scarlatina.—Dr. John N. Taylor relates (*Southern Journal of Homœopathy*, September) an experience decidedly favourable to the claims of belladonna as a prophylactic against scarlatina. He gave two drops of the 1x dilution every three hours to four children whose brother had the disease pretty severely. Isolation was impossible, and three out of the four showed symptoms of the malady, but it was incompletely developed and ran a short mild course. The fourth escaped free.

Tetanus, Traumatic.—Dr. Charles W. Smith reports a case of this disease, of no slight severity, resulting from a lacerated wound, in which complete recovery ensued under homœopathic treatment. *Hypericum* was first given alone, then in alternation with *nux vomica* 1x, and subsequently the latter with *hyoscyamus* till the termination of the case.—*North American Journal of Homœopathy*, October, p. 683.

Urine, Suppression of.—Dr. Lamb, of Dunedin, records a case of suppression of urine (cause not stated) in a child of two. After ten days' steady diminution, and twenty-six hours' entire absence, *terebinthina* 3 was given. After ten hours, a small quantity was passed, sp. gr. 1004. Two days later, quantity still being insufficient, *cantharis* 3 was substituted, with complete cure.—*North American Journal of Homœopathy*, September, p. 628.

[Several excerpts from German homœopathic journals have to be left over for next time.—Ed.]

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COLOCYNTH: A SUGGESTION FOR A REVISED
MATERIA MEDICA.¹

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A PURE and trustworthy materia medica is so absolutely necessary for the successful practice of medicine according to the formula "*Similia similibus curentur*,"—"Let likes be treated by likes," that the pathogenic material at our disposal cannot be subjected to too severe an ordeal of criticism. When I consider how very carelessly many of the experiments for ascertaining the influence of drugs upon the healthy human organism have been conducted; the total absence in many cases of any allowance for the results of expectant attention; the introduction into the pathogenesis of symptoms noted during the administration of drugs to persons suffering from chronic disease; the fact that in some instances so-called drug-provings have been instituted by individuals whose whole interest in the matter has been the earning of a pecuniary reward—no doubt proportioned to the

¹Read before the British Homoeopathic Society (Liverpool Branch) January 12th, 1893.

multiplicity and variety of the symptoms produced by the prover if not by the drug; when I consider the many sources of error which beset our system of drug-proving I cannot but sympathise with one of our American colleagues who recently characterised a considerable proportion of the pathogenic material of our school as "bosh!"

The only attempt on any large scale to grapple with the difficulty of deciding what is and what is not to be considered as the pure result of drug action has been the recently concluded noble work of Drs. Hughes and Dake, "The Cyclopædia of Drug Pathogenesy." By the elimination from this work of the results of experiments made with dilutions above the 6th centesimal, and of all symptoms appearing after the administration of drugs to other than persons in average health, we are now able to obtain a clearer picture of the physiological and pathological effects of drugs; and could we easily refer to the material there collected in narrative form, there is no doubt but that our prescriptions would be given with a greater feeling of confidence than under the old *régime*.

But the "Cyclopædia of Drug Pathogenesy" is not, nor is it intended that it should be, a handbook for the practitioner, and no index to it can prevent the necessity for reference to a materia medica where the symptoms of the various drugs are arranged with a view to facilitate easy comparison—an arrangement which has so far been best met by the Hahnemannian schema. Allen's Handbook, the best of the present day works of reference, contains many symptoms which *must* be expurgated; and the "Materia Medica, Physiological and Applied" is so far too incomplete, and, perhaps, too extensive in arrangement for ordinary use; and it seems to me that we ought now to put our shoulders to the wheel and produce a materia medica—the pathogenetic material of which shall be confined to that contained in the "Materia Medica Pura" of Hahnemann, the "Cyclopædia of Drug Pathogenesy," and any more recently published and trustworthy provings or experiments.

I have referred to the "Materia Medica, Physiological and Applied," of which so far only a single volume has been

published. Though the general conception of this work cannot be sufficiently praised, I feel that as a book of reference—and that, I maintain, is what we want *now*—it stands to what is wanted for the consulting-room desk much in the same relationship that “Reynolds’ System of Medicine” does to “Bristowe.” To include only the more important drugs several volumes would be required, while to treat of all those in use by the homœopathists, the completed work would rival, if not surpass, the ten volumes of Allen’s Encyclopædia. What we want for practical use is, it seems to me, a book in a single, not too cumbrous volume, if possible, which shall contain the purified pathogenic material arranged in schema form with a brief pathological and therapeutic commentary on each drug, with a still briefer reference to its natural and general history, together with the mode of preparation and administration for medicinal purposes. And if one volume will not contain all this, then let us have the pure pathogenic material in one, and the remainder in another companion volume.¹

Such a work would, in my opinion, do more to advance the study of pure homœopathy than any time and labour spent in compiling from our periodical literature the oftentimes very dubious results of the administration of drugs, more or less homœopathically selected, in diseases of, frequently, very uncertain diagnosis—a work which, though strongly advocated by our late colleague, Dr. Drysdale, would, I believe, tend rather to foster the spirit of empiricism everywhere so rampant. Twelve months ago I was urged by the late Dr. Drysdale to prepare a monograph on colocynth for the “*Materia Medica, Physiological and Applied*,” and the following pages are intended rather as a sketch than a finished picture of that drug, introduced on this occasion to invite your criticisms as to the possibility and probable utility of such a manual of materia medica as I have advocated. In the

¹ While these thoughts have been passing through my mind, I find that an American society has already commenced a revision of the materia medica much on the lines I have advocated. A sample of their treatment of the drug *Thuja occidentalis* which includes all I desiderate above, and in addition a comparison with its analogues, occupies 11 octavo pages of the *Hahnemannian Monthly* for August, 1892, while the same drug in schema form with very brief clinical notes only, fills nearly 14 large quarto pages of Allen’s Handbook.

pathogenic material arranged in schema form I have adopted the plan of affixing a number to each symptom indicating the frequency of its occurrence in the whole of the provers, and this was done principally with a view to ascertain how far one might be justified in omitting all symptoms not occurring in at least two of the provers of any particular drug—a proceeding which has recently been advocated by many students of the materia medica in the United States. I entered into the work with a strong bias in favour of such omission—I leave it as here presented fully convinced that by the admission of *all* the symptoms of every prover we run great risk of recording much that is fanciful, but that we can only refuse admission to the symptoms not occurring in at least two provers at the risk of losing much that is really explanatory of the pathogenic action of the drug—much that is valuable to us in practice. Let us turn for an illustration to the pathogenesis of colocynth in so far as the symptoms of the lower extremities are concerned. These, as presented, are 34 in number, while if we limit the presentation to those recorded by at least two provers we at once diminish these symptoms to the number of 6, and some even of these are most indefinite in character, while we find that many of the uncorroborated symptoms represent evidence of similar drug-action in different provers, but expressed in variety of language.

Colocynth.

FOREIGN NAMES.—*Fr.* and *Germ.*, Coloquinte : *Span.* and *Ital.*, Coloquintida : *Dut.*, Koloquint : *Arab* and *Pers.*, Hunzil. ABBREVIATION, Coloc., Col.

The bitter apple (*Citrullus colocynthis*, L., N.O. *Cucurbitaceæ*) which furnishes the colocynth of medicine is a trailing plant, in general appearance resembling the common cucumber, having angular hairy stems, bearing tendrils and deeply lobed hispid leaves, from the axils of which arise in early summer solitary, bell-shaped, yellow, monœcious flowers, which are each succeeded in the autumn by a yellow fruit of about the size of an orange, with a thin, smooth, and leathery



rind. The plant is a native of the Levant, Egypt, Arabia, Palestine, the Cape of Good Hope, &c., and is also cultivated in Spain, from whence and from Smyrna and Trieste the dried, usually peeled fruit is imported for medicinal purposes. Only the pulp of the fruit, carefully freed from the seeds and rind, is officinal, and this pulp consists of a spongy or paper-like material, of a yellowish-white colour, with an intensely bitter taste, a character from which the popular name of the plant has been derived.

The drug is used in homœopathic practice both in the form of a trituration of the pulp with sugar of milk, and as a tincture, prepared by digesting the pulp in alcohol. Colocynth appears to owe its medicinal property to a glucoside, *colocynthin*, which is soluble in water and alcohol; and it also contains a resinoid material—*citrullin*, insoluble in water.

Colocynth appears to have been used in medicine from the earliest ages of which we have any record. It was prescribed by Hippocrates, in the form of enema, in coxalgia from taking cold; Dioscorides recommends it in the same disease but in the form of friction with the fresh juice, and in paralysis, colic, and toothache. It was highly esteemed by the early Arabian physicians in such diseases as chronic headaches, obstinate hemicrania, melancholia, articular pains, asthma, and especially in colic and coxalgia. Paulus Ægineta follows Dioscorides in recommending it in the form of friction with the fresh juice in coxalgia; Rhazes is said to have cured many thousand cases of ischialgia (sciatica) by means of enemata of colocynth and saltpetre. "Colocynth and Agaricus were the principal ingredients in the famous Hiera Pachi Antiochii, a secret remedy employed by the greatest physicians of antiquity in gout, paralysis, epilepsy, &c." (Watzke). It was used by Bonetus and Timœus in deficient catamenia, and as an ecbolic. Among more recent writers we find that Van Helmont and Zacutus Lusitanus have regarded it as an excellent antisyphilitic remedy; Junker used it in asthmatic paroxysms, hæmorrhoids and toothache; and Dolberg praises it in gout. But in a great measure owing to the ill effects which followed the carelessness with which colocynth was

often administered (to such an extent that some counselled that its prescription should only be permitted to old and experienced physicians) it gradually fell into the category of "good remedies out of fashion," and in the present-day works on Therapeutics we find colocynth referred to simply as a powerful gastro-intestinal irritant and hydrogogue cathartic, rarely prescribed alone but usually in combination with mercury or with other purgatives, and carminatives, and then generally in conditions where it is deemed expedient to quickly unload the bowels in cases of cerebral congestion, ascites, &c.¹ Though not generally alluded to in works on materia medica, the drug is still used by certain classes of women as an abortifacient and emmenagogue.

The Pathogenesis of Colocynth.

We owe our knowledge of the pathogenetic effects of colocynth upon the healthy human organism to the following sources:

1. Hahnemann's experiments with the drug upon himself, his son Frederic, and Drs. Stapf, Rückert, Langhammer, Gutman and Hornberg, which with observations on colocynth by Zacutus Lusitanus, Schenck, Alibert, &c., and cases of poisoning by this drug recorded by Staalpart van der Wiel, Hoyer, Tulpius, Plater and Hoffmann, were recorded by him in the sixth volume of the first edition of his *Reine Arzneimittellehre* (published 1821). This contained 17 symptoms produced in himself by colocynth, and 210 in others. The second edition, vol. vi. (vol. i. of Drs. Dudgeon and Hughes' English translation),² contains 26 symptoms from himself, 195 from fellow-provers, and 29 from authors; 250 symptoms in all.

2. Experiments conducted for the Vienna Proving Society by Drs. Arneth, Böhm, Fleischmann, Fröhlich (on himself and two girls), Gerstel, Hausmann, Mas-

¹ For an interesting historical account of Colocynth, see the monograph on this drug by Dr. Watzke, in Metcalf's *Homœopathic Provings*, from which much of the above information has been derived.

² *Materia Medica Pura*: Hahnemann Publishing Society.

chauer, Puffer, Reisinger, Rothansl, Wachtel, Weinke, Wurstl, Wurm and Watzke, the latter of whom edited the results of the proving in a valuable monograph on colocynth in the first number of the "Österreichische Zeitschrift für Homœopathie," a translation of which appears in Metcalf's Homœopathic Provings (New York, 1853).

3. Experiments conducted for the Jena Proving Society by Drs. Krumbholz, Martin, Mayer and Runge, and published in Hom. Vierteljahrschrift, x. 1.

4. A monograph on colocynth by Hechenberger (Kolocynthologie oder Beobachtungen über die vortrefflichen, viel zu wenig beachteten, Heilkräfte der Kolocynthis.—Insb. 1840).

The Cyclopædia of Drug Pathogenesy (II. 345) contains in narrative form the provings in 2, 3 and 4; it also contains a so-called proving by J. V. Müller, in whom certain acute symptoms are supposed to have been produced by a single dose (20 drops) of the fourth dilution; and a proving by Dr. Lembke, whose *bona fides* has been rendered doubtful by recent researches on the part of Dr. Dudgeon. The symptoms recorded by both these so-called provers have been omitted from the following pathogenetic material.

Pathogenetic symptoms in schema form.

Provers: 27 males, 2 females.

(The figures in brackets refer to the page and line in the Cyclopædia of Drug Pathogenesy, vol. II., where the preceding symptom occurs. The absence of a figure denotes that the symptom is from Hahnemann's *Materia Medica Pura*, or that it is one of such frequent occurrence as to need no special reference. Where a symptom occurs in both these works only the reference to the Cyclopædia is given.)

MIND.

Unusual weakness of the memory.¹ (348, 45).

Depression of spirits.² (350, 38).

Morose, fretful state of mind.² (355, 47).

Disinclination for speaking.² (355, 47).

Disinclination for bodily and mental exertion.¹ (351, 6).

HEAD.*(General).*

Confusion of the head⁵ [as if after a debauch¹; especially in the sinciput¹].

Vertigo³ [apparently arising in the left temple on turning the head quickly¹].

Weariness and weight in the head.¹ (360, 49).

Whole head painful, worse on stooping.¹ (356, 8).

Headache as though sinciput and temples were compressed, worse on stooping and in the open air, with pain in the eyeballs.¹ (356, 14).

Burning pain in left orbit, temple, and nose with a feeling as if the eye and nose were swelling.¹ (349, 7).

Twitching pain from the right deltoid insertion through the shoulder to the upper teeth, temples, and vertex.¹ (350, 38).

(Frontal region).⁷

Weight in the forehead² (349, 47; 351, 36), [on awaking at night¹ (351, 36)].

Pressure in the forehead⁵ [left² (351, 27); right¹ (359, 8); increased by moving the eyelids¹].

Aching in the forehead² (356, 4), [worse on stooping² (356, 4); worse while lying on the back¹].

Throbbing frontal headache¹ (359, 50).

Burning pain in the skin of the forehead above the eyebrows.¹

Stitches above the right eye with itching of the scalp¹ (349, 9).

(Temporal region).⁹

Right temple⁴; left temple⁵; both temples.⁴

Pressive pain⁶ [worse while walking, but relieved by sitting still¹ (358, 47); worse by stooping¹ (348, 48); in both temples, with heaviness of the eyelids without sleepiness, and which disappeared after café noir¹ (346, 46); with twitching of the right upper eyelid¹ (353, 20)].

Boring.¹

Digging.¹

Cutting in left temple with itching of scalp¹ (349, 39).

Throbbing.¹ (349, 39).

(*Vertex*⁴).

Pressure² (348, 24), [in the vertex and left eye, and then in both eyeballs¹ (348, 24)].

Aching, worse on stooping and from movement.¹

Burning on left side of the scalp.¹

Soreness of the scalp at the vertex, as if the hair had been dragged.¹ (354, 50).

(*Occipital region*).²

Pressure.² (351, 29 ; 355, 2).

EYES.

Pressure in the orbits towards the root of the nose.¹ (354, 2).

Frequent attacks of pain and aching in (forehead and) eyeballs.¹ (356, 30).

Pain in the eyeballs, increased by stooping, relieved in the open air.¹ (356, 15).

Pain in the eyeballs with smarting in the eyes.¹ (355, 46).

Pressure in the eyeballs which feel harder than usual.¹ (351, 48).

Burning in the right eyeball.¹

Sharp cutting pain in the right eyeball.¹

Pressure on both eyeballs.¹ (348, 26).

Twitching of right upper eyelid lasting three days, with headache.¹ (353, 21).

Burning in right upper and lower eyelids and inner canthus.¹

Stye.¹ (356, 46).

Shimmering before the right eye in the shape of a circle with rays.¹ (351, 47).

A great white light at the side of and below the line of vision of the right eye, which disappeared when the eyes were turned towards it.¹ (352, 6).

EARS.

Earache in right ear.¹

Shooting in right auricle.¹

Shooting pain from the eustachian tube to the membrana tympani, relieved by boring with the finger.¹

Painful drawing behind the right ear.¹
 Noises in the head: tinnitus³ [ringing² (347, 47; 351, 46),
 roaring¹ (361, 29); roaring and throbbing¹ (349, 33)].

FACE.

Pain in cheeks.³ [Pricking in the right malar bone,¹ (349, 36);
 burning pain¹; pressure in the malar bones² (349, 5;
 360, 39)].

Transient stitches in the upper jaw¹ (347, 1).

Tearing on the left side of the face to the ear and into the
 head.¹

Constriction of left cheek, extending into the eye¹ (349, 11).

Pimple on left cheek, discharging watery fluid.¹

Feeling as if the upper lip were swollen, accompanied by
 toothache.¹ (347, 46).

Burning at the right angle of the mouth.¹

Pustule at the left angle of the mouth.¹

Burning of lower lip.¹ (348, 27).

MOUTH.

Toothache⁵ [in upper teeth³ (350, 26; 358, 49; 360, 43); in the
 lower teeth² (349, 46); in all the teeth for two days¹
 (345, 45); with twitching extending to the left arm¹
 (349, 40)].

Sensitiveness of the incisor teeth.¹ (348, 20).

Swelled feeling in the roots of the lower teeth.¹ (349, 46).

Smarting inside the right cheek and side of tongue.¹

Tongue white and rough, as though from tobacco smoking.¹

Tongue rough, as though sand were strewn upon it.¹

Sensation as if the tongue had been scalded.¹ (354, 42).

Smarting at the tip of the tongue.¹ (357, 21).

Burning at the tip¹ (349, 12) and on dorsum of tongue.¹
 (349, 48).

Bitter taste.²

Disgusting, putrid taste.¹

Scraped feeling in the palate.¹

THROAT.

Dryness and roughness² (349, 5; 355, 46); [with frequent
 hemming¹].

Scraped feeling in the throat.² (350, 7 ; 354, 15).

Pricking as from an awn of corn.¹

Sense of compression.¹ (355, 26).

Constriction, causing frequent swallowing.¹ (352, 45).

Sensation as of a foreign body in the throat, as though he had to swallow over a lump.¹ (350, 19).

Sensation as of a ball, the size of the fist, rising up into the pharynx, with oppressed respiration.¹ (349, 24).

APPETITE AND THIRST.

Diminished appetite.⁴

Increased appetite³ (354, 13 ; 360, 12 ; 360, 44) ; [feeling of emptiness in the stomach with voracious hunger,¹ (354, 37) ; voracious hunger followed by heartburn,⁴ (360, 44)].

Disgust before eating.¹ (355, 28).

Thirst.³ (354, 13 ; 348, 21 ; 360, 12).

STOMACH (for pains, etc., in epigastric region, *see* ABDOMEN).

Hiccup.¹

Eructations⁵ [empty³ (349, 30 ; 355, 30) ; of bilious fluid¹ ; of bitter, white, frothy matter¹ (355, 39)].

Heartburn.¹ (360, 44).

Nausea.³

Vomiting.³

ABDOMEN.

(*General*).

Sensation of coldness in abdomen.¹ (346, 34).

Heat in the abdomen.² (360, 23 ; 349, 11) [rising towards the chest and ending in sweat.¹ (348, 49)].

Sensation of emptiness in abdomen.²

Distension of abdomen.⁶ [tense and very sensitive to touch.¹ (352, 14)].

Rumbling in the abdomen.⁷

Pains (of uncertain location) :

Attended by a rush of blood to the head and face, followed by perspiration in those parts, which, after

the pain had ceased, felt as if cool air blew upon them.¹

Like an electric shock through the abdomen to anus.¹
(354, 38).

As if severely clawed.¹

After eating.² (353, 12).

Worse from pressure.¹ (348, 37).

Relieved by bending forward or pressure.³ (359, 3).

Relieved by drinking coffee.² (356, 18).

Relieved by evacuations.³ (360, 23 ; 355, 15 ; 359, 3).

Relieved by emission of flatus.¹ (353, 7).

(Epigastric region).

Inflation of epigastrium.¹ (347, 47).

Aching in gastric region with a sense of hunger.¹

Pressure as if from a stone.¹

Cutting in epigastrium.¹

Spasmodic pains, griping² (350, 18 ; 353, 3) [rising to the throat¹ (350, 18) ; with tenderness¹ (353, 3)].

Burning pain.¹ (350, 13).

(Umbilical region.)

Distension.² (348, 19 ; 355, 26).

Soreness and tenderness.¹ (355, 40 ; 356, 10).

Shooting pains² [compelling him to crouch forwards¹ ; from umbilicus to loins and spine¹ (355, 43)].

Cutting pains.³ (351, 28 ; 346, 20 ; 356, 25).

Griping, constrictive pains⁸ [relieved by the emission of flatus¹ (352, 50) ; accompanied by a cutting pain deep into pelvis and then upwards¹ (351, 28) ; worse after fruit¹ (346, 50) ; with painful stitches in bladder and subsequently in rectum, disappearing on the discharge of flatus.¹ (346, 43)].

(Hypogastric region).

Sensation as if the intestines were gathered into a ball and lying in the hypogastrium.¹ (350, 48).

Pressure as if from flatus that will not come away.¹

Aching after dinner, relieved by discharge of flatus and stool.¹
(358, 45).

Cutting pains² (346, 20) ; [increased by walking²].

Constriction, gripping³ (348, 12) [relieved by strong pressure¹; with rumbling and a sense of inflation.¹ (348, 12)].

(*Hypochondriac region*).

Pressure in right, oppressing breathing.¹ (351, 6).
Stitches.² (354, 19). [under the last ribs¹; in the hepatic

region.¹ (354, 19)].

Shock, from behind forward through the hepatic region and then through the head.¹ (351, 21).

Pulsation in left hypochondrium.¹ (351, 37).

(*Iliac region*).

Tensive pain in right, increased by pressure.¹
Drawing in right iliac region.¹ (348, 25).

Boring pain in left iliac region.¹

Stitches.² (347, 34; 356, 31) [in both flanks alternately.¹ (347, 34)].

Pain above the hips with nausea and chilliness.¹

RECTUM.

Sensation of weakness or paralysis of the sphincter.² (352, 3).
[great effort to prevent the evacuation from coming away before reaching the night chair¹; as if weakened by continual diarrhoea¹].

Stitches in the rectum.² (348, 22; 359, 33) [with insufficient stool¹ (359, 33)].

Twitching in anus.¹ (353, 50).

Tenesmus.³ [alternating with vesical tenesmus.¹ (351, 18)].

Itching of the anus³ (354, 11; 346, 14; 360, 37). [with itching in the orifice of the urethra¹ (354, 11).]

Burning at the anus⁵ [with burning along the sacral region¹ (360, 16)].

Discharge of mucus (moisture) from the anus.² (348, 21; 351, 2).

Swollen blind hæmorrhoids.¹

Hæmorrhage from the anus³ [in the case of Dr. Fleischmann this symptom continued for more than a year afterwards, with sticking and burning pain in the small of the back and anus—symptoms never before experienced by him (346, 37)].

STOOL.

Loose stools¹⁹ [with discharge of much flatus³].

Pappy⁷ [with coldness in the whole body.¹ (352, 48)].

Watery.³

Copious, yellowish brown with a putrid smell.¹

Thin, frothy, saffron-coloured, with a mouldy smell.¹

Greenish-yellow diarrhoea.¹

Copious, yellow, and almost inodorous¹ (355, 50).

Bloody³ [first watery and slimy, then bilious, and at last bloody¹; first fluid and fæculent, later almost of pure blood with pieces of the intestinal mucous membrane, with frightful tenesmus¹ (365, 52)].

Viscid and slimy.¹

Hard⁶ [in small pieces¹; as if he were passing stones¹ (354, 32)].

URINARY ORGANS.

Frequent micturition.² (350, 18; 358, 19).

Abundant discharge of urine.⁵

Urging to urinate, tenesmus, strangury⁴ [with scanty discharge of urine¹; alternating with rectal tenesmus¹ (351, 18)].

Retention of urine.¹

Urine: of intolerable odour, became thick, gelatinous, and viscid on standing.¹

Copious, light brown, becoming cloudy on cooling and depositing a copious and sometimes sandy sediment.¹ (360, 13).

Pale red, with light brown sediment depositing reddish crystals on the vessel.¹ (356, 33).

Copious, clear, and watery.¹ (354, 7).

Itching in the orifice of the urethra [and in anus]¹ (354, 12).

Prickling in the orifice of the urethra after micturating.¹ (348, 33).

A stitch like lightning from the point of the glans through the abdomen to the left flank.¹ (349, 14).

Burning in the orifice of the urethra after micturating.¹ (359, 31).

Aching pain at the end of the urethra after urinating.¹

SEXUAL ORGANS.

- Retraction of prepuce.² (358, 42).
 Retraction of testicles.¹ (366, 28).
 Drawing pain in left testicle¹ (345, 29).
 Increased sexual impulse² (349, 27 ; 351, 46).
 Frequent erections.¹ (350, 8).
 Priapism.¹ (366, 29).
 Impotence, without deficiency of sexual desire.¹
 Voluptuous dreams with seminal emissions.¹
 Swelling of the vulva, with a sense of bearing down and heat
 in the vagina.¹ (366, 19).
 Menses profuse and too early.¹ (360, 17).

CIRCULATORY ORGANS.

- Palpitation⁴ [felt through the whole body² (349, 34) ; with
 heat in the head¹ (355, 12)].
 Pulse quick and full.¹
 Pulse small and accelerated.¹ (366, 25).

CHEST AND RESPIRATION.

- Stitches in chest⁴ [right² (354, 41 ; 361, 36) ; in the cardiac
 region¹ (356, 45) ; under left pectoralis (354, 41) ; in both
 sides of the chest, with oppressed breathing¹ (356, 13)].
 Twitching pain in intercostal muscles.² (350, 26).
 Grasping pain in intercostal muscles.¹
 Dryness and tickling in the larynx.¹
 Irritability of the larynx, the voice became rough and hoarse ;
 distressing dryness of the air passages with fatigue in
 the affected parts.¹ (345, 38).
 Pressure in the middle of sternum, as though something lay
 on the chest.¹
 Tightness of the chest, with slow and difficult breathing.¹
 Oppressed breathing⁴ [lung appears unable to expand¹ ; with
 a sensation of a ball as large as the fist rising up in the
 pharynx.¹ (349, 23)].

NECK AND BACK.

- Pressure in nape towards occiput.¹
 Stiffness in nape² (354, 5) ; [felt on moving the head¹ (354, 5)].
 Drawing pains in the nape.² (347, 25).

Pain in left cervical muscles⁴ [drawing³ (359, 24); sharp¹; tearing¹ (348, 16); in left sterno-mastoid¹].

Stitch under right scapula during inspiration.¹

Aching under the right scapula with tensive pain from thence downwards.¹ (352, 5).

Drawing in right scapular region.¹

Sensation behind the right scapula as if the arm were sprained.¹

Sore pain in left scapula.¹

Shooting pain between scapulæ, worse on walking.¹

Bruised pain in lower part of back.¹

Shooting pain in right loin on inspiration, worse by lying on the back.¹

Throbbing in right lumbar region.¹ (350, 1).

Burning pain in the loins.¹ (366, 19).

Throbbing in left iliac region and right loin over the iliac crest towards the buttock.¹ (348, 25).

Burning pain in the small of the back and arms.¹ (346, 39).

Pain in the sacrum⁴ [pressive³ (355, 8; 359, 14); as if beaten¹ 353, 15)].

Aching in left sacro-iliac commissure.¹ (349, 43).

EXTREMITIES.

(General).

Weakness in all the joints, especially the knees and elbows.³ (351, 5).

Drawing pains in all the joints, especially the fingers and toes.¹ (359, 15).

(Upper).

Twitching pain at the insertion of the right deltoid, extending through the shoulder towards the upper teeth, and as far as the temple and vertex; the parts, after its frequent recurrence, became sore to pressure.¹ (350, 38).

Twitching in the left arm as far as the elbow, with toothache on the right side.¹ (349, 40).

Pain in the arms as if bruised.¹

Pain in the shoulders⁴ [aching in both¹ (355, 11); drawing in the right¹ (345, 45); painful tension in the right, worse on movement¹ (351, 42)].

Stitches in the elbow and forearms.² (354, 23 ; 355, 37).

Aching in the arm bones, especially beneath the head of the humerus and above the wrist, worse by rest.¹

Stiffness of the right forearm, with painfulness of the extensor muscles.¹ (352, 28).

Numbness of right forearm.¹ (348, 14).

Crampy pain in left forearm.¹ (360, 45).

Tearing in left arm down to finger-joints.¹ (347, 26).

Pain in the right palm so that the fingers were opened with difficulty.¹ (356, 48).

Pain in thumb² [right¹ ; left¹ (353, 25)].

Drawing pain in finger-joints of the left hand.¹ (347, 24).

Pain in right middle fingers.¹ (356, 21).

Pain in left little finger.¹ (358, 26).

(Lower).

Weakness of the legs as from fatigue.¹

Weariness of the thighs, especially noticed when going upstairs.¹ (350, 11).

Burning pains in the bones of the lower extremities.¹ (355, 5).

Tearing in both thighs, and in the left calf as far as the heel.¹ (347, 27).

Drawing pain from left ilium to the groin and inner side of the thigh.¹ (346, 1).

Pain in the right thigh when walking, as if the psoas were too short.¹

Stitches in the inner side of the left thigh from the ischiatic tuberosity towards the knee, when walking.¹ (357, 16).

Drawing pains in thighs² [outer side, while walking¹ (357, 22); inner side¹ (359, 40); as far as the knee¹ (353, 33)].

Weight in both knees.¹ (353, 26).

Pain in the knee when walking² (351, 41) [as if the joint were tightly bound¹].

Tearing in left knee, disappearing on walking.¹ (353, 26).

Stitches in left knee.¹ (355, 33).

Pain in patella² [with heat and swelling so that walking became painful¹ (346, 12); passing off as walking was continued.¹ (353, 42)].

Pulsation in left popliteal space.¹ (350, 2).

Numbness down the outer side of the right calf, ultimately extending into the great toe.¹ (348, 6).

Numbness, heat, and swelling of left foot gradually invading the whole leg.¹ (350, 32).

Pain in the hitherto painless varicose veins of the right leg.¹

Cramp-like drawing in the left calf.¹ (347, 2).

Sharp cutting on the inner side of the left calf, when at rest.¹

Pain in left tibia³ [drawing, extending to the ankle¹ (354, 30); tearing in night¹ (349, 22); burning¹ (353, 11)].

Tearing in the ankle³ [when sitting¹; while walking¹ (347, 7)].

Drawing in the right ankle¹ (358, 50).

Aching in the left instep¹ (354, 47).

Cutting pain, as though a nail were driven through the right instep¹ (354, 48).

Twitching in the dorsa of both feet towards the tibiæ¹ (356, 1).

Tearing on the dorsum of the left foot.¹

Pain in the dorsum of the right foot, and a pale, painless swelling, the size of a pigeon's egg, at the outer edge of the tarsus.¹ (358, 2).

Stitches in the dorsum of the right foot and great toe.¹ (354, 19).

Stiffness in the left great toe.¹ (346, 4).

Pressing and throbbing in the first joint of the great toe, as if the boot were too tight¹ (358, 34).

Sprained feeling in all the toes of the left foot, felt while going upstairs.¹ (359, 27).

Tearing in the sole of the right foot.¹

Drawing pain in the inner ball of the left foot.¹ (356, 44).

Stitches along the outer border of the left sole.¹ (347, 2).

SKIN.

Itching while in bed, causing restlessness and inability to sleep.¹

Itching, especially on the chest and abdomen, in the morning on awaking.¹

Boils² [face and back¹ (345, 30); on the hands¹ (356, 46)].

SLEEP.

Restless sleep³ (356, 5 ; 353, 32).

Dreams¹⁰ [vivid⁵; horrible, exciting¹ (355, 24); pleasant¹ (351, 35); voluptuous³; voluptuous, with seminal emissions²].

Pathological Action.

“ Most pharmacologists of the present day,” says Watzke, “ do not seem to consider it worth while to seem to know anything specific about the peculiar powers of colocynth. They content themselves with setting it down as ‘ *Purgans acre vehemens*’ or ‘ *Drasticum heroicum*,’ and with a few words refer to its former dangerous employment ” (Monogr. Coloc., Metcalf’s Hom. Provings, p. 378).

And after the lapse of nearly half a century pharmacologists appear to know little more about colocynth than than they did in Watzke’s time. “ Colocynth,” says Ringer, “ produces diarrhoea, colic, and sometimes vomiting. The diarrhoea is watery, and after large doses serous, mucous, and bloody. In large doses it may excite gastro-enteritis and peritonitis ” (Handb. of Therapeutics, 11th ed., p. 593.) “ Röhrig, from his experiments with fasting animals, is led to place colocynth high among cholagogues. It makes the bile more watery, but also increases the solid constituents. It powerfully stimulates the intestinal glands ” (Id.).

A study of the symptoms during life, and of the *post-mortem* appearances after fatal poisoning by colocynth (*vide* Cyclop. Drug Pathogenesis, II., 365, *et seq.*) indicates that the drug acts primarily as a stimulant to the sensory nervous system, affecting more especially the sensory nerves of the gastro-intestinal tract. And experiments conducted by Orfila and others on animals show that this action is not merely mechanical, but is distinctly specific, for it occurs whether the drug be administered by the mouth, injected into the tissues, or applied to a raw surface of the body. Moderate doses, by stimulating the sensory nerves of the stomach and intestines, produce vaso-dilation and exalted glandular activity; resulting in an increase of the natural

secretion, and a softened or pappy stool. A larger dose causes a still further increase in the quantity, and an alteration in the quality of the fluid secreted, which becomes more watery, and at the same time acrid, giving rise after its discharge to burning and smarting at the anus. The increased stimulation of the sensory nerves results in (reflected) motor irritability, varying in degree from a slightly increased peristalsis to the most violent tormina; and the same condition affecting the rectum produces intense tenesmus. A further continuation of the irritant effects of the drug leads to vaso-motor paresis, the mucous membrane becomes deeply congested, blood escapes from the over-distended vessels, and the mucous coat becomes so softened as to be easily detached. Gangrene of the bowel may take place (as Hoffman¹ notes to have been of frequent occurrence after medicinal doses of colocynth for ascites), or the inflammation, at first limited to the mucous coat and the sub-mucous tissues, may extend through the muscular to the serous covering, and fatal peritonitis may ensue. As is usually the case in muco-enteritis of any severity, the continued over-stimulation of the intestinal motor nerves eventually leads to an opposite condition, a weakening and finally paralysis of the muscular coat, the gut becomes easily distended from an accumulation of gases, and tympanites results. In the dogs which were the subjects of experiment by Orfila, the drug seemed to have a stronger affinity for the stomach and rectum than for the portions of bowel intervening; but the results of *post-mortem* examination do not show this to be the case in any marked degree in the human body.

But while the pathogenetic action of colocynth does undoubtedly centre on the sensory nerves of the stomach and intestines, we find by the method of drug experimentation almost peculiar to our school—the administration of small doses of the drug at tolerably frequent intervals to healthy individuals—that colocynth has a wider range than is indicated by the symptoms in cases of acute poisoning.

¹ *Op. Omn. Gen.* 1740, III., 332.

With or without increased intestinal activity, and sometimes after the cessation of such activity, provers experience well-marked irritation of a large portion of the general sensory nervous system, and more especially of the trigeminus and the sensory portions of the brachial, lumbar, and sciatic plexuses. Whether this irritation is due to direct (primary) stimulation of these nerves, either centrally or peripherally, or whether it is the result of a stimulus reflected from the gastro-enteric mucous membrane remains to be decided; but that the latter is probably the correct conclusion seems borne out by the great general resemblance between many of the symptoms experienced by provers of colocynth and well-known manifestations of gastro-enteric disturbance, such as the mental confusion, the various forms of headache and facial neuralgia, the vertigo and tinnitus aurium (which is most often produced by reflex excitation of the vaso-motor nerves of the labyrinth), the dryness of the throat and irritability of the larynx, the oppressed breathing, the pains and stiffness about the neck, the brachial and intercostal neuralgia, the sciatica and the articular symptoms. Even the great increase in the secretion of urine, so characteristic of the administration of colocynth in small doses, is a known physiological result of stimulation of the vagus at the cardiac end of the stomach—which produces a reflex dilatation of the renal vessels.

Therapeutic applications.

The fact that any drug should have fallen into disrepute among medical practitioners because of ill effects noticed to follow its administration to the sick would be considered by the student of homœopathic medicine *prima facie* evidence of its power for good in properly selected cases of disease; and colocynth is no exception to the rule of practice "*Similia similibus curentur.*" It is just in the condition produced by its maladministration, and which led to its disuse by the general body of the profession except as a purgative—its tendency to cause violent colic and purging, and to set up muco-enteritis, that colocynth has gained its laurels in

homœopathic practice, and our literature contains many records of its curative power in such conditions.¹

From the pathogenesis of the drug, as well as from practice, we find that the chief indications for colocynth in muco-enteritis are: pain of a spasmodic (cutting or griping) character affecting chiefly the umbilical and hypogastric regions, generally relieved by stooping forwards and by pressure, and usually accompanied by diarrhœa and flatulent distension. The pains are also relieved temporarily by discharge of stool or flatus, and are usually increased by food, although we note that two of the provers found the pains greatly relieved after taking coffee.

The diarrhœa for which colocynth is applicable may be merely a loose, pappy stool, usually preceded by some colic or pressure in the hypogastric region, and often attended with much rumbling of flatus; or it may be watery, or bilious, or even bloody; and although in two provers the pappy stools were accompanied by a feeling of weakness of the sphincter which rendered retention of the stool, even for a short period, so difficult that there was scarcely time for the necessary "change of base" (Aloes), the characteristic rectal condition attending the severer forms of colocynth diarrhœa is one of violent tenesmus (Merc. corr.).

Nearly all our writers on colocynth refer to its value in colic and diarrhœa due to emotional causes: this may be the case, but this prescription is not deduced from the pathogenesis of the drug.

Our literature does not seem to contain any records of the use of colocynth in entero-peritonitis, but where this condition has ensued upon muco-enteritis it is probable that colocynth might be helpful.

The hard stools produced in some of the provers are evidently due to a secondary action of the drug.

¹ The following is a typical illustration: "Dr. Böhm cured radically with colocynth, 3rd dil., attacks of colic, with pressure at the stomach, flatulence, eructations, and mucous diarrhœa, in a man of 54, subject to hæmorrhoids; the colic came on daily, and was brought on by taking food even of the lightest description. The patient had undergone the water treatment at Gräenberg for three years, with partial amendment. Soon after the first dose of colocynth he was seized with a more violent colic than he had ever experienced. Ten months after he had experienced no return" (Watzke's Monograph).

After muco-enteritis probably sciatica has been the principal sphere in which colocynth has been found curative, and not only by homœopathic practitioners, but, as was referred to in the history of the drug, it was one of the favourite and most successful drugs used against this disease by the Greek and Arabian physicians. It is distinctly homœopathic to sciatica and to neuralgia affecting the anterior crural nerve, as is evidenced by the richness of our provings in these symptoms. It is probably in sciatica and neuralgia dependent upon rectal irritation, and in that of a rheumatic character (note here the relation between chronic rheumatic manifestations and digestive disturbances) that colocynth will be found most useful; where the pain is shooting or tearing, usually worse at night, and where it may be accompanied by numbness or cramp of the muscles of the leg. Hughes remarks (Pharmacodynamics, 5th ed., 433) that he has found colocynth curative only in recent cases of sciatica, preferring Rhus or Arsenicum in those of longer duration.¹

Although colocynth has been recommended (and the recommendation copied by one author after another) in morbus coxarius, it is not probable that it would be of any value in pure hip-joint disease.

The headaches produced by (and therefore similar ones would be curable by) colocynth are mostly frontal and temporal in situation, and most frequently pressive in character; there is some tendency for the left side to be more affected than the right, though the disproportion is not great. In most cases the headache is increased by stooping and by movement, and is frequently attended by neuralgic pains in the eye-balls, orbits, and face. In those provers in whom pain attacked the vertex the scalp became

¹ Dr. Böhm removed with colocynth 8 an *Ischias postica* which had attacked a hearty, healthy man, of 40, without assignable cause, with violent pain extending from the trochanter to the ankle, which had for 12 weeks returned every week and lasted 20 or 30 hours with extreme intensity. Rhus tox. had been tried without effect. The paroxysm returned once, but in a feeble degree, and went away permanently under a continuance of the colocynth" (Dr. Watzke's Monograph).

A young man about 20 had sciatica for several weeks. The pain was lancinating, flashing along the track of the nerve whenever an attempt was made to raise the limb. One drop of tincture of colocynth in water effected a prompt and permanent cure (Hempel's *Materia Medica*, I. 457).

tender, a symptom again foreshadowing a rheumatic condition. Whether colocynth will prove of service in pure migraine, or whether good results will only follow its administration in sympathetic headache, facial neuralgia, and toothache (for all branches of the trigeminus may be affected) from gastro-enteric disturbance must be decided by experience. Lilienthal specially refers to its value in "bilious and gouty" headaches, and Watzke remarks that "the hemicrania and prosopalgia which colocynth cures proceed from increased sensibility from rheumatic, gouty, or gastric irritation—in organic disease from deeper causes the efficacy of colocynth is very doubtful."¹

Colocynth has been referred to (by Allen) as a palliative of the pain of acute glaucoma and iritis, and Hughes says "it has been found of service in the violent pains in the eye-ball which precede the development of glaucoma," but Angell does not include colocynth in his list of medicines useful in ophthalmic practice. Farrington refers to it, and I think with more propriety, as a good remedy in gouty affections of the eye, and in this condition compares it with Staphisagria. Dr. Trites, in Arndt's System of Medicine, II. 326, regards colocynth as "one of the sovereign remedies in orchitis" (one prover had drawing pains in the left testicle). Colocynth has been found useful in ovarian neuralgia, while in that form of ovaritis accompanied by general abdominal tenderness, Dr. Ludlam considers it (after belladonna) more useful than any other medicine. In the case of one of Dr. Fröhlich's female provers there were produced "stitches in both flanks, *apparently connected with the ovaries,*" but without any other symptoms of

¹ Dr. Schüler records a case of severe headache where after the continuance of the pain for some time the left eye became quite blind, and the other, though still useful, attacked with cutting, burning pain, with an acrid discharge from both eyes. Two drops of coloc. ϕ every three hours removed the headache completely within 24 hours, and had a sensible effect in diminishing the pain in the eye. Under a continuance of the colocynth the sight of the eye was preserved, and the patient completely restored in eight days (Dr. Watzke's Monograph).

A hemicrania in a woman of over 50, occupying the left side, returning periodically at five in the afternoon, and which had lasted several years was, after fruitless treatment by allopathic means, somewhat alleviated by asarum, and disappeared entirely and permanently under a few days' use of colocynth (Attomyr, Archiv. f. Hom. H. xi. 2, 144).

disturbance of these organs: Cases of the dissipation of ovarian tumours by the administration of colocynth have been recorded, but the records are so vague that little reliance can be placed upon them.

From the similarity of its arthritic symptoms to those dependent upon the rheumatic or gouty diathesis, colocynth deserves a trial in these conditions, while the dry, scraped throat, the laryngeal irritability, the oppressed breathing, the stiff neck, the intercostal neuralgia, and the sacral aching with hæmorrhoids so closely resemble similar conditions in gouty or lithæmic subjects as to warrant the expectation that colocynth will be found useful in the treatment of such individuals.

Dose.—Colocynth may be considered one of the more potent of our drugs, and the best results appear to have been obtained by doses of the third to the sixth centesimal dilution, either of the tincture or triturated pulp. Dilutions lower than the third are liable to be followed by medicinal aggravation of the symptoms.

Dr. HAWKES said he did not feel that he could give an opinion as to the use of the terms "pathological" and "physiological" in reference to the actions produced by drug provings; he thought it was a question to be discussed. Referring to the proving of drugs he thought that some were more true in their action in disease to their pathogenesis than others, colocynth being one that was not quite true. He was very much disappointed in its use in colic cases, and much preferred bell., dioscor., &c. Neither did he find it of much service in sciatica and neuralgia.

Dr. J. MURRAY MOORE was much pleased with the paper, as after Dr. Dudgeon's exposure of the fallacies of Lembke's provings, something ought to be done. He liked colocynth in the colic that was relieved by pressure, and a cup of strong coffee. He referred to the distinct pathological and physiological effects of some drugs, and read some extracts on colocynth from Bell's "Diarrhœa."

Dr. ROWLAND WILDE said that whether physiological or pathological effects were produced was simply a question of dose, instancing constipation, which was differently affected according to the different strengths of medicines.

Dr. JOHN HAYWARD said that the subject was one of special interest to him, as Dr. Drysdale had asked him to prove colocynth. He agreed with Dr. Wilde as to the use of the terms pathological and physiological. Aconite given in large doses would produce pathological effects; in small, physiological. He thought that the proving actions were pathological. As to colocynth, he thought it a pity that there were no more provings of it, as amongst them there were those of two women only. He used colocynth much more frequently since he had studied it, and found it useful in certain forms of colic and neuralgia; the colic being worse at night as most of the colocynth symptoms were. He mentioned its use in most hospitals as a very efficient purgative.

Dr. DAVIDSON mentioned a case of superior maxillary neuralgia cured by colocynth.

Dr. MAHONY thought that colocynth was more useful in cases where pain was worse about 4 p.m. If we could only find out the way in which the drug affected the nervous system, it would probably prove very much more useful.

Dr. HERBERT WILDE had found colocynth useful in sciatica, but not in muco-enteric cases.

Dr. C. W. HAYWARD had found it very useful in right sided sciatica.

Dr. ELLIS, in responding, asked Dr. Hawkes whether he had had any experience of the use of colocynth in gynæcological cases, to which Dr. Hawkes answered in the negative. He referred to many symptoms of colocynth as being merely clinical, and which are therefore out of place in the pure pathogenesis. He thought that the neuralgia of colocynth was of a reflex character. Colocynth was probably of no use in neuralgia which was not sympathetic with gastro-intestinal troubles. He did not consider that the symptoms "worse at night" and "worse at 4 p.m." were of any significance. As to the use of colocynth in sciatica he had had no experience; but muco-enteric troubles were liable to be increased by even the lower dilutions of colocynth.

ON GERM CONTAGION.¹

BY STAMMERS MORRISSON, M.D.

THESE brief notes refer to the contagion of anthrax in animals, but their bearing upon the human side of the question will be apparent. In Dr. Klein's book there is a reference to the pertinacity with which germs retain their hold upon grass in an open field. To my mind, they have a direct relationship to preventive inoculation, and especially to vaccination. Some years back I nearly lost an adult patient from blood poisoning consequent upon heifer lymph vaccination; I have seen an infant die from blood poisoning; and while I was in Montpellier four soldiers died in the hospital from erysipelas caused by re-vaccination. Hence the question of germ contagion is to me of special interest.

A gentleman farmer in a West-Midland county has just given me the following account of infection among cattle. In June, 1888, three head of cattle were placed in a particular field. Three days after one of these was taken ill, and died within a few hours; the other two animals became affected, and both died. Four head of cattle were placed in this field in May, 1889; one of these became affected, and died; the others were closely watched, and upon a second showing similar symptoms it was driven, evidently in great pain, to a neighbouring butcher's to be killed. The butcher said, "Try some Epsom salts." One pound of salts were administered and the beast recovered; the other two were treated in like manner, and removed from the field, and they escaped; but the butcher lost two of his own cattle through placing them where the infected animal had been. No cattle were pastured again in the infected field till February, 1892—nearly two years, when fourteen animals were placed there. It was not long before one of these was seized with

¹ Read before the Society, October 6th, 1892.

the old symptoms, and died. The others had been skinned, but the farmer had recognised the contagiousness of the complaint, so this carcase was buried some eight or nine feet deep, and shrubs planted over the spot. The other animals were removed from the field, and one pound of Epsom salts given to each. This was on a Monday. All the animals became somewhat queer, probably from being so thoroughly dosed, but the salts were repeated on the Wednesday, and not one of them contracted the fatal disease.

An interesting point was, that on the day on which the one was lost all the herd were observed feeding upon turnips at noon, and three hours later the infected bullock was lying dead. A second point of interest is, that during the intervals between the periods mentioned, both sheep and horses had been pastured in that same field without taking any harm. A third point of interest is, that since the last incident the upper portion of the field, where the carcase was buried, has been railed off, and cattle have been safely pastured in the lower portion. A fourth point of interest is, that the butcher who skinned some of the animals escaped being inoculated, but the butcher who would have skinned the last animal that died, had it been done, was shortly after this incident removed to a neighbouring infirmary suffering from blood poisoning through another source.

The disease from which these cattle died was anthrax, the highly infectious nature of which is now well known.

How was the infection first introduced, and by what was it retained? The farmer supposes that it may have been due to an infected animal having at some time been buried there, and contaminating the herbage.

Experimenters handling anthrax germs have to be extremely careful, both in regard to themselves and to any animals in adjacent rooms. But my farmer friend was not at first aware of the contagious nature of this disease, and the record of his losses shows how readily maladies arising from infectious germs may be passed on from one individual being to another. With the method of treatment I have only to deal thus far:—salts of many kinds are inimical to

germ life; probably the germs in these instances were conveyed to the stomachs of the animals; and the salts administered to those that were saved when infected acted destructively upon the germs before a sufficient time had elapsed for the germs to seriously affect the system. Anthrax germs multiply with great rapidity, and they enter the circulation, destroying the blood cells and filling the capillary vessels; hence the frequency with which their effects prove fatal.

HABITUAL CONSTIPATION.¹

BY EDWARD BLAKE, M.D.

THE symptomatic method of treating this subject has been so well threshed out by our school that I will approach the subject from the etiologic side. To do this properly, it is needful to contemplate briefly the physiology of enperistalsis and the mechanism of normal defæcation.

In the year 1888,² Dr. Hughlings Jackson put forth his thoughtful "Nerve Theory of Normal Defæcation." He predicted the existence of a motor (viscero-motor) centre, possibly in the medulla, and a controlling (viscero-inhibitory) centre, probably in the dorsal³ region of the cord. From the former, he believes that polio-enteric or gray fibres pass, probably by way of the left vagus, to the bowels. These cause intestinal contraction. From the latter, the dorsal centre, he describes leukenteric, or white fibres, as proceeding to the intestine direct. These latter possess the property of keeping the intestines dilated. These two centres are, of course, united by communicating fibres to secure harmony of action. When both act in unison, all is well. When one set is paralysed we have constipation. From paresis of the other, diarrhœa ensues.

¹ Read before the British Homœopathic Society, February 2nd, 1893.

² "Diseases of the Brain," *British Medical Journal*, July 14th, 1888.

³ The researches of Professor Gaskell, of Cambridge, have since made it certain that this centre is situated somewhere between the second thoracic and the second lumbar roots.

In childhood it is possible that the intrinsic muscles of the rectum may have the power of voiding the lower gut ; but as life advances, the rectal detrusors need more and more to be reinforced by the diaphragm and by the parietal muscles. As these lose tone, constipation becomes a habit. Part of the splendid effect of *nux vomica* in overcoming the costive tendency is due doubtless to its influence in increasing the innervation of the abdominal muscular surroundings. It is probably through these centres that the hypnotic influence acts. The main outlines of the Jacksonian theory are supported by the valuable work of Gaskell,¹ of Cambridge, on "Visceral and Vascular Innervation."

The scheme of Hughlings Jackson is no doubt correct as far as it goes; and standing alone, it would serve to explain many familiar phenomena,—such, for example, as "mental" constipation and "emotional" diarrhoea. But it is not all. In 1887 Mr. Bland Sutton, followed by Gaskell, demonstrated that developmentally the alimentary canal precedes in life history the neural canal; that, in point of fact, the spinal cord is developed from the food tube.

We can and must infer the existence of an automatic motor nerve-centre in or near the intestinal canal, associated with the nerve plexuses of Auerbach and Meissner. A centre which is alert in health, at least during the waking hours. A centre prone to be affected by many stimuli, but which, when unstimulated and also after over-stimulation, possesses the property of arresting the vermicular movements. Landois and Sterling have shown that the integrity of this centre depends immediately on a certain kind of blood, holding certain gases in solution, and flowing at a definite rate through the intestinal vessels. Upon the blood supply doubtless depend, at least in part, the normal diarrhoea of the newly-born and also the equally natural costiveness of the aged.

There are many more natural movements of the intestines than we are apt to suppose: all are probably contributory to normal and healthy function. I will content myself with

¹ *Journal of Physiology*, Vol. VII., p. 1. 1886. Cambridge Scientific Inst. Co., St. Tibbs Row, Cambridge.

describing seven of the most obvious movements. Of these some are automatic or passive, and some are voluntary.

Second method of intestinal movement.—If we look at the abdomen of a healthy male adult at rest in the dorsal recumbent posture, we notice that the abdominal wall rises with inspiration and falls during expiration.

Third method of intestinal movement.—If we watch still more carefully, we note that the recti abdominales constantly throbb with the impulse of the cardiac ventricles. The movements of ordinary breathing are greatly accentuated during such forced expiratory and inspiratory efforts as are involved in walking, talking, sighing, sneezing, coughing, laughing, vomiting, micturating and defæcating. These tend, on the whole, to thrust the contents of the abdominal cavity downwards and backwards.

Fourth method of intestinal movement.—If we direct the patient to contract the iliaco-psoæ, supplied, as you know, by the anterior branches of the lumbar nerves and the anterior crural, the largest trunk from the lumbar plexus, derived from third and fourth lumbar, with a fasciculus (inhibitory?) from the second lumbar, we get an entirely different effect on the intestines. They are now thrust forward and a little upward. When all the parietal muscles, including the iliaco-psoæ and the quadrati, act together suddenly, then is the favourable moment for hernia to be established.

Fifth method of intestinal movement.—In a natural state when the posterior muscles come forward, the abdominal recti, the obliqui and the transversales, supplied chiefly by the lower six dorsal intercostals, act consensually and, by contracting, push back the viscera and their contents. Both the viscera and the vessels are now exposed to considerable pressure between these opposing surfaces. They cannot escape the squeezing process, for the levator ani is thrown into contraction below, whilst above, the diaphragm, having already descended, remains fixed during effort. Thus a powerful compressing influence is exerted on the intestines, on their contents and on the abdominal organs and vessels generally. The receptaculum chyli is emptied, and for a time lymph is driven back into the cerebro-spinal cavity and into

the lower extremities. Venous blood, too, is for the moment delayed in the leg-veins, and is driven back on the tributaries of the superior cava.

Dr. Lauder Brunton, in a paper read before the West London Medico-Chirurgical Society, June 12th, 1891, spoke of the important part played by the levator ani in normal defæcation. He made some sensible remarks on the encouragement afforded to constipation by the height of the ordinary closet-seat, which leaves the levator ani flaccid and drooping. With a pouched state of that important muscle, it is very difficult to expel a stool: this difficulty is overcome in the normal crouching position of primitive man.

We can readily see why shouting, cycling, rowing, running and hill-climbing must be potent factors in assisting the portal circulation and thus preventing constipation. Lauder Brunton has shown that mountaineering, perhaps more than any other form of exercise, forcibly squeezes the sponge-like liver, stimulating its sluggish portal vessels and its own intrinsic circulation.

Sixth method of intestinal movement.—When we travel, we carry the intestines with us and thus they move in relation to the surface of the earth.

Seventh method of intestinal movement.—We have accounted for six common methods of movement. We may add to these a seventh, which is a kind of natural succussion of the spine. The trunk is jarred every time the heel is placed on the ground. Whilst riding a horse, this jarring is especially felt. It takes place in a train and in a carriage to a less marked extent. If carried to excess, this vibration may produce constipation, which, in many persons, follows a prolonged journey.

Thus we see that there are, at least, seven sorts of movement of the intestines. Two of these movements are always at work, one of them during the waking hours at least. All of them are in active play during the normal life of labour. It is plain that everything which tends to modify any one of these movements, may become a contributory factor in bringing about a state of constipation.

We can quite well understand now why some lazy

people, especially those who breakfast in bed, may suffer from a torpid condition of the bowels. The habit of lying later in bed, coupled with the fact of eating more, of doing less and of being insufferably "bored," may serve to explain in part why some persons are not so well on Sunday.

Constipation in the Young.

As the causation of constipation is so much bound up with the questions of age and of gender, I propose to treat, under separate headings, the three chief epochs of life, and I will afterwards devote a special section to the consideration of the influence of sex on the regularity of the bowels.

Diarrhoea, normal in early life on account of the exceeding hurry of metabolism, is a disease, and a very fatal one, at an advanced period of existence.

I think Vogel was right when he said that nitrate of silver is the specific for costiveness of the newly-born, when that symptom occurs in connection with jaundice. If it fail, then a capital combination is podophyllum 30 by day, with aconite 3 at night. Mercury is indicated by red gum, itself probably a septic rash, by adenoma, green stools (duodenitis), copious frequent micturition with consequent intertrigo, and the troubles of teething. Sulphur is also most valuable. Nux vomica, so useful in adult life, is rarely called for during babyhood.

I will pause here for one moment to suggest a reason why convulsive fits form such a prominent feature during infancy and why they are so intractable on occasions. The tremendous activity of tissue-metabolism during infantile life loads the blood with toxines, just as pregnancy does; if these are promptly removed as soon as they are formed, by vigorous action on the part of the ordinary emunctories, all goes well. But if, on the other hand, something interferes with one or more of the four great sewers of the body, the skin, the lung, the kidney and the bowels, then poisonous products rapidly accumulate in the nerve centres. These, acting on an irritable and unstable nervous system, would readily induce toxic convulsions.

I must admit that the constipation of later childhood is, in many cases, due to sheer idleness or inattention. Unless the call of nature be imperative, the duty will be postponed through pre-occupation, inadvertency or petulance. Therefore the child should be educated from the first with regard to the gravity of neglect of this plain duty; and a daily visit, with patient waiting, must be insisted on, at a definite hour.

Costiveness in boys, with prolapsus ani, may mean either thread-worms, phimosis, or renal calculus. The first calls for ignatia, podophyllum or sulphur; each of these remedies is greatly aided by some appropriate chalybeate. The two latter will of course be met by surgical measures.

Constipation with either unilateral ptosis, chorea, sore navel or enuresis nocturna should draw the attention of the physician to the possibility of round-worm.

Men who have lived freely, and have abused athleticism, present a familiar group of symptoms, which we have all seen relieved by sulphur, hepar, æsculus, mercury or nux vomica. We know well the athletic list of ailments, seen to perfection in the so-called "gouty" subject. Pulmonary vesicular emphysema, enlargement of the liver, especially of the small left lobe, hæmorrhoidal troubles, fits of irascibility alternating with gloomy forebodings. With this group is usually associated the clerical or more correctly the athletic throat, follicular or granular pharyngitis and, in old cases, a condition of pharyngeal varicosis, which has been graphically if not elegantly described by Mr. Lennox Brown as "piles of the throat." These people have, I am ashamed to say, been sometimes condemned as consumptives, merely because they spit a little blood, a process usually followed by a considerable sense of relief. Patients have come to me who have been profoundly depressed by the wholly unnecessary gravity of the prognosis delivered by my predecessor. Nothing is more delightful than to see the complete revolution worked in these persons by a few cheering words, associated with a strict dietary, *i.e.*, abstinence from meat and liquor. With the exception of lung education, complete bodily rest should be insisted on. A type of the sad history of many athletes is to be found in Charles Kingsley, who

died much too early in his career, of pleurisy following extreme over-exertion. Such men, having the congested liver which is secondary to tricuspid insufficiency, find themselves growing "bilious," yet they will not dock their dainties nor take rest. They are goaded on by the deep-rooted Saxon conviction that everything may be cured by violent exertion, if only you take enough of it! Often urged on too by foolish companions, the emphysematous, middle-aged man takes more and more exercise, seeking in vain to remove by exertion the symptoms which have been induced by violent effort, with most calamitous results.

Hydrophathy and rest improve these people. A vegetarian dietary is a grand aid in restoring them. A glass of water on waking, taken hot if the heart be thin and dilated, often produces the needed evacuation. Mercury, nitric acid, nuxvomica, sulphur, bryonia or *æsculus* may be thought of; also high dilutions of the hepatic stimuli may be administered before meals. A drop of aconite in the form of mother tincture or the first decimal dilution, given at bed-time in a pint of very hot water, sometimes acts admirably. These patients are prone to have acute pains in the great occipital or second cervical nerve. This pain may be promptly relieved by ten to twenty grains of the bromides, it is sometimes rapidly removed by five to ten grains of antipyrin. I have seen it permanently cured by a course of sanguinaria in the lower dilutions. At the same time, possible errors of refraction and accommodation should always be accounted for.

Constipation is the bane of old age. We must not expect to cure it. But we mend matters by looking carefully after the teeth, removing septic material and replacing by art that which is denied by nature. If appropriate exercise be impossible, an attendant may work the knees up and down. Then, whilst an attendant holds the ankles, the patient should be requested to rise without the use of the arms—counting the while to prevent rupture.

For colic of the aged, especially for the nocturnal form associated with constipation, I have found *plumbum metallicum* in the third trituration of signal service.

There is a form of senile constipation, first described, I believe, by Arbuthnot Lane, of Guy's, the author of some admirable observations on the modifications of bony tissue produced by age and occupation.

Old men sit much more than the young and they usually sit in a particular way. The body is pitched forward, whilst the hands grasp the arms of the chair. Owing to this peculiar posture, and to the natural senile atrophy of the soft parts which surround the ischia, there is a progressively increasing pressure on the coccygeal tip, which slowly curls towards the front of the sacrum. I have met with this condition when the tilted coccyx blocked the advancing faecal mass, acting just as a moraine does on the travelling glacier. I have been able to mend matters by gently, yet firmly, pressing the coccyx downwards and backwards.

Costive and corpulent old gentlemen sometimes derive considerable benefit from dieting. Sugar, starch and alcohol may be replaced by plentiful fruit and vegetables. They improve with the use of passive movements, of deep abdominal effleurage, with the employment of de Watteville's thick wire induction coil applied to the abdomen. The occasional injection into the sigmoid flexure of a hot solution of Epsom salts, by means of a long tube, sometimes brings away a vast accumulation of scybala.

Constipation in Women.

Costiveness in girls, residing at a boarding school or engaged in a factory, often arises from inadequate provision of time and accommodation. Dr. Arthur Clifton, who has had a large experience in such cases, tells me that he can quite endorse the observations of Sir Andrew Clark in the relation that coprostasis may bear to chlorosis. If anæmia may arise from constipation by autotoxis, then neglect of a regular relief is not quite such a venial offence as some of our veterans would have us believe.

It is certainly monstrous that a large boarding school should depend on a single water closet, a few minutes only being allowed for its use by the entire community. There is a detestable custom in some schools, that if a girl ask to

leave the room for a relief of nature, she receives forsooth a bad mark!

Spinal curvature may lead to constipation as we all know. I am not sure whether it is as well recognized that a costive habit may lead to spinal curvature. On this important point I will refer you to my authority—Mr. Warrington Haward.

Mr. Warrington Haward, in an excellent article, on "Surgical Aspects of Constipation," in the *Lancet* for April 28th, 1888, gives the following case, with some remarks which may interest you: "A young lady of nineteen was brought to me on account of a lateral curvature of the spine. There was a slight curve, the convexity in the lumbar region being to the left.¹ The patient complained much of a dull pain in the loins, especially on the left side. She stooped a good deal, and was very easily fatigued. She was, moreover, extremely thin and anæmic, had but little appetite, a coated tongue, foul breath, and very cold hands and feet. An examination of the abdomen revealed a large fæcal accumulation in the sigmoid flexure; and, on being questioned, she admitted that the bowels were extremely constipated, often acting only once a week. This is one case out of a series of the same kind which have come under my notice. In them, a supposed lateral curvature is merely the habitual position assumed by young girls suffering from obstinate constipation and loaded sigmoid flexure. Such cases," Mr. Haward goes on to say, "are best treated by massage, feeding and aperients, under which the anæmia disappears, the bowels recover their power, appetite is regained, flesh is made, and the yielding of the spine comes to an end."

Constipation, alternating with lientery, should suggest defective teeth.

Constipation, varied by mucous diarrhœa, may arise from a vast number of causes, prominent amongst these being retrorse uterine dislocation. It is a mistake to view piles as constituting a proof of backward displacement of the womb. They are much more suggestive of cervical hyperplasia. A

¹ This is probably a misprint for right. A loaded left abdomen would lead to flexion towards the affected side. So would pain in left erector spinæ.

very hot hazeline enema, the more copious the better, at bed-time, tends both to cure the cause, and to relieve the results, in both kinds of cases.

Constipation, associated with persistent pain in middle cutaneous of thigh [a branch of the anterior crural from the third and fourth lumbar, with connecting filaments to second lumbar, see Dr. Murray on "Our Mistakes," *Lancet*, May 7th, 1892], should lead at once to a search for rectal carcinoma.

Possibilities of fistula, fissure, piles, polypus and pocket should be borne in mind. The existence of a forgotten pessary should be contemplated, whilst such foreign bodies in the vagina as a cork, a stick or a jam-pot have been known to explain otherwise inexplicable constipation.

Sea-side constipation may be relieved by iris versicolor 1 or 3x before the meals and aconite low at bed-time.

There is a form of constipation, which I do not remember to have seen described. It is quite common in cases of old-established pelvic stasis, and is very curable by a mechanical manœuvre. It is produced in the following way: Organisable lymph is slowly poured out in the meshes of the connective tissue which surrounds the internal sphincter. This, in process of time, forms a cylindrical ring, which can be rolled between the finger and thumb, imparting to the touch a sensation as if it resembled an umbrella ring of caoutchouc. Dilatation by means of the two index fingers, after carefully cleansing the bowel and using cocain, often effects a permanent cure.

I had designed to bring before the Society cases illustrating the successful treatment of constipation by isolating the particular element at fault, and artificially supplying the special need. This, however, time forbids. I will content myself with a single example.

A delicate lady, aged 40, during two years after spinal meningitis, lost all power of defæcating. The lost art of evacuating was completely restored by systematic morning succussion. The colon was cuffed by the cupped hand. This was effected by the patient herself.

Dr. CLARKE doubted whether much practical good was derived from a too minute analysis of all the nerves brought into play in the relief of the bowels. Dr. Lauder Brunton had explained to the world the action of the nerve-centres when Eve plucked the apple for Adam. But no good advance was thereby gained for either science or theology. Most of them had experience of the successful use of the simillimum, without too careful an analysis. Aconite had done good without any examination of the relation between constipation and the general condition of the patient. Some of the worst cases had yielded to alum and alumina; alumina was good when the stools were in hard, small lumps. The longest case of constipation he had known was a patient in the hospital who did not defæcate for three months. He had heard of a case of a whole year's constipation. It was an Irish case. Natrum muriaticum was also useful in bad cases in the sixth decimal dilution. A lady, of an age about the climacteric, who had suffered from uterine hæmorrhage and had been under many specialists, had ultimately found relief from hydrastis.

Dr. HUGHES's experience had been similar to Dr. Clarke's. Dr. Blake's physiological hypotheses were interesting, but somewhat unpractical. But he agreed with his remarks about hygiene. It was most important to ascertain habits to bring the patient into a suitable condition. But Dr. Blake should not underrate remedies. When they had done all that their fellow practitioners of the old school could do, they had remedies to fall back upon which acted marvellously; sulphur, bryonia, nux vomica, opium, among the old medicines, and hydrastis and collinsonia among the new. Bryonia 30 had often set a young child's bowels at work. After doing all that hygiene could suggest, it was important to find the medicine which best corresponded to the symptoms.

Dr. MORR thought Dr. Blake had thrown out excellent suggestions. But could they hope, without medicines, to keep the bowels regular? They might, of course, resort to enemas. He had found that medicines could not be relied on to take the part of nature. There was, not long since, a case of peritonitis in the hospital. The patient died, and there was found that ulceration and perforation of the colon had been caused by a mass of hardened fæces. It was not safe to leave such cases to nature. The seats in closets were too high. In old people he had found new masses of muscular tissue formed around the anus, and relief in such instances was afforded by simple dilatation.

Dr. GOLDSBROUGH was rather surprised that Dr. Blake did

not mention opium in babies, which he regarded as one of the leading medicines, especially if there was a tendency to convulsions. *Nux vomica* was also useful in babies, in the sixth or twelfth dilution. He was also surprised no mention was made of *hepar sulphuris*, especially when there was catarrhal jaundice. He had reported one case in the *Homœopathic Review*. *Hepar sulphuris* had produced a marked effect in a bad case of constipation with jaundice. In chronic cases where there was ballooning of the rectum, Dr. Drysdale, at one of the Congress meetings, had advocated physiological rest. Mr. Harris had a case of retroflexion of the uterus with pelvic stasis—difficult menstruation—obstinate ballooning of the bowel. She had been under treatment at Guy's, and when he saw her she was put into bed and given nothing but bovril for 35 days. She then had a natural movement of the bowels. He carefully watched the symptoms from day to day—noticed the condition of the tongue, the bowels and the temperature. The patient had another natural movement 9 or 10 days afterwards. Another case was that of a lady three months pregnant. The bowel was constipated. The patient was highly neurotic. She was left alone without evacuation by enema. She got relief every five or six days, although painful, a large stiff stool over which she had no control. He could not find a simillimum to that, though he had looked through the repertories. *Plumbum*, *collinsonia*, *opium*, had no effect. The attractive physiological reasoning of Dr. Blake was hardly applicable to ordinary practice.

Dr. THOMAS said he had an old lady of 76 who had been troubled with constipation since she was 20. For the last six years resort had been had to enemas. She came to him in October; he began with sulphur, then opium, then alumina, 3. She now had an action of the bowels every second or third day.

Dr. DUDGEON observed that when a constipated person was afflicted by an acute disease—such as bronchitis for example—which had no direct connexion with the bowels, it had often been found that the constipation ceased although the medicines were not directed to its removal.

Dr. BURFORD said that he had happened to be for the first time at a meeting of the Royal Society, the object of which was to raise a memorial to Owen, when Dr. Flower said that most of Owen's work was not permanent. Certain anatomical observations had been controverted by Clarke. Then Johnson Symington had advanced a third set of views. If in these circumstances where observations, not theories, were concerned, three different

views could be held by those eminent men of science, we might dismiss the question of finality. It had been said that no physiological fact lasted more than three years. But this did not give much aid with regard to effective treatment of anomalies which constantly occurred, and could not be explained by physiology. With Dr. Dudgeon he saw a case of strangulated hernia in which the use of enemata produced a considerable stool. But after death there was no doubt of the real condition of things. Of remedies *natrum muriaticum*, 6, was among the most valuable. With regard to absorption from the gut, when he was house surgeon at Soho Hospital there was a case of cancer of the colon which led to an enormous accumulation of *fæces*. He gave enemata for 20 days. About the middle of the treatment the woman developed septic pneumonia. There had been for many days absorption from the gut. This explained the general condition. Young girls sometimes showed all the symptoms of spinal irritation, which were relieved if they were sent to bed and the bowels relieved two or three times a week. Massage and electricity are also useful. If the paper were printed he hoped Dr. Blake would reconsider the question of remedies, as they all looked upon him as one of the *patres conscripti* in the homœopathic treatment of disease.

Dr. BIRD remarked that one cause of infantile constipation was constriction of the anus, which nurses removed with a greased finger. How would homœopathic remedies affect such condition?

The PRESIDENT approved the hygienic measures which had been recommended. He had found singing, especially if the girls were taught to take breath in the modern scientific way, a remedy for constipation. Dr. Blake's paper was full of matter, and they would all look forward to seeing it in print.

Dr. EDWARD BLAKE, in reply, said that he had listened with great interest to the references to *natrum muriaticum*, a quite invaluable drug, possessing, like most of the salts of alkaline bases, a strong elective affinity for the endometrium. It is a grand remedy for profound hydræmia with constipation, especially if the mouth be dry and a vesicular rash invade the lip.

It is a fact that patients, with marked pelvic congestion, often improve as regards their constipation when confined to the bed. No doubt this is partly mechanical, the heavy and depressed organs float upwards, the weight of the uterus being taken off the rectum, the obstruction to the onward passage of the *fæcal* mass is removed. Then of course the congestion itself is relieved, because the syphon-like vessels of the uterus are emptied through their improved position.

Dr. Blake proceeded to say:—"I do not believe that the persistent relaxation of the abdominal wall due to maternity is a mechanical matter. It is a far more deep-seated affair. No amount of supporting before or of bandaging after delivery will prevent it. Ptomaine poisoning goes on in many women during pregnancy aggravated by constipation, for as I have shown they have not only their own toxins to dispose of, but also those of the unborn child. Nature makes large provision for this in the enormous foetal liver, and in glands devoted during this time to special functions of metabolism, as for example the thymus which, reaching its maximum development at two years of age, fades away at puberty.

"This epoch also doubtless sees the highest activity of the adrenals. Witness also the enormous development of adenoid tissue in the naso-pharynx in the case of the young, under the irritation of inhaled bacteria and their proteid products.

"I have shown that when the functions of the adrenals are paralysed by purulent products, the pigment changes first described by Addison are seen.

"When their functions are suspended by arsenic, we see Cheadle's disease. But the poisons which flow through the suprarenal capsules affect also the thyroid gland and they then may give rise to those pigment changes which have been described by Drummond, West, Carrington, and some continental observers as 'thyroidal bronzing.'

"We see the same pouching of the abdominal wall carried to an extreme degree during the course of puerperal fever and in typhoid. The causation is identical in both. Virulent toxins have invaded the motor spinal roots, and the patient, if the disease be not checked, falls a victim to true ascending palsy. The paralysis attains its lethal point when the poison, reaching the anterior roots of the fourth cervical, overwhelms the nucleus of the phrenic.

"A collateral piece of evidence of the truth of the above statement, is that at the same time that women become pouched or 'pot-bellied,' they also are prone to become flat-footed. This is not due, as has been thought, to relaxation of the ligaments of the foot, but in great part to paralysis of the flexor longus pollicis and, in less degree, to paresis of the flexor brevis digitorum, both of which muscles derive their nerve supply from the posterior tibial.

"The accuracy of this pathological position is attested by the clinical fact that flat-foot, a serious item in accentuating the constipation, by obviating exercise, may be removed by direct

stimulation of the two muscles at fault, by means of the combined current.

"I have not, in my experience, found that the neurotic and muscular elements predominate in the constipation of the very young. Pot belly, nearly normal in babies, does not in their case arise from defective innervation of the abdominal wall. We know this from their proneness to colic, which I have shown to lie in tonic contraction or tetanic cramp of the rectus abdominis.

"Primarily it is the mere anatomical accident of a shallow pelvis and of undeveloped ilia.

"Their constipations are usually due to arrested glandular action—they call for such remedies as aconite, mercurius, podophyllum and hepar."

NOTES ON A CASE OF SUPPURATIVE PERICHONDRITIS, WITH ŒDEMA OF THE LARYNX, OCCURRING DURING AN ATTACK OF TYPHOID FEVER.¹

BY MR. LEO ROWSE.

Resident Medical Officer, London Homœopathic Hospital.

MR. LEO ROWSE showed a specimen taken from a girl, aged 14, who was admitted to the hospital under Dr. Blackley with typhoid fever. She came in at about the third week of the disease, during the first week of September. During the first two weeks of her illness the disease was of the asthenic type, with a comparatively low and certainly very irregular temperature. She got much better, and on the 19th her temperature became normal for the first time. It did not remain normal more than a few hours, and went up in the regular typhoid character till it reached again 104°. The symptoms then pursued the usual course, but on the 28th there was some slight stridor noticed in her breathing, and she complained of having some sore throat. He examined her throat and found the tonsils slightly enlarged,

¹ Read before the Society, October 6th, 1892.

and the pharynx just a little injected. She complained, however, of no pain in swallowing. On the 30th, in the morning, he was called to see her, and found that she had a somewhat sudden and great dyspnœa; this not yielding to treatment, tracheotomy was performed, as death seemed imminent. As soon as the operation was finished she breathed very well and seemed to be doing nicely for a few hours, but the purulent expectoration simply poured out of the tracheotomy tube, and she died on the afternoon of October 1st, about thirty to thirty-two hours after the tracheotomy was done, from cardiac failure due, he believed, to bronchitis. Dr. Moir very kindly made a *post-mortem* on the following day, and this was the specimen he produced.

There was a great deal of œdema of the larynx occupying the aryteno-epiglottidean folds to be seen. It showed very much greater in a fresh state, the larynx being then completely closed. Another point of interest about it is that there was evidently an abscess all round the cricoid cartilage, a suppurative perichondritis, separating the perichondrium completely from the cricoid.

The PRESIDENT stated that he saw the patient just at the last—she having been admitted during his absence on his holiday. It appeared to be a perichondritis akin in its character to the periostitis which is so common after typhoid fever. The case was a relapsing one, a fresh crop of spots having come out about a week before her death.

Dr. BYRES MOIR said he never before remembered any case of typhoid where tracheotomy had been necessary. When he made the *post-mortem* the whole of the upper part of the larynx showed the existence of extensive œdema very plainly, so that the opening of the glottis must have been quite closed: then in cutting into the larynx, there was pus surrounding the cartilage, and it was quite separated. What was peculiar in the case was that the periostitis, which the President mentioned, was usually sequela, but this occurred in the active stage of typhoid.—(*Pathological Specimen, October 6th, 1892*).

ON A CASE OF EXTRA-UTERINE GESTATION,
IN WHICH LAPAROTOMY WAS SUCCESS-
FULLY PERFORMED TO REMOVE A SUP-
PURATING FŒTUS FROM THE PERITONEAL
CAVITY.¹

BY GEORGE BURFORD, M.B.

Physician to the Gynaecological Department, London Homœopathic Hospital.

At the present day, when the diagnosis of extra-uterine gestation has been so carefully elaborated, that in place of being a rare lesion, it is now detected with surprising frequency, and when the successful operative treatment has also been correspondingly developed, the narration of a recent case where the diagnosis was exact and the treatment successful will not be without special interest.

The patient was a married woman, 25 years old, with a history of one labour some five years back, and a clear account of regular menstruation from thence up to October, 1891. At this juncture the period suddenly closed, and she became pregnant. The ordinary course of pregnancy apparently supervened for three or four months, after which the course of events was constantly interrupted by various symptoms and crises, detailed later on. She was twice in hospital for treatment of urgent conditions during the next few months; but after ten months of patient waiting the confinement seemed as far off as ever. She now came under the care of Surgeon-Captain H. E. Deane, who directs the hospital for soldiers' wives and children at Aldershot, and by whom, the condition being detected, I was asked to undertake the case.

In the history of this remarkable case of extra-uterine gestation, the events in the earlier stadium were so marked, and their import so clear, that it is difficult to exonerate the supervisors of that period from failing to recognise the extreme gravity of the condition. A patient, with a clear history of four months' pregnancy, presents herself with a swelling in the flank so painful and tender, that a three-

¹ Read before the Society, October 6th, 1892.

weeks' residence in the hospital is requisite to subdue the urgency of the symptoms. With the assurance of pregnancy she is discharged from hospital, and a week later some of the phenomena of labour set in, in the shape of labour pains, followed by a discharge, in which is observed pieces of "flesh"—probably decidual. This discharge lasted for five days after the pains, attending which was a systemic collapsed condition continuing for twenty-four hours. She revives and is able to travel, and in three weeks' time these symptoms repeat themselves—a sudden sense of violent movement in the abdomen, a loss of consciousness, with a reappearance of the discharge, again containing "fleshy" masses, and this time lasting three weeks. The first stadium is now complete, and we have here clearly delineated the history of a tubal gestation proceeding calmly, as is its wont, toward the twentieth week. The tube has now become distended to its fullest capacity; an attempt is made to discharge the foetus, in which attempt the tube is ruptured. Simultaneously the uterus takes on the function of labour, discharging its contents as partially liquefied decidual masses, together with the oozing of blood. A prolonged period of unconsciousness attends this epoch: and gradually the patient recovers, to have these phenomena repeated in a more striking form three weeks hence. The extrusion of the foetus from the tube, probably only partial the first time, now becomes complete; it is expelled into the peritoneum, the uterus finally evacuates the remainder of its contents, and goes through the process of involution, the completion of which process is determined at the time of operation. The extraordinary and striking anomaly, hitherto observable in these crises, is the complete absence of the usual evidences of intra-peritoneal hæmorrhage, a complication so usual, that in the majority of cases the patient's history goes no farther, unless immediate operation be resorted to.

The early crises are over, and we have now to deal with a foetus, detached from its vascular connections, lying as a foreign body freely among the intestines, and commencing to undergo retrograde processes.

Let us continue the symptoms through the second or

post-ruptured stadium up to the time of operation. The patient notices that her abdominal girth becomes less and less; a previously existing œdema of the legs now disappears, and the milk, hitherto running from the breasts, now ceases to be secreted. A backache, with a bruised sensation, is developed and persists, and recurring states of collapse, of varying gravity and duration, repeatedly manifest themselves. Through one of these she was watched by Mr. Deane, who summarises the events thus: "On the evening of September 8th, she suddenly complained of a sinking feeling, and became collapsed, with a feeble pulse; she rallied, but experienced the same condition next evening, though her pulse was not so weak. She was not blanched, but complained of great pain in the back and left side. The next day she had regained her usual health." When I state that exactly such an attack occurred in hospital, after the administration of an enema, you will see in these citations the account of recurring crises of shock, due to the presence of a mobile and detached foreign body of some bulk in the peritoneal cavity.

The first week in August a menstrual period supervened, and the occurrence was repeated the first week in September, lasting about seven days. The pulse and temperature were never observed to be other than normal; the appetite was good, the capacity for sleep unimpaired.

Late in the history of the case the patient came under the care of Mr. Deane, who, recognising the gravity of the condition, kindly asked me to see her. We determined the presence of a foetus free in the peritoneal cavity; of an emptied uterus; and, recounting the history, we had no difficulty in unifying the series of events in the patient's case which had culminated in the condition under observation.

After the storm now reigned a delusive calm. Here was a patient of healthy aspect, of excellent appetite, of unimpaired capacity for sleep, and possessing with it a normal pulse and temperature. There was no sickness, no constipation, no impairment of digestion. Save for a backache, which, whilst reclining, was only moderate, and for an

occasional wave of pain and tenderness in the left side, and for recurring conditions of collapse which were moderate in their intensity, and not prolonged in their duration, there were no symptoms indicating that we were dealing with a present condition of great gravity, and with a patient literally on the very verge of a catastrophe. That such might be the case we had reason to expect; that such actually was the case, operation proved. With a view of averting any critical development, and with a desire not to wait until the vital resources had been seriously impaired, with the concurrence of my colleagues I operated. In the abscess cavities, on the verge of rupture, into which the tissues of the scalp and buttocks had developed, we recognised the imminence of that deadly peril which our timely action had averted. A little time longer, and that foetid fluid would have been poured into the peritoneal cavity, and probably one more would have been added to the list of preventable deaths from which timely operation might have been all-powerful to save.

Mr. KNOX SHAW asked what evidence there was that the cavity contained pus. He was extremely interested in the case, but unfortunately was not present when the foetus was opened, and he could not be sure that the yellowness which they saw was not due to a condition of mummification or even adipocere. He observed that the buttock had been opened, and he supposed pus was found there, but he thought that in drawing attention to the case it would be interesting to have it clearly stated where the pus was found. The case was one of immense interest, and it might be many years before they saw such a case again. It was a case, as they saw it, in which the difficulty of diagnosis was not very great—whatever it might have been in the earlier stages. It appeared to him highly probable that in bygone times it would have been believed that the foetus was germinated in the peritoneal cavity itself—that it was developed totally *ex utero*, and was formed in the sac of the peritoneum itself, and was not connected either with the broad ligament or the Fallopian tube.

Mr. ROWSE, who had examined the foetus, stated that on incising the buttock he had discovered a mass, exactly such as one finds in caseous tuberculous disease, that is to say, no liquid

was but a cheesy mass, which had been for some time probably undergoing caseation; such a condition as was often seen in tuberculous glands.

INFANT LIFE INSURANCE.¹

BY FRANK H. SHAW,

Surgeon to the Buchanan Cottages Hospital, St. Leonards-on-Sea.

I MAKE no apology for bringing before this Society a subject which is in no way connected with the art of healing, considered either from a medical or surgical aspect, believing, in addressing my fellow-members, I am appealing to men who do not regard the administration of drugs or the use of the knife as the "be all and end all" of our position as medical men.

I shall endeavour as far as possible to regard my subject—that of "Infant Life Assurance"—from a medical, or shall I say from a medical practitioner's point of view, for it is a many-sided subject, and has a vast social bearing which cannot be altogether left out of sight.

It is now five years ago since the Rev. Benjamin Waugh, the energetic founder and director of the "Society for the Prevention of Cruelty to Children," startled the complacent and easy-going British public by stating the fact that at least *one thousand helpless little children* were annually *done to death* for the sake of the insurance money due to their unnatural parents or guardians, on giving satisfactory proof to the Insurance Society of such death.

A statement so appalling, so sweeping, called forth at once, as was natural, much comment and criticism, and, from those interested in the maintenance of the present system of Infant Life Assurance, much abuse. But the more the subject is investigated, the more light that is

¹ Read before the Society, Feb. 2nd, 1898.

thrown upon it, the more those who are competent to give an opinion and to add to the already existing and damning evidence are questioned, the more painfully evident does it become that Mr. Waugh has rather under than overstated the facts of the case.

Here let me at once say, before I appeal to the evidence that I intend briefly to lay before you, that those of us (and I am convinced this will include all the members of this Society, when they have given the subject the due consideration it deserves, many doubtless having already done so), who are anxious that the law as regards Infant Assurance as it now stands should be speedily and materially altered, are thereby bringing no charge against the industrial classes of this country as a whole. It is only because there exists in that class, as in every other class, a small but appreciable minority destitute of every virtue, destitute of what is seldom lacking in the brute creation, namely, natural affection.

It is not a question altogether of depriving the British workman of his rights. Let us remember it is the industrial class only that is permitted by law to gamble with its offspring—the death certificate of an unwanted child against three, or six, or ten pounds from the Insurance Societies. The game was long ago recognised as far too tempting and dangerous for the wealthier portion of the community, and, by an Act passed in the reign of George III., *forbidden*. It was the *repeal* of this law in the reign of our present Queen, as far as the industrial classes are concerned, that makes the evil now possible.

If there be a *libel* at all in the above statement it is a libel upon the frailty of human nature. To say that “One in every thousand of the working classes is not to be trusted” is not a libel on the nine hundred and ninety nine.

It is, then, with this appreciable minority of the wage-earning class—for one in a thousand comes to be an appreciable minority if you put down the wage-earning class as ten millions—we have to consider; chiefly the very poorest or most dissolute portion. But for convenience I will roughly divide them, and place them under the following heads:—

1. The indifferent.
2. Those parents devoid of natural affection.
3. The deliberate child destroyers.
4. Those who are parents or guardians of illegitimate children.

1. *The indifferent.*—Perhaps not such a very large class, who certainly would never become criminal, but for the temptation held out to them. The balance would probably be evenly held, but for the accursed gold that is thrown into one side of the scales by the insurance agent. The methods of this class to rid themselves of their children are nearly always passive; they let things go; they don't send for the doctor till too late, for it is the doctor's fee *to pay*, versus six pounds *to be paid to them*, a loss against a gain; or, perhaps, they neglect to carry out the doctor's instructions, or to give the medicine when they have sent for him. If the child had not assumed a *financial value*, its life might have been saved; it is just this fact which has handicapped it.

2. *Those parents without any natural affection.*—A surprisingly large portion of the minority, a far more difficult class to deal with than the first, for their methods are coarser. The unwanted child is ever standing between them and the wanted gold. The methods used to rid themselves of a nuisance, and to give them the means of satisfying their lusts, will be more determined and less passive. The children are starved or improperly fed. They know, as well as we do, that you may kill a child as effectively by improper food—such as an exclusive diet of bread, or biscuits, or by sour milk—as by withholding nourishment altogether. In fact, they are far too crafty to adopt the latter course. Medical aid is never sought until the child is *in extremis*; the medicine is sure to be thrown down the sink, and the advice not followed. The only reason for seeking medical aid at all is that the "*papers*" may be all right. About these papers I shall have a word to say directly. There is only one other method of these parents or guardians without natural affection, that I need mention, it is their unscrupulous use of soothing syrups and powders. This method has, at least, this to recommend it, that it is painless and merciful compared with some of the means used.

3. *The deliberate child destroyers.*—I need say but very little of these, they belong usually to the most dissolute and debased portion of society. The money, to them, would not be the only inducement to rid themselves of the children, it would be only one more *added* inducement. Their methods are chiefly poison and wilful exposure of the children, scantily clad, during cold and inclement weather. And lastly :

4. *The parents or guardians (baby-farmers, etc.) of illegitimate children.*—Between fifty and sixty thousand illegitimate, and therefore *unwanted*, children, are born in this country every year—a population equal to that of a town like Hastings. Far be it from me to say that many of these helpless babes do not bring with them the fullest share of a mother's love, but the fact remains that the majority of them are a hindrance and a burden to their mothers, even before they are born into this world. Is it to be wondered at, therefore, that these children should figure largely in the death-roll of those let die, or deliberately killed for the sake of the insurance money? For the more virtuous portion of the community adds one more temptation to the already overburdened souls of these unfortunate mothers, in the shape of so many pounds, shillings and pence available upon the death of the child.

Now about those "papers" I alluded to just now, the *Death Certificates*. I am sure this question of giving death certificates will come home to every medical man. It is one most of us have to face in our dispensary, hospital, and the poorer portion of our private practice. If I may draw for a moment from my own personal experience, I can without any effort call to mind more than one case in which I have given a certificate that in the light of my present experience I feel convinced I ought to have withheld. In future I should look with the gravest suspicion upon any case in which those who brought the child for treatment (and it is not generally the mothers who bring the children, they are always said to be ill, or engaged) displayed anxiety as to "whether 'the papers' would be all right if anything happens," especially if the child so brought be *in extremis*. The difficulty in detecting cases of neglect

or wilful exposure is always increased when the children are brought to us at the dispensaries or hospitals and not seen at their own homes. That my experience is not peculiar, I judge from the evidence of some of the medical men before the committee of the House of Lords. To take two examples.

(257) Mr. Branson, M.R.C.P., said "The experience of every man I have spoken to has borne out the same thing, namely, the difficulty of giving certificates."

(258) Asked if medical men do give many certificates which they ought not to give. The answer was "Yes, we do."

Mr. WILLIAM JACKSON CLEAVER, M.B., M.C., of Sheffield, said:—

"It is a very common idea in the profession that there is a good deal of wilful neglect and child murder connected with insurance. In years gone by I used to have a great number of very weakly infants brought to me close upon their death, for whom I used to give a certificate, not thinking there was anything wrong about the case. It is only in the last four or five years that I have got to know that those children had many of them been insured, and I cannot help thinking that the reason why they have dwindled away from my hospital is because of the great care I have exercised in the last four or five years in questioning the mothers before granting death certificates."

I have the report here of several cases in which children have been poisoned, and deaths from ordinary diseases certified, which I have no need to read.

The profession is, I believe, becoming more and more alive to its responsibility in the matter of giving these certificates in doubtful cases; the knowledge of the evil use that is made of them, makes us, I trust, all more careful.

And now one word as regards the methods in which the children are insured. The old-fashioned custom of the "friendly-lead" in which the neighbours met in a public-house, and the plate was passed round, between the songs and glasses of beer, to collect the necessary funds to meet the funeral expenses arising from a death in the home of a fellow workman, has given way to the apparently more seemly efforts of the insurance agencies to meet similar

emergencies. Roughly speaking, these agencies may be divided into two classes :—

(a) The friendly societies and burial clubs, “ The Odd-fellows,” “ Hearts of Oak,” &c.

(b). The collecting societies, such as the “ Prudential,” “ Pearl,” &c.

The former are usually local and mutual, the latter purely trading companies. I should like to emphasize this distinction, because in suggesting remedies to meet the evils of infant life assurance it will be necessary to refer more particularly to these distinctions.

I must tax your patience for a few minutes, whilst I read to you evidence given by experts, if I may call them so, before the committee of the House of Lords, with its able chairman, the late Archbishop of York, better known perhaps as the Bishop of Peterboro'. The men called before that committee cannot be accused of being mere enthusiastic sentimentalists. Parish doctors, or those attached to large dispensaries and hospitals, are not usually led away by their feelings. Coroners are not given to over-statements, and the highest judges of the land are accustomed to weigh both their statements and the evidence brought before them. Yet they combine unhesitatingly in their condemnation of the present system of infant life insurance, with one exception, and he a coroner. This is what some of our medical men have to say on the subject, and I quote their evidence as arranged for one of the supplements of the “ Children's Guardian.”

Mr. ALGERNON HODSON, L.R.C.P., M.R.C.S., of Brighton :

“ I have formed a very strong opinion as to the connection between murder or ‘ the putting away ’ of children and insurance. It is impossible, under the present state of the law, to bring home this crime of wilful neglect and child murder to the parent. I have in many cases been perfectly satisfied that a child has been literally murdered, for I can call it nothing else. At the General Hospital at Hove, Brighton, we have a very large number of cases of *marasmus*, which is a wasting disease, in which we are perfectly satisfied that the children are simply starved for the sake of the insurance money.”

Mr. JOHN BRANSOM, M.R.C.S., M.R.C.P.Edin., L.S.A.Lond.,
of Rotherham :

“The general effect of infant insurance amongst the improvident classes of the poor is to make them careless as to the treatment of their children. It has generally demoralised them; their natural care has been lessened by the inducement to neglect which insurance holds out to them. It is only the flagrant cases we can lay hold of; nothing is more easy than to kill a child, but nothing is more difficult than to detect the crime. When they wilfully mean to compass the death of the child, as I know they do in many cases, they can time it so as to kill it in a few days. They become perfectly wooden and indifferent to the prospect of the child's death. The thought which is constantly before their minds is, ‘If the child dies I shall get so much money.’”

Mr. HENRY BURRY PULLEN-BURRY, L.R.C.P., M.R.C.S., of
Liphook, Hants :

“My opinion is strongly against the system of infant insurance. Frequently I have been called to cases of moribund insured children; they were dead within a few hours. They were all cases in which a certain amount of medical attention would probably have pulled the child through. I was called in just in time for them to get a certificate of death, and for nothing else. I do not believe the law knows anything about these cases, or gets hold of 5 per cent. of them. It is my distinct opinion that the insurance money is an inducement to bad parents either to do away with the child or to criminally neglect it.”

Mr. JOHN JAMES RITCHIE, M.R.C.S., L.R.C.P., Medical
Officer of Health of Leek :

“My experience as medical officer of health confirms the view that child-life assurance as at present carried on is unfavourable to child life. The history of our experience at Leek may be interesting and useful. There has been a burial society here for upwards of thirty years, which has been well worked and proved of great service to the inhabitants. For certain reasons the directors saw fit in the year 1876 to discontinue the insurance of lives of infants under one year. At that time the infant mortality was 156 to 1,000 born, a little over that of England generally. In the following year the mortality dropped to 109—the lowest point ever reached. As soon as the local society declined this class of business, the branches of several large insurance offices took it up, and vigorously canvassed for the same, and in the year 1878 the

mortality rose to 170; the average for the last seven years has been 170, and during the year just closed it reached 186, while that for the whole of England and Wales was 147."

Mr. FREDK. DUNN, M.R.C.S., of Wolverhampton :

"When I held the appointment of Union Medical Officer, I was struck with the frequency with which children suffering from diseases of an asthenic type, such as atrophy, tabes, diarrhœa, convulsions, etc., were brought to the dispensary at the last moment, mainly with the object of obtaining 'the certificate,' such children being almost invariably insured. In reply to my question: Why has not this child been brought to the doctor sooner? the general answer was: It has always been a delicate child, but has got worse the last day or two. The truth of this statement I had no means of verifying, but I noticed that generally after one or two visits at the most the mother came for the certificate. This I could not well withhold, having nothing to go upon. I feel morally convinced that the child had been allowed to 'go out,' or, at least, to become so ill as just only to allow of its being rushed up to the doctor at the last moment to cover themselves."

Mr. SIDNEY BARWISE, M.B.Lond., M.R.C.S., of Blackburn :

"Child-life insurance is certainly, with the lowest class, an inducement to neglect children. My practice has been entirely with the pauper class. Outdoor paupers insure their children in large numbers, and in my opinion the sum of £2 or £3 is sufficient to upset the balance of motive in bad parents."

Mr. C. S. REDMOND, L.R.C.S., Gateshead, formerly Medical Resident Officer of Dispensary :

"Over and over have I been called to cases too late to do any good, but where it was only too apparent that a doctor was sent for, not in the hope of rescuing the child from death, but of saving the parents from punishment—their only anxiety being evinced by the hackneyed inquiry, 'If anything happens to it, I suppose you will give me a certificate, doctor?' In many of such cases I find the infants' lives insured."

Mr. W. CAREY JEFFERIES, L.R.C.P.Edin., of Brighton :

"The fact that at last steps seem about to be taken to inquire into the practice of insuring the lives of young children cannot but bring a sense of relief and satisfaction to the minds of all

medical men who have, in the out-patient department of the hospital or in general practice, been brought in contact with a large number of the children of the poor. . . . It is not easy to define the reasons that excite the medical man's suspicions. It may be that he is struck with the fact that the child brought for treatment a little sooner; that a rather long interval takes place before it is brought again; or that there is always a full bottle of milk or other food near it somewhere when his visit is expected. A second and generally older woman than the mother is almost invariably present, who asks questions and volunteers statements as to the child having 'screaming convulsions,' 'Can't keep its food,' etc., as if to prepare the practitioner for what will soon happen. Meanwhile the child wastes away, perhaps gets convulsions, and dies. The certificate of death and insurance money are obtained, as the medical attendant cannot say its death was not due to natural causes, and there it ends."

It will naturally be asked "Why don't you as medical men send more of your suspicious cases to the coroner?" And I think the answer is: Experience has taught us that it is useless to do so in the hope of getting the cases committed to the assizes, for on suspicion alone they certainly cannot be committed. Even when the evidence seems strong and the coroner commits, it is often found that in the time that must elapse between the inquest and the assizes the evidence invariably gets watered down and weakened. The first outburst of indignation on the part of the neighbours is over, and in all probability they have been "got at" by the friends of the accused. But let the coroners speak for themselves.

Mr. JOHN TROUTBECK, M.A., B.C.L., Coroner for the City and Liberty of Westminster:

"The result of my observation is that child life insurance is prejudicial to child life. The features in cases of insured children which attracted my attention were that they were badly and insufficiently fed, and exposed to cold and rain, and found suffocated in bed with their parents. I have found the parents come to the inquest drunk; sometimes from the proceeds of the insurance. I sometimes find that they have told my officer that the child is not insured, and when they are on oath they admit that the child is insured. I do not commit for trial. In all these suspicious cases it is very rare to get a verdict."

Mr. MAURICE FREDERIC CARTER, Coroner for the Forest
Division of the County of Gloucester :

“From my twenty-two years’ experience as coroner, my opinion is that the practice of child-life insurance is very prejudicial. It is my distinct impression and belief that it tends to crime. I always ask in suspicious cases that come before me if the child is insured. I think, from my experience, that the familiarity of the parent’s mind with the death of the child being connected with money has a tendency to deprave the mind of the parent. I have never sent a suspicious case to the assizes, because I find jurors will not find ‘culpable’ neglect; they always attribute it to the ignorance of the parents, and acquit where there ought to have been a committal and trial.”

Dr. GEORGE THOMPSON, Coroner of Oldham :

“As a coroner and medical man, I hold the opinion that child-life insurance has a decidedly prejudicial effect. Children on which I have held inquests in most cases were insured. I believe that in those cases infant insurance tends to the neglect and death of the insured. In three years there would be about 150 cases, where the child was buried without investigation, that ought to have been inquired into. I have not in many cases sent for trial at the assizes, because it is almost impossible to get evidence that people could be convicted upon. Insurance agents never give me any help. I have never been told of a suspicious case by one.”

Very briefly as to the remedies to meet the above-stated evils. First and foremost the *total abolition* of insurance for all infants till they are two years old; for pathologists tell us it is more difficult, nay, almost impossible, in the earlier stages of infant life to distinguish between starvation and mal-nutrition due to disease or improper feeding on the part of ignorant mothers.

And, further, greater encouragement and facilities should be given to friendly and burial societies; these are usually local and mutual, the members are known to each other, which naturally has a beneficial and controlling effect over their actions: also, these societies often provide for sickness as well as death, a most important point.

Again, a far more strict supervision should be kept over the purely commercial insurance companies (the collecting

societies). Pestering and touting by their agents should be altogether forbidden. The maximum sum for which a child is insurable should be reduced to the same as the sum for which children are insurable in societies conducted by working men themselves. This, practically, from the Chief Registrar's returns, is about a fourth of the sum insurable in these collecting societies.

We, as medical men, may do much without waiting for any Act of Parliament, by exercising greater care in the giving of death certificates in all cases in which we have any suspicion that the children have not had fair play. In spite of what I said just now about the difficulties of the evidence at inquests, send all doubtful cases with a note to the coroner. This will insure, at least, some investigation on the part of the police, which may act as a warning to other careless parents, and should you have in your neighbourhood an Inspector of the Society for the Prevention of Cruelty to Children, it would be well to communicate your suspicions to him also.

I cannot believe that with a full knowledge of the dangers and evils attending infant life assurance, in spite of the fact that a Bill has already been brought before Parliament and failed to become law, means cannot be devised which shall, whilst enabling the working class to provide against sudden and heavy expenses attendant on the death of their children, also at the same time safeguard children of the minority against their unnatural parents, who may scarcely be called working classes.

In proportion as we have stood by the working classes when we have thought they have been oppressed, so should we have the courage to say them nay when they lay claim to that which we believe it is to their best interest they should forego.

No one is more aware of the very inadequate way in which I have dealt with my subject than I am myself, but I shall be content if I have aroused a greater interest in a subject in which we, as medical men, should take a special interest, and in which I think we may lay claim to have a large share of influence for good or for evil.

Dr. MOIR said he was afraid that he had not been so vigilant as he ought to have been. He had always assumed that much of the marasmus he had discovered was due to the ignorance of parents, and possibly not wilful neglect on their part. A child of 18 months old was brought to him last Tuesday. He was told, in good faith, that the child had been fed on raw onions. They ought to get information from the neighbours in such cases.

Dr. GOLDSBROUGH said the question came home to him as he had a great deal to do with people of this class. There was a great deal of neglect, not wilful, on the part of mothers. Much harm was done by the abominable system of insurance agents calling at the houses of the poor. He had known men, who could earn nothing in any other way, turn to insurance canvassing. They got each new baby insured. The remedy lay in the extirpation of this system. Some children were not insured until they were ill. Then the temptation began. The mother sometimes resisted. The agent did not take the trouble to inquire. He had known the Insurance Company refuse to pay because the child had been ill longer than insured. The mother blamed the agent, but the Company did not blame the agent. He had made a practice of telling people he should not certify should the child die. He was afraid that coroner's officers were too often open to metallic persuasion, and on being so persuaded they were ready to say a child had died from natural causes. To deal with the cases satisfactorily, one must be either a medical officer of health or a district officer, so as to be able to get at the coroner himself, instead of through his officer.

Dr. BRYANT, of San Francisco, said that he had not been in practice at home. But he was under the impression that child insurance was not allowed in America.

Dr. BLACKLEY said that in times gone by he was afraid he had not been sufficiently wide awake either in the Hospital or in private practice. When mothers were admonished for not having done all they ought to have done, they were apt to say it was the Lord's will. Mr. Shaw had struck a suggestive chord in bringing the subject before them. If they could not secure concerted action, they might each do something to prevent the reckless continuance of such abuses. The daily papers were very severe on doctors in these matters.

Mr. SHAW, in reply, said if all had been as careful as Dr. Goldsbrough there would have been little need of complaint. He hoped others would be more careful in the future. He was not

aware of the difficulties arising from the coroners' officers. In the country they had not to do with the constable or the beadle, but communicated directly with the coroner.

A NOTE ON THE PREPARATION OF APOCYNUM CANNABINUM.¹

BY EDMUND ALLEYNE COOK, L.R.C.P., &C.

THE root of this plant may be expected to undergo some changes in properties in the drying, similar to those which certainly take place in the cascara sagrada, willow bark, and other vegetable products, hence it would be better were the medicinal preparations made from it in the fresh state. I ascertained from the curator at the botanic gardens, Kew, that the root is grown there without any difficulty in the open air, and he kindly sent me a specimen. From the root I made two preparations, an acetic and a weak spirituous preparation, samples of each of which I presented to Dr. Moir for experiment in his wards. It is evident that in making such preparations it is eminently desirable that as few operations as possible should be used, and those the least likely to cause chemical changes. The succus is an ideal preparation when just sufficient of a preservative is added to it, and any dilution should be mainly with water and without heat. The above mentioned preparations were made by adding to the thinly sliced root cold water, allowing to rest 24 hours, and then in the one case $\frac{1}{4}$ acetic acid B.P., and in the other sufficient spirit to make a mixture of spirit and water of a gravity of .935 was added; the exact strength of spirit being of small moment provided there be enough to keep the preparation and not enough to precipitate any active matter. These liquids so prepared have a far more powerful aroma of the root than any other I have seen, and so far as I have tried them are very active.

¹ Specimens presented to the Society, January 5th, 1893.

ANCHYLOSTOMUM DUODENALE.¹

BY DUDLEY WRIGHT, M.B.C.S.

Surgeon for Diseases of the Throat and Assistant-Surgeon to the London Homœopathic Hospital.

THE parasitic Nematode, *Anchylostomum Duodenale* vel *Dochmius*, is the cause of a peculiarly progressive form of anæmia, which is seen almost exclusively in hot countries, more particularly in Egypt, India, and Brazil. In these various localities, the disease is known under different names, e.g., Egyptian, chlorosis; in India, Kâla Azâr; and, in Ceylon, Beri-Beri. In Switzerland it gave rise to the death of more than 100 of the workmen employed in the St. Gothard Tunnel.

The parasite is a small round worm, with a stiff body and a head bent at right angles, which is provided with a round mouth and three sharp teeth.

The female measures about half an inch in length, and the male—which is more slender, and is distinguished by the corolla-like expansion of the caudal extremity, from which a double whip-like penis projects—is about half as long again.

The female is extremely prolific, and discharges ova about $\frac{7}{100}$ inch in length, which, when passed from the bowel, do not contain a manifest embryo.

The worms attach themselves firmly to the mucous membrane of the duodenum and upper part of the jejunum. They wound deeply, and suck the blood therefrom, causing sub-mucous ecchymoses, and, occasionally, hæmorrhage into the lumen of the bowel.

The symptoms caused are mainly those of anæmia, with general debility and dropsy.

The parasites now shown were sent to me from Assam, and were passed by a prisoner in the Ganhati Gaol.

The treatment out there consists, I believe, in administering large doses of the extract of male fern.

The life history is said to be as follows:—The ova, on

¹ Microscopical Specimen: Clinical Evening, March 2nd, 1893.

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Wright, del et lith.

being passed, gain access to mud or water, and in that medium they produce slender worms which exhibit active movements: These require no intermediate host, but develop into sexually mature animals when they reach the human alimentary canal.

DESCRIPTION OF PLATE.

The figures are taken from some plates in a report on Kála-Ázár and Beri-Beri by Dr. Giles, Surgeon I.M.S., on duty in Assam.

FIG. I.—Mature male rhabditis of *Dochmius Duodenalis* viewed laterally.

- M. Mouth.
- b¹. Anterior bulb.
- G. Central Ganglion.
- b². Posterior bulb.
- H. Hepatic cells.
- L. Lemniscus.
- T. Testis.
- i. Intestine.
- S. Copulatory Spicule.
- B. Copulatory Bursa.

FIG. II.—Shows the changes in the gastro-intestinal mucous membrane.

“A portion of a vertical section of the upper part of the ileum from a case of Anchylostomiasis, showing the space between two villi filled up with blood clot, in which is embedded an immature *Dochmius* (the worm is cut twice by the section, so that two sections are seen). At the highest part of the blood clot may be seen a deep erosion of the mucous membrane.”

A FATAL CASE OF PERFORATING ULCER OF THE STOMACH.

BY GERARD SMITH, M.R.C.S.¹

A GIRL aged 19, who died seven months after a severe haematemesis, from which she had apparently completely recovered (as she had resumed her work as a governess, and had taken an active part in games), having one day eaten something that caused vomiting, fell back during the attack with an extremely severe pain in the stomach. She developed symptoms of peritonitis, but not rapidly, and there was no condition of collapse; there was very rapid and remarkable distension of the abdomen, with continued vomiting, but no symptoms of intestinal flatulence, except the distension; as the distension increased, the tenderness became less, until there was little pain on pressure, unless very deep. There was no haematemesis, and no action of the bowels, nor escape of flatus by mouth or anus; the patient was evidently sinking: an eminent surgeon made a diagnosis of volvulus, without peritonitis, and advised immediate laparotomy, remarking specially the absence of tenderness on pressure. Mr. Gerard Smith submitted to his judgment, but subsequently withdrew from the operation, feeling sure from the history and symptoms of the case that there had been a perforation of the stomach, setting up peritonitis, notwithstanding that there was little pain on pressure (the temperature was steadily rising, and pulse getting wiry and rapid; temperature, 102°; pulse, 120), and notwithstanding that there was no haematemesis.

The operation was performed; at the first opening of the peritoneum there was a free escape of gas without faecal odour; the intestines were seen to be quite flaccid and empty, far back in the abdomen; there was abundant peritonitis, and no twist or obstruction of the gut.

Death took place 20 hours afterwards, and the *post-mortem* specimen now exhibited showed a very large old

¹ Pathological Specimen: Clinical Evening, March 2nd, 1893.

ulcer, as large as a five-shilling piece, firmly attached to the pancreas, and completely perforated over its whole area; this was intact, and had been in no way responsible for the fatal illness, but there was another smaller perforating ulcer, which had been as firmly attached to the under surface of the liver. The edge of this had been recently torn off from its abnormal attachment; being on the upper border of the pylorus, the escape of stomach contents (except gas) had been slow, hence the collapse was not rapid; no doubt, the attack of sickness had been the cause of the tearing away of the attached edge of the ulcer.

The failure of the diagnosis, on account of the presence of a deep layer of gas between the intestines and the abdominal wall, is a warning; and the fact that the girl had recovered health and been able to take part in work and games—lawn tennis, &c.—with so large an ulceration of the stomach, perforated, but previously attached to subjacent structures, seems very unusual and unexpected.

A CASE OF ABDOMINAL TUMOUR, PROBABLY
MALIGNANT, AND ASSOCIATED WITH THE
RIGHT KIDNEY OR ITS RELATED STRUC-
TURES.¹

BY GILES F. GOLDSBROUGH, M.D.

A.S., man, 39, jobbing builder. Always sober and temperate. No history of syphilis. Had scarlatina with a consequent nephritis and dropsy at six years of age. Rheumatism from getting wet at eighteen, otherwise he had been quite well until the summer of 1890, when he accidentally fell twice during his work (June and July). No apparent injury resulted until August when, after lifting a heavy weight, he passed some bright blood in his urine. He did

¹ Clinical Evening, March 2nd, 1893.

not lay up, but consulted his doctor (allopathic), and was under treatment until October, when he came under my care. The hæmaturia had become worse; it was intermittent in character, always bright red, and usually clotted, so that he often suffered considerable pain in voiding urine. The attacks would last several days, gradually subsiding, then recurring again in a few days. When the man came to me he was very anæmic, and weak. I have no note of his temperature at the time. He was under treatment for one or two months without success, the medicines administered being *bell.*, *ham.*, *arn.*, *millefol.* I then put him on a course of *china* 1 and *secale* ʒ alternately, which seemed soon to check the quantity of blood, and the attacks became less frequent, but they did not finally cease until about a year after his coming under treatment, and he continued the medicines for a month or two longer. His health gradually improved; he had been laid up for a week or so at a time, and did odd jobs in the interval. I had not seen him from about December, 1891, until the 9th of last month. He had not felt *well* since his previous illness, and had not been able to take continuous work. Was always languid and sleepy after meals. Six months ago he commenced retching in the morning, and subsequently had vomiting of frothy green mucus; also nausea on beginning to eat, aggravated by going to the fire, or on stooping. A poor appetite, constipation, and fulness of the abdomen, are other symptoms he has gradually come to complain of. On stretching out in bed he has been seized with cramp in the calf of the left leg.

Family History.—Father living in fair health, of a very phlegmatic temperament. Mother died at 43 from consumption (patient aged 12 at the time). Two brothers and one sister died in infancy. One brother died at eight years from marasmus, following a succession of abscesses, and one at 16 from epilepsy. An uncle on the mother's side died of softening of the brain, an aunt still lives in good health. A half-sister of the patient I attended at 11 years of age for excessive metrorrhagia, she is now about 20 years of age in good health. There is no history of tumour or cancer in the family.

Present condition.—Height 5ft. 2in.; weight 7st.; pale

face, rather cachectic and anæmic. Reddish sandy hair and beard, stooping gait, teeth carious, tongue red and fissured. Lungs normal. Heart normal, except that first sound at the apex gives a sharp click. Pulse 78 in the morning, regular; 90 in the evening. Abdomen on inspection is very full, especially to the right of the umbilicus, and this prominence comes much more into view on stretching the body at full length with the arms above the head. On palpation a hard, slightly elastic, non-fluctuating, somewhat irregular tumour is felt, growing, as it were, from behind forwards. It is most prominent about midway between the umbilicus and the edge of the abdomen, shading off slightly to the left of the former region with increasing hardness to the right. The growth seems disconnected from the liver, and extends downwards to within two or three inches of the iliac region. Percussion gives the liver-dulness normal above; and a narrow space towards the middle line between the liver and the tumour below is clear. Also on the right side of the tumour there is a small space clear above the crest of the ilium. Complete dulness is noticed over the defined regions of the tumour. There is no pain in the tumour, nor tenderness on pressure, although the patient has complained lately of feeling his clothes rather uncomfortable.

The temperature is normal in the morning, and rises to 100° F. in the evening. This has been tested on several occasions. Urine normal; specific gravity 1018; free from albumen. The gastric symptoms complained of on Feb. 9th have disappeared under *ars.* and *merc.* He is now taking *hydrastinin* 2x; (gr. ii. bis die were ordered on Feb. 13th, and gr. v. on 27th).

Mr. Knox Shaw has seen this patient, and he will henceforth be placed under his care in the hospital.

Dr. DYCE BROWN could not quite agree with Dr. Goldsbrough as to the non-fluctuating character of the tumour. His opinion was that there was distinct fluctuation. He thought that there were one or more cysts containing fluid, and that they were evidently connected with the kidney.

Mr. KNOX SHAW thought they might congratulate themselves

upon the interesting cases which the members had brought forward. Not the least interesting of an interesting series of cases was that of Dr. Goldsbrough. With respect to diagnosis he was inclined to agree with Dr. Dyce Brown that there might be a cyst, but sarcomata often gave a sense of fluctuation. The case was clearly that of the kidney. There was a previous history of hæmaturia. In differentiating they had to consider whether it might not have been caused by a calculus. The ureter becoming entirely blocked, the hæmaturia ceased. Thus there might be either hydronephrosis or cystic degeneration of the kidney. If anything surgical had to be done it would have to be by an abdominal excision. It would be impossible to remove the growth through a lumbar incision. The operation would be a grave one, and the result of the removal of a kidney for sarcoma was generally such. The prognosis depended to a great extent upon the diagnosis. If it was simply a cyst, it was not so grave. In any case anxious thought would be required, for in all operations on the kidney care must be taken to enquire into the condition of the other kidney, lest there should be suppression of urine.

Mr. GERARD SMITH said there was a cystic feel about it. If it had been a woman he should have thought it was papilloma.

Dr. BLACKLEY had examined the case, and although he thought there was a feeling of fluid, he was more inclined to think it was a malignant growth. There might be a small cyst, but the rapidity of the growth was in favour of its being malignant. The rest of the tumour was wonderfully solid. He agreed with Mr. Knox Shaw that it would be impossible to remove it by a lumbar operation.

ABSCESS OF THE ABDOMINAL WALL: A SEQUELA OF TYPHOID-FEVER.—Dr. John Hayward, at the January Meeting of the Liverpool Branch of the Society, drew attention to a case in the Hahnemann Hospital, in which an abscess had formed just below and a little to the right of the umbilicus, during convalescence from an attack of typhoid fever. He thought that the condition bore some relationship to the necrosis occurring after typhoid: a sequela to which he claimed to have been the first to draw attention.

THE IDEAL TREATMENT OF URETHRITIS IN
THE MALE.¹

BY EDWARD BLAKE, M.D.

THOSE who have been at the pains to keep themselves at all *au courant* with recent continental views as to Gonorrhœa will admit that the mildest attack is not to be lightly viewed.

Those again who have seen much of its treatment, will scarcely be prepared to deny that at its very best it leaves much to be desired.

That owing to a number of causes a really scientific treatment cannot always be carried out in civil life is quite true, but it may be remembered that when we have urged a right course and it is not carried out, our responsibility is lightened, and the probability of subsequent reproach is lessened.

I wish it to be understood that I attach enormous importance to the internal use of appropriate drugs; but to name them to my present audience would be a formality.

1. Perfect rest in the recumbent posture.
2. Abstinence from all alcoholic drinks and from meat diet.
3. Success is so largely a matter of good drainage, that if the meatus be congenitally small or artificially contracted by old hypertrophic urethritis, it should be freely enlarged.
4. The canal having been rendered aseptic, the patient is put under the influence of cocaine or of ether, and the meatus boldly slit on one side of the mesial line down to the root of the frænum, and, if stricture be present, a series of sterilized metallic bougies are passed into the bladder. The slitting may be done by means of the galvano-cautery, or with Reginald Harrison's most convenient probe-pointed triangular knife, devised for this purpose. At the same time, if the frænum be broad, it should be snipped through to prevent pocketing, as pockets are apt to form nests of infection.

¹ Clinical Evening, March 2nd, 1893.

No upward cutting is needed, nor are any sutures necessary.

The wound is kept open, and bleeding is arrested by means of a pledget of lint dipped in hazeline, or with Ehrle's styptic wool.

5. Make a careful search for intra-urethral chancre, and dress it frequently with iodized phenol.

6. Till the acute purulent stage be passed, keep the penis immersed in some simple germicide solution. A mixture of boric acid and borax answers very well.

7. Under all ordinary circumstances avoid direct injections; they are a fruitful source of deep-seated stricture, and are most pernicious.

Use a reflux syringe, such as Reginald Harrison's Irrigator, introduce it very slowly indeed, and in a rotatory fashion, the liquid running all the time to avoid carrying pus back; it should pass well behind the inmost point of tenderness.

8. Differing cases require different solutions; Ichthyol can be highly recommended, strength twenty grains to one ounce of distilled water.

9. Never use any organic material in the form of a bougie or catheter when metal can be employed.

10. Never pass anything into the urethra without sterilizing both the tube and the instrument.

11. In using a strong solution of cocaine, prepare the patient by giving *two or three grains of quinine*, as severe fainting has followed the employment of solutions above 10%; with this precaution I have used cent. per cent. solution.

12. All gleans call for patient scrutiny, under electric illumination, with air ballooning.

13. Morning agglutination, shuddering during micturition, and the presence of mucous shreds or "pennons" in the urine, suggest granulating surfaces on the urethral mucosa.

14. Bear in mind the possibility of wart or polypus, the latter very rare: also of congenital diaphragm; the last, however, is a pathological curiosity.

15. Sterilize the urine from within.

By way of prevention, when circumcising the young, slit down the meatus freely, for it is probably more important to do this than to remove the foreskin.

According to one of our transatlantic brethren, Dr. Williamson, stenotic meatus is usually present in masturbators.

CONTINUOUS IRREGULAR ACTION OF THE HEART, IN A LABOURER, AGED 42.¹

BY BYRES MOIR, M.D.

Physician to the London Homœopathic Hospital.

W. G., labourer, age 42. Admitted 8th February, 1893.

Complains of shortness of breath on exertion and tendency to faintness.

No previous illness except syphilis, 1872. Family history good.

Present illness began twelve months ago by slight attacks of faintness; they did not last long and he took no notice of them till three months ago. One night, about three months ago, he was awakened in the night by an attack of coughing which lasted for some time and left him in a heavy sweat and very faint; after this, the fainting attacks got more frequent and more severe, though he never lost consciousness. The cough also became worse. He also now felt pain in the left side, going through to shoulder-blade and up to the shoulder.

States that he has lost three stone in weight since the beginning of the illness.

Physical signs.—Chest shape good, expansion good.

Percussion.—Right side normal. Left side, comparative dulness between first and third ribs, then resonant to cardiac dulness.

¹ Clinical evening, March 2nd, 1893.

Breath sounds normal; no adventitious sounds.

Cardiac. — No increased dulness. Apex normal in position; at apex the sounds are confused, first sound always reduplicated, second sound occasionally. Nothing heard at base (beyond the reduplication), nor in carotids, nor subclavians. No bruits.

The pulse beat is quite irregular, both in force and rhythm; difficult to count, but about 120 a minute. The sphygmographic tracing shows considerable irregularity, a distinct beat being followed by either one or two incomplete waves.



RIGHT.



LEFT.

Tracing of right and left radial, taken on the 2nd of March, four ounce pressure.

There is no complaint about swallowing, or any laryngeal trouble, and except for the faintness, the patient says he feels quite well.

Dr. GOULD suggested that smoking might be the cause of the irregular action. The man smoked two ounces of shag a day. He himself had been obliged to give up smoking twenty years ago for the same cause.

Dr. DUDGEON said this case was similar to several which he

exhibited on one occasion. The main interest was the long continuance of the irregular action. The pulse varied very much in character. There was sometimes more, sometimes less, stammering. He had no doubt, although the case had lasted a long time and though there was considerable weakness and emaciation, there was no element of heart disease. He had not the slightest doubt that, within a reasonable time, the patient might recover. But sometimes these cases did not right themselves. Cases went on in this tumultuous manner until death came rather suddenly. Some serious disease might be expected to accompany these symptoms. The chances were, however, that some day he might recover. Even after five years he had known a heart suddenly recover itself.

Dr. BLACKLEY admitted that tobacco might have some effect upon such a heart. He had had two or three cases within the last two or three years, both of which Dr. Dudgeon had seen with him. In one case—a man of seventy—the patient was a non-smoker; in the other case, tobacco was an element. Both lasted a good while; but both patients died within the twelve months, and did not appear amenable to treatment. All the recognised cardiac tonics were tried; *strophanthus*, *digitalis* and *cactina* “pillets.”

Dr. MOIR said: This case comes under those which Dr. Dudgeon brought to our notice lately, viz., “Stammering Heart,” and Dr. Ernest Sansom has also just read a paper on the same subject. The latter puts down syphilis as a cause of the irregular action, and suggests that morbid changes, due to syphilis, may cause a disturbance of the vagus. He could not accept the view that tobacco was the cause of the irregular action. Dr. Gould had said the man smoked two ounces a day; but this was wrong, half-an-ounce of shag a day was the man's allowance, and that had been now stopped for some time. He was more inclined to put syphilis as the cause. He would give a bad prognosis in such a case; the loss in weight he considered a grave symptom, and before long, if the man continued going about, would expect a fatal termination.

SUBCOSTAL ABSCESS; INCISION INTO LOIN:
RECOVERY.¹

BY J. GALLEY BLACKLEY, M.B.

Physician to the London Homœopathic Hospital.

A YOUNG man, aged 20, had been an in-patient of the hospital last June with what was diagnosed before admission as pleurisy with effusion. When first seen by Dr. Blackley the right chest was found to be dull posteriorly as high as the tip of the scapula, and breath sounds over the dull area were very faint. No ægophony was heard however at the upper limit of dulness, only some loud moist rales. Above and in front the percussion note was clear; on the left side below the clavicle was a comparatively dull spot, and breath sounds were much exaggerated all over, with some moist crackling rales. Temperature was very high on admission, being 105.4° at night, and 100° in the morning, and this continued for many days with but slight variation. About four days after the patient's admission, a shallow circumscribed swelling about the size of the palm of a good large hand and slightly boggy in feel, was found in the right loin just below the lowest rib. This was poulticed until fluctuation was evident, and after a few days was freely opened by Mr. Knox Shaw. On introducing the finger into the abscess cavity it was found to pass downwards for about 2½ inches, and upwards *inside the floating ribs* as far as the finger could reach. A 12-inch silver probe was next introduced and passed freely in an upward direction for about 10 inches, and evidently was inside the ribs. About 10 ounces of laudable pus were evacuated at the time of opening, and some ounces came away daily for several days. The temperature within ten days was subnormal, and the patient left the hospital cured within a month. The lower lobe of the right lung speedily cleared up; and the chest, although expansion is somewhat deficient over the site of the previous dulness, shows no signs of the falling in usually found after empyema. Dr. Blackley

¹ Clinical evening, March 2nd, 1898.

inclined to the idea that the abscess was in the posterior mediastinum, and did not penetrate the pleural cavity. Vertebral caries as another possible cause was practically eliminated, as very careful examination both then and now failed to reveal the slightest indication of a spinal origin for the abscess.

Mr. KNOX SHAW observed that the case was interesting chiefly from the point of view of diagnosis. He could not say with certainty where the pus originated, but his strong impression was that it was not pleural. On opening the cavity it did not behave in the way usual with empyema. He came to the conclusion that the pus existed between the pleura and the ribs. He thought this opinion was probably right, otherwise the lung would have shown evidence of old mischief, and there would have been some falling in of the ribs.

SOCIETY NEWS.

At the February Meeting of the Society it was resolved that a deputation consisting of its President, Treasurer, and Secretary should present a congratulatory address to Dr. Wielobycki, a former member, on his having attained the great age of one hundred years. Dr. Wielobycki was originally elected a member of the Society, on the nomination of Dr. Quin, on the 10th of December, 1851. He seems to have been an active member of the Society, taking frequent part in the discussions, and on several occasions presiding over its deliberations in the absence of the President, Dr. Quin. In 1852 he read a paper on "Neuralgia," and in 1854 one on "A case of complicated labour from the locking of the heads of twins in their descent in the pelvis."

On February 13th, the officers of the Society, together with Drs. Cameron, Jagielski, Epps, and Clarke, waited upon Dr. Wielobycki and presented him with the following address:—

"Dr. Severin Wielobycki,—The British Homœopathic Society desires to congratulate you on the attainment of the great age of one hundred years. When, after obtaining your degree of M.D. in Edinburgh and practising for a few years in Canada on the old system, you became a convert to Hahnemann's doctrine, you settled in London as a practitioner of homœopathy, and joined the British Homœopathic Society, of which you became an active

member, and to the Transactions of which you contributed a valuable article on an obstetrical subject, which is preserved in the twelfth volume of the *British Journal of Homœopathy*.

“ Though, owing to your great age and virtual withdrawal from medical practice, you have long ceased to be a member of this Society, we do not forget that you were the associate of some still living members, and we have great pleasure in cordially congratulating you on having attained a length of years seldom accorded to man. Born three years before the promulgation of the homœopathic therapeutic law by Hahnemann, you are doubtless the oldest living representative of homœopathy in the world.

“ While warmly congratulating you on the remarkable health and vigour that have hitherto attended you, we trust that your life may yet be long spared to enable you to pursue the philanthropic work of promoting temperance by precept and example, to which you have devoted yourself since retiring from medical practice, and in which, notwithstanding your patriarchal age, you still take a lively practical interest.

“ (Signed)

“ J. G. BLACKLEY, *President*.

“ R. E. DUDGEON, *Treasurer*.

“ C. KNOX SHAW, *Secretary*.

“ HUGH CAMERON.

“ VICTOR JAGIELSKI.

“ WASHINGTON EPPS.

“ JOHN H. CLARKE.

“ London, February 13th, 1893.”

At the June Meeting of last year, Dr. Hughes suggested that the Gresham University Commission now sitting should be approached with reference to the necessity of authoritative instruction in homœopathy being provided by the new University. An account of this proposal, which was unanimously accepted, will be found in the *Monthly Homœopathic Review* of July. A memorial, based on its lines, was presented to the Commission, and request was made that one or more of its signatories might be heard as witnesses. The Commission, however, has adjudged the question to be beyond its powers; but will print the memorial as an appendix to its Report. It will, we trust, meet the eyes of some of the public, and will bring to their knowledge the crying need that exists for provision of systematic instruction in the principles and practice of our method.

On Thursday, January 5th, the following gentlemen, having been duly nominated as candidates, were elected by ballot:—

Francis Sorell Arnold, M.B., B.C.Oxon, 332, Oxford Road, Manchester; Frederick Flint, M.D.Aberd., 8, Ramshill Road, Scarborough; William Ombler Meek, M.B.Ed., 256, Oxford Road, Manchester; Peter Proctor, L.R.C.P., M.R.C.S., 17, Hamilton Square, Birkenhead; William Henry Roberts, L.R.C.P.Ed., 63, Lower Mount Street, Dublin; John Wilde, L.R.C.P., M.R.C.S., Park House, Weston-super-Mare; Arther Llewellyn Williams, L.R.C.P., 127, Moss Lane, East Manchester.

On Thursday, March 2nd, the following gentlemen, having been duly nominated as candidates, were elected as members:— S. Henry Woodgates, M.D.Glasg., Mona Lodge, Lyndhurst Road, Exeter; Edward Robert Bradley Reynolds, M.R.C.S., Highcroft, Shepherd's Hill, Highgate, W.; Charles Edwin Waddington, L.R.C.P., 55, Queen Road, Manningham, Bradford.

We are receiving from our Exchanges words of commendation and welcome upon the fresh departure of the Society in the manner of publishing its proceedings. We hope that every member will feel that it is his duty to maintain the high ideal at which we aim by contributing something of his experience to the work of the Society. With the large number of members that the Society now possesses, there will be found no difficulty in obtaining valuable information upon all branches of homœopathic therapeutics. The parent Society does not meet often enough to receive all the communications that are due, so that it becomes imperative for some of the more active provincial members to bestir themselves into forming branches for the better development of our work.

The *Southern Journal of Homœopathy*, commenting upon our new issue, says:—"To judge from the contents of the initial number, the JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY will be of interest not only to the members of this association, but it will be both interesting and valuable to every medical man who appreciates the experience and the literary productions of educated physicians and surgeons, put together in the form selected by Dr. Hughes. . . . There can be no doubt that with the aid which the English profession will furnish their accomplished editor, the JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY will hold an enviable position in the world of periodical literature."

Dr. W. W. Van Baun, of Philadelphia, welcomes us with:—"England has at last a homœopathic journal the profession can be proud of. Success and long life to it."

The *Clinique*, in noticing the Journal, says:—"This publication is a new and timely departure for a Society that was founded in 1844, and which has been in successful operation ever since. It has already issued its very valuable annals in twelve portly volumes, and now proposes a serial that shall be up with the times, and with the advanced position not only of the flourishing Society itself, but also of the general interests of the profession 'over there.' That the enterprise is in the editorial charge of our good friend, Dr. Richard Hughes, establishes its character and assures its success. Our readers should subscribe for this journal from the start, and so help along the good work. It is clinical and practical to the last degree."

Of our new venture the *Hahnemannian Monthly* writes:—"An excellent publication, ably and carefully edited by one thoroughly versed in the work. . . . A magazine, the character of which is second to none, and which, if maintained, will present a review of medicine and surgery no one can be without."

SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

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

DECEMBER, 1892—FEBRUARY, 1893.*

PHARMACODYNAMICS.

Aurum.—Johann C., aged 36, had for several years been subject to a head affection, that tormented him by day and night. Melancholy, anxiety, with fear of impending serious illness. Then occasionally great excitement and restlessness, vertigo, pressure on chest and epigastrium. Face red; blowing noise in place of first sound of heart. Bell. 6x, on Sep. 25th. Oct. 5th.—Improvement reported. Heart's action very excited; eruption of pustules on thigh. During past week had suffered much from toothache. Aur. m., 3x, three times a day. Oct. 15th.—Better in all respects. The medicine was continued. Oct. 15th.—Quite cured, and able to resume his work.—Amberg, *A. H. Z.*, 29th September.

* With some arrears.

Belladonna.—On Sept. 23rd, 1890, at 5 p.m., two children ate an unknown number of belladonna berries.

1. Franz Lehner, aged $2\frac{3}{4}$ years, one hour afterwards was very ill, sad and dejected; complained of pain in mouth and chilliness; asked for sugar, lay down in bed and began to be delirious. The whole skin was scarlet, burning hot; head, hands and feet in constant convulsive movement; both pupils much dilated, anxious expression, wild restless look, red inflamed eyes and lids, the whole face intensely red and puffy, burning hot, hair matted with perspiration, mouth dry, tongue very red and swollen, difficulty of swallowing, constant chewing movements, stiffness of neck, boring of head backwards on pillow, continued jerking of hands and feet as from electric shocks, great distension of abdomen, rapid pulse, palpitation of heart, beating of carotids, great restlessness. This lasted all next day (24th). 25th.—The redness and swelling of body began to decline, only the face remained bluish red and swelled, pupils still strongly dilated, the convulsive movements of extremities and restlessness became weaker and seldomer, the delirium and unconsciousness only ceased for intervals; had two diarrhœic stools, two berries passed, after which the distension of abdomen diminished greatly. 26th.—Temperature of head and body still very high, pulse still rapid, twitchings became rarer, consciousness frequently returned, and for longer periods; in evening, increased heat and excitement. 27th.—Consciousness perfectly restored, still some excitement, heat and redness of face in evening, sleep quieter. 29th.—Well, except great weakness.

2. Joseph Lehner, aged 5. Three quarters of an hour after taking the berries, burning in mouth, pains in stomach; at 7 p.m., great anxiety and restlessness, trembling of limbs, pale and drowsy, with constant restlessness and movements of whole body. At 2 a.m., vomiting with relief. 24th.—6 a.m., pupils much dilated, gait unsteady and staggering, talks nonsense and cannot express himself properly, violent fit of dry cough. He will not lie down, and is always on his feet. 25th.—Still great restlessness, constant walking about and wish to run away, whirling vertigo, dilated pupils, is as if blind, when walking lays hold of chairs, &c., speaks continually in unconnected phrases; sees pears, apples and plums hanging, which he tries to catch hold of; much perspiration on head, two diarrhœic stools, in which were the skins of the berries, no appetite: heat and excitement increased in evening. 26th.—Restlessness and excitement less, but the vertigo and staggering gait, dilated pupils, with perspiration on head and evening aggravation, continue. 27th.—Attack of chilliness

and heat with rapid pulse, perspiration of head, deception of sight, talking nonsense, great forgetfulness, constant restlessness and evening exacerbation. 28th.—All symptoms gradually subsided, appetite returned, but he is very weak, and though he had slept well still staggered; his mental powers returned slowly.—W. Huber, *Archiv. f. Hom.*, i., No. 8.

Camphor.—The *Therapeutic Gazette* of December calls attention to this drug as one “in danger of passing into obscurity” in ordinary practice, commending it not only as a diffusible stimulant, but also as anti-diarrhœic. In virtue of these properties, and because “volatile oils and their derivatives act as internal antiseptics,” its repute in cholera is well warranted. It may be given here in common red wine, which also “inhibits the growth of the cholera spirillum.” It often relieves cardiac distress, with or without organic disease to account for it.

Carbo vegetabilis.—An analytical study of the pathogenesis of this drug, one of a series issued by the Medical Investigation Club of Baltimore, appears in the *Southern Journal of Homœopathy* for November.

Cocaine.—Dr. Piedvache contributes to *L'Art Médical* of Jan. a thorough study of the physiological action of this drug. His conclusions are that it is not, as it has been styled, “the curare of the sensitive nerves,” acting only on their terminal extremities; but that it affects the nervous centres generally, first as a stimulant, and secondly as a depressant.

Colocynth.—A typical case of the sciatica calling for this drug is reported by Dr. Hobart. The pain had commenced in the stomach and left ovary, then shifting to the left leg, where it had continued at intervals for a year. It was drawing, crampy and throbbing. Colocynth 3x cured in four days.—*Med. Era*, Jan., p. 12.

Conium in Cataract.—Dr. Talbot communicates to the *Medical Century* of January two cases of cataract (so diagnosed by oculists), in which the administration of Conium 3x seems to have dispersed the opacity and restored vision. In the former of the two general symptoms of the drug were present. [Dr. Talbot quotes several symptoms from the pathogenesis of conium as indicating its homœopathicity to cataract. But surely these sensations, coming and going during provings of the drug, cannot be due to any substantive changes in the lens.—ED.]

Crocus in Imaginary Pregnancy.—A woman supposed herself to be three months gone in pregnancy, and stated that she had felt “something living jumping about in her abdomen” several times. Examination found no change in the uterus; and

after a third dose of crocus 15, there was no recurrence of the movements.—*Hom. Journ. of Obstetrics, &c.*, Jan., p. 25.

Cuprum arsenicosum.—A severe case of the nausea and vomiting of pregnancy, with great prostration and emaciation, was rapidly cured by this drug, in the 3x trit.—*N. Amer. Journ. of Hom.*, Jan., p. 53.

In the *Hom. Recorder* of Feb. 15th, there is a case of poisoning by C. ars. Besides the symptoms of local irritation and of general collapse, there was tremulousness of the whole body (including the tongue).

Digitalis.—Dr. Huchard, in giving this drug for cardiac dropsy, adopts a new method which seems to obviate many of the objections to it, and must find favour in our eyes. After a few days of milk diet and absolute rest, he gives a single dose of the crystallised digitalin, and then waits for six to fifteen days before repeating it.—*Therapeutic Gazette*, Oct., p. 689.

Mr. Wyborn sends a note on the alkaloids of this plant to the *Monthly Hom. Review* of Feb., from which it would appear that Huchard's crystallised preparation mentioned above is impure, being nearly pure "digitonin," which is "useless as a remedy for heart disease"!

Dolichos pruriens.—Dr. Mifflin finds the tincture of this plant, in 1 to 4 drop doses, give great relief to the itching of the skin caused by the presence of bile in the blood, as in jaundice.—*Southern Journ. of Hom.*, Nov.

Filix mas.—It is beginning to be found that the large doses of male fern in vogue for killing tape-worm cannot always be given with impunity. "The extract of male fern has a toxic property, acting principally upon the digestive system and the nerve-centres, and producing such symptoms as vomiting, diarrhoea, colic, cephalalgia, difficult locomotion, dilated pupil, impaired vision, hurried respiration, motor paralysis, depression, &c." These are the conclusions of Katayama and Okamoto (*Therap. Gazette*, Oct., p. 710). The amblyopia seems to occur only in weak and delicate subjects, or in those of poor health.

Graphites in Chronic Blepharitis.—Another case illustrative of the curative power of graphites in chronic inflammation of the edges of the lids is communicated by Dr. Edward Kirkland to the *N. Am. Journ. of Hom.* for February (p. 116). It was of several months' standing. Improvement was noticed within a week, and continued without interruption to cure. The 3rd trit. was given four times daily.

Guaræa in Epiphora.—Dr. Parenteau confirms from his

experience Dr. Claude's recommendation of guaræa in watering of the eyes, where there is no mechanical obstruction to the out-flow of the tears, but simply an excess of formation. He gives the 1x dil.—*N. Am. Journ. of Hom.*, Feb., p. 84.

Hydrastis.—Mrs. Z., landlady of an inn, aged 60, had for months been ailing, and the treatment she had hitherto undergone had been of no avail. She was first seen on the 30th July. She complained of tenderness and pressure in gastric region, anorexia, increase of sufferings by the liquid food she was confined to, as she could take no solids; vomiting of food, mucus, and stuff like coffee grounds, obstinate constipation, faintness and emaciation, earthy complexion. She had already been under three doctors, who pronounced her disease to be cancer of the stomach. Examination showed a hard tumour the size of a pigeon's egg betwixt xiphoid process and umbilicus, enlargement and tenderness of liver, pulse slow, hard, intermitting every fourth or sixth beat, second sound of heart obscure, the arteries hard and rigid. As the symptoms seemed to indicate carcinoma of stomach and atherosclerosis of heart and arteries, the prognosis was doubtful. As no decided guiding symptoms were present, hydrastis 3x, one drop every three hours, was prescribed on pathological principles. The liquid diet was continued. Heard nothing of the patient for three weeks, and then, Aug. 20th, learnt that soon after commencing the medicine improvement had set in, pain and vomiting had ceased, strength and nutrition had returned, she was again busy in her household duties; could go upstairs without the dyspnoea that had previously plagued her. She could eat meat and other solid food with comfort. Continued hydrast. Seen a fortnight later, she was in every respect well, though a small remnant of the tumour could be detected by careful examination: a few weeks later even this entirely disappeared.—*Amberg, A.h.Z.*, 29th Sept.

In the *London Hom. Hospital Reports* for 1892, Dr. Burford communicates much experience with the hydrastis derivatives in menorrhagia and metrorrhagia. The alkaloid "hydrastin" has been resolved into "hydrastinin" and opianic acid, and most of the Continental therapeutists have used "hydrastinin." Dr. Burford and several colleagues have used the same preparation in the 1st, 2nd, and 3rd dec. triturations, and report similar results, especially from the two lower potencies. Dr. Burford says that "there are few non-parturient uterine hæmorrhages that it will not immediately control, and few contingent uterine conditions that its continual use will not more

or less benefit." Dr. E. A. Cook has furnished him with a note on "hydrastin." He uses an alcoholic solution of gr. xx. to the pint (= one part in 350), and finds 2- to 5-drop doses of this (= gr. $\frac{1}{175}$ to $\frac{1}{70}$) "all-sufficient for the purpose of stopping hæmorrhage." When the dose is too large, it sets up "a peculiarly intensive headache, the head feeling as though the scalp would lift, with giddiness on turning, and an intense irritability, always provoked by any noise." Dr. Burford's experience with "hydrastin" is confirmatory of these conclusions.

Dr. Burford gives references to, and an outline of, the old-school literature of the subject. In the *Therapeutic Gazette* for October there is a further communication upon it by Dr. Gottschalk. He finds gr. $\frac{1}{4}$ of "hydrastinin" the maximum dose, and thinks that 20 drops of the fluid extract will accomplish the same work, though less quickly and surely. The drug acts by narrowing the vessels, and is useful whenever uterine hæmorrhage depends on congestion or relaxation of the organ.

Hydrocyanic Acid in Infantile Convulsions.—Dr. A. H. Croucher communicates to the *Hom. World* of February a case of this kind in which drop doses of the 1st dil. of the acid effected a satisfactory cure. (As the patient's age— $3\frac{1}{2}$, 3 when attacks first commenced—was beyond that of dentition, this case might rather be called epilepsy.—ED.)

Icthyol.—This substance—a distillation product of bituminous material, containing a large proportion of sulphur—has been much employed of late by dermatologists. It seems now ascertained that it acts by constricting the arterioles, and accordingly finds use as a topical application for boils, erysipelas, &c. An ointment containing from 20 to 50 per cent. is the usual form; but the "sulphichthyolate of ammonium" is soluble in water in these proportions.—*Therapeutic Gazette*, Oct., p. 684.

Lachesis in Sore Throat.—Mrs. B., aged 38, had for three weeks suffered from pain in throat; she felt as if the throat was raw, and as if a round lump stuck in œsophagus that she must continually swallow down, but it immediately returned. At night woke up with feeling of suffocation. She is best when lying on left side with head raised. Relieved by swallowing solid food, but empty swallowing aggravates. Throat very sensitive to external pressure. Urine dark and turbid, bowels confined, worse in cold, damp, windy weather. Appetite good, menstruation regular. Much thirst, and longing for coffee. Laches. 30, 2 globes. every evening, cured her in a short time.—Waszily, *Archiv. f. Hom.*, i., No. 8.

Lappa major.—Dr. S. A. Jones has an article on this plant in the *Hom. Recorder* of January 15th. In it he mentions that a colleague consulted him for what he called “spermatorrhœa,” but which Dr. Jones found to be an excessive deposit of amorphous phosphates. He had never, he said, observed this “white stuff” in his urine until he had made a proving of the burdock, which he took in large doses, and which brought on an alarming prostration “like typhoid fever.”

In the number for February 15th, Dr. Jones begins the narrative of a proving of the plant.

Lilium Tigrinum.—A woman, aged 33, had formerly suffered from chlorosis. Had a child at full term two years ago, and a miscarriage last year. For six weeks has suffered from violent pains in abdomen, frequent urging to stool and to pass water—a feeling as if all the genitals would be forced out. On examination, uterus was found to be slightly swollen. *Lilium tigr.* 3x three times a day removed all these symptoms in a week.—Amberg, *A. h. Z.*, September 22nd.

Mercurius Corrosivus.—A case of poisoning from the continual handling of disinfectant solutions of this salt is recorded in the *N. Engl. Med. Gazette* of January. The first symptom was the dysenteric diarrhœa of the drug, with proctitis; then vomiting and collapse. The use of the drug was discontinued, and the patient became well again. On its resumption, after nausea and slight vomiting, fever ensued, temp. 103°, with severe headache and partial stupor. A very offensive diarrhœa set in, with severe pain and much mucous discharge. Then came pain and swelling of joints of hands, which on their inner aspect became red and tender, as though denuded of cuticle.

Natrum muriaticum.—Miss P., aged 33, was last year treated for a nervous affection of stomach. For a fortnight has suffered from headache from the nape to above eyes. Pain over the eyelids so that she can hardly open eyes. In the first days the pain came on in forenoon, now she wakes with it in the morning; it increases gradually till noon, then declines towards evening. Towards the end of the attack the pain is concentrated in temples. The right side is chiefly affected. Vomiting sometimes ensues. Pain worst when lying, is aggravated by mental exertion; sleeps well, appetite bad. Much thirst and dryness of mouth, most at noon. August 30th.—*Nat. mur.* 11, three times a day. Sept. 26th.—Reports that the next day the pain was better. After three days it was completely gone.—Dahlke, *Zeitsch. d. Berl. Ver.* xii., 52.

Mrs. R., aged 53, has suffered from childhood from chronic conjunctivitis. Photophobia, lacrymation. The tarsi much thickened and red. Warmth does good. Occasionally mist before eyes. Skin of hands rough; sometimes there is a vesicular eruption on them. Constipation. Natr. mur. 30, a dose every third night. After fifteen days the eyes were wonderfully improved. Photophobia, lacrymation and mistiness of vision gone, and the red tarsi very much better. She got Natr. mur. once a week. No more medicine required, and after a year no relapse.—*Ibid.*

Phellandrium in Phthisis.—Dr. Terry confirms the favourable repute of this drug in certain cases of pulmonary tuberculosis. It appears to be "pneumonic phthisis" in which it does good; and the general symptoms melt away under its use in from four to six weeks, leaving only the physical signs, to disperse which other treatment is needed. He gives the mother tincture, or 1x dilution, 2 to 5 drops three times a day.—*N. Am. Journ. of Hom.*, Feb., p. 118.

Phosphorus.—Dr. Thornton has experimented, in the laboratory of the Jefferson Medical College, on the reputed antidotes for phosphoric poisoning, and comes to the conclusion that permanganate of potassium is the only one to be relied on. "It must be used before the poison has become absorbed, and must be well diluted (.5 to 1 per cent. solution), or vomiting will result before the chemical re-action has taken place in the stomach. It must be given in excess, as much permanganate is reduced by the organic substances in the stomach."—*Therap. Gazette*, Jan.

Physostigma.—In a case of neurasthenia in an old lady, with great mental and physical debility, and rapid feeble pulse, the 3rd dil. of this drug had a marvellously "tonic" effect. After five days' administration she felt better than for six months past.—*N. Am. Journ. of Hom.*, Jan., p. 56.

Sabal serrulata.—Dr. D. H. Ray, of Calcutta, relates two cases in which urinary fistulæ have healed under the action of the tincture of this plant.—*Hom. Recorder*, Nov.

An old-school practitioner, in the *Chicago Medical Times*, bears his testimony to the value of this drug in prostatic irritation and enlargement. He claims that it will reduce the gland to its normal size, and effect a permanent cure.—*Ibid.*, Feb.

Scutellaria.—Dr. Gorton writes in the *N. Y. Med. Times* of "the valuable assistance he has derived from 1 minim doses of the tincture of this drug in cases of neurasthenia."—*Monthly Hom. Rev.*, Feb.

Sepia in Polyarthritic Rheumatism.—Mr. S. was seized

on October 28th with acute articular rheumatism. The pains were chiefly in ankles and wrists. Temp., 38.2° to 38.9°. Copious perspiration of intense sour smell. Pains aggravated at night, especially before midnight; constant desire to change position. Rhus 3 every three hours. After three days no improvement. The pains are in almost every joint, change their seat frequently, and extend into the body; are aggravated by cold and wet weather, and by the slightest draught of air. Urine dark. Oct. 31st.—Sepia 6 every three hours. Nov. 2nd.—Patient out of bed and greatly pleased that he is so much better. Sepia continued less frequently. After eight days he was free from pain. A slight stiffness only remained, which went off without further medicine.—Waszily, *A.h.Z.*, cxxvi., 56.

Sticta in Cough.—Dr. Malcolm Leal contributes his experience with this remedy, which he uses in the mother tincture. The cough for which it is effective he describes as “dry, hacking, or single concussive; worse at night; apparent cause, tickling; apparent seat, upper trachea or larynx; unaccompanied by pain, though cough may seem to jar whole chest.”—*Am. Homœopathist*, Jan. 15th.

Sulphur in Pulmonary Catarrh.—A governess, aged 27, sought advice on July 10th for a lung affection of long duration. Frequently suffers from cough; last winter had moderate hæmoptysis. Now coughs much day and night, with yellow expectoration, great dyspnœa, anorexia, looks very ill, has some fever, menses regular, no hereditary taint. Dulness on percussion at apex of right lung; peculiar respiration and bronchophony before and behind; at apex of left lung posteriorly small râles, leather-creaking sounds on respiring in left scapular region and dry rhonchi extensively heard on both lungs. Sulph. 30 every three hours. July 15th.—Much better in subjective symptoms, cough and dyspnœa; the catarrh of apex of left lung, the rhonchi and leather-creaking sound gone. She now got Bry. 3 for a little time, and was soon able to return to her work.—Amberg, *A.h.Z.*, Sept. 29th, 1892.

Tellurium.—Three cases by Dr. Shelton, confirming the value of this metal in spinal irritation, will be found in the *Monthly Hom. Review* of Sept., p. 548.

Thlaspi Bursa Pastoris.—A hæmaturia of weeks' duration, in a subject of Bright's disease, was entirely checked in forty-eight hours by 5-drop doses of the tincture of this plant, after the ordinary remedies had failed.—*N. Am. Journ. of Hom.*, Jan., p. 57.

Vinca minor in Diphtheria.—The widow of an apothecary in Munich enjoyed a great reputation for the cure of diphtheria by means of a secret remedy, which she wished to sell for the modest sum of 100,000 marks (£5,000). A sample of this wonderful remedy was obtained and on examination proved to be *vinca minor*. Of this the astute widow prepared for each case a fresh decoction, which she administered to the diphtheria patients by tablespoonfuls. The remarkable success of this remedy in many undoubted cases of severe diphtheria was certainly to be attributed to its homœopathicity to the disease, for we read in its proving by Dr. Rosenberg that among other symptoms it caused sore throat when swallowing, hoarseness, ulcers in the nose, with obstruction of the nasal passages, flat ulcers on the buccal mucous membrane. Hitherto this drug has been but little used by homœopathic practitioners, and its usefulness has been almost confined to the cure of a case of *plica polonica*. It might be worth while to give it a trial in cases of diphtheria, which is not always so amenable to the ordinary homœopathic treatment as we could desire.—*Mœsex in Allg. hom. Ztg.*, cxxvi. 56.

THERAPEUTICS.

Acute Hydrocephalus.—A case of what seemed to be this disease, in a boy of 12, delirium being very marked, presented to Dr. Crosby's eye so strong a resemblance to poisoning by cocaine, that he put two drops of a 2 per cent. solution into half a tumbler of water, and gave a teaspoonful every two hours. Delirium soon abated, and convalescence set in and proceeded uninterruptedly.—*Med. Era*, Jan., p. 16.

Cancer of Stomach.—Dr. Winterburn relates a case generally diagnosed as, and apparently being, scirrhus of the pylorus. Under *Bryonia 30*, chosen on account of the subjective symptoms, and given every six hours, improvement speedily set in, and went on to complete recovery.—*Medical Advance*, Nov.

Cancer of Tongue.—Dr. Ridpath contributes a case to the *Hom. World* of December, where, in a subject of abdominal cancer, the disease appeared in the tongue. Under *Silicea 1x* all the symptoms disappeared, and they did not recur before the patient's death.

Cholera.—A layman, who seems to have treated a good many cases, reports his experience of the recent Hamburg epidemic of cholera. He found arsenic the great remedy, camphor and *veratrum* proving ineffective. The 6th dilution answered for

the slighter cases, but for those of more serious or advanced character the 4x and 3x triturations were required. Of these (excluding the slighter cases), he lost at the rate of 5 per cent. only.—*Leips. Pop. Zeitschr.*, Nos. 23 and 24, 1892.

Dr. Hesse communicates his experience in the same epidemic to the *Allg. hom. Zeitung*. He seems to have made most use of camphor and veratrum, which latter medicine he has given in drop doses of the mother tincture. He does not say how many cases he treated, but gives his death rate at 20 per cent., in contrast with the 40 to 45 per cent. of the general mortality.—*Revue Hom. Belge*, Feb.

Cornea, Ulcer of.—Dr. Alton G. Warner records a case of sloughing ulcer of the cornea, with intense conjunctival injection—which last, at any rate, was of a month's standing under old-school treatment. A marked aggravation of pain and photophobia every second day induced him to give chininum muriaticum 1st cent. Rapid improvement ensued, and cure within a week.—*N. Am. Journ. of Hom.*, Jan., p. 18.

Croup.—A girl, aged 7, was treated for croup by an allopathic doctor, who thought the case hopeless, and as a last resort proposed tracheotomy. On this the parents sent for a homœopathic practitioner, who found the child lying in an apathetic state, with loud gasping and sawing respiration, violent fits of coughing, which threatened suffocation; the larynx and trachea seemed to be clogged up with mucus; great desire for warmth, head thrown back, temperature 40° C. He gave hepar 30 and spongia 30 in solution alternately every hour. In two hours all the suffocative attacks ceased, and the cough was much diminished. The child made a perfect recovery.—*Waszily, Allg. hom. Ztg.*, cxxvi., 53.

Diphtheria.—A man, aged 56, after feeling poorly for some days got sore throat. Last night he had symptoms of suffocation of a dangerous character. When seen in the morning he was hoarse, had dry, short cough, great prostration, desire for cold drinks, profuse sweat in sleep, head must be elevated, worse when he lay on left side, mouth and lips dry, constipation, drowsiness, pulse small and intermitting. Phos. 6 every three hours. Next morning the diphtheritic deposit was diminished to the size of a bean [we are not told how big it was before], but heart's beats and pulse very weak. Next day the throat was nearly well, but he felt poorly after each dose. The phos. was then continued in the 30th dil., a dose night and morning. After this, the cardiac weakness continuing, and there being great chilliness, he got kal.

carb. 30, and afterwards cupr. 30, which completed the cure.—*Ibid.*, 54.

A girl, aged 19, got diphtheria yesterday. To-day the membranous deposit covers both tonsils, which are much swollen. Externally the swelling is greater on the right side of neck. She cannot bear to be in a warm room, in spite of the cold (it was January) she must have the window open, must lie with head high, is best on back, sleep restless before midnight, cold drinks allay the throat pains; urine with red sediment. Lycop. 30, one dose in evening. Next morning the membrane had entirely disappeared. She got for three more days lycop., and then was quite well.—*Ibid.*

Eczema.—1. S. P., a blonde lady, aged 27, suffered for half-a-year from eczema of palm and between fingers; the eruption on the hand was dry, that between the fingers was vesicular. Aggravation from washing. Leucorrhœa after menses. She got, Dec. 8th, sepia 30, one dose once a week. After four weeks the eruption was much improved.—Hesse, *Archiv. f. Hom.*, i., No. 8.

2. F., a governess, had suffered for three months from dry eczema on both hands. Complained of heat of hands and flushings of face. Sepia 30, once a week. Reported on Dec. 5th that she had only used three powders, which cured the eruption.—Hesse, *Ibid.*

3. A custom-house officer, aged 30, had long suffered from itching eruption on backs of hands. Six years ago was treated homœopathically for a scabious eruption on the body. On April 7th, 1891, he got sepia 30, once a week. Nov. 18th.—Came under treatment for an acute affection which was cured by puls. The eruption was then quite gone. April 11th, 1892.—Slight gonorrhœa for a week. He got sepia 30, five powders, one every night. May 7th.—Gonorrhœa gone, but the eruption on hands returned. No medicine.—Hesse, *Ibid.*

4. S., a retired railway luggage guard, aged 67, sought advice for a cutaneous disease of long standing. In his early youth he had always suffered from papular and pustular affections. When serving in the army he had eczema of the thighs, which the army surgeon soon removed by a zinc ointment. It returned, however, after some years, and was nearly limited to the thighs. It was worst when he was about 34 years old. He had a great deal of medical treatment of all sorts. It was at length cured, or disappeared for sixteen years, he knew not by what remedy. In March, 1889, the disease broke out again with increased intensity. It was again treated with a variety of remedies, without any good

result. Seen Dec. 1st, 1891, he presented the following appearance:—His face and head (which had lost all its hair) were inflamed and red, with moisture constantly exuding from them, that had to be continually mopped up. His extremities were in the same state, but only a few spots over the body. If any spot became dry for a short time, a white glittering scaly skin was formed on it, under which the moisture still formed. The patient was in despair. Lycop. 3x every evening was prescribed. Dec. 14th.—No change. Prescribed graph., 6 trit., every evening. Jan. 18th.—Still no change. Sulph. 30, one dose. Feb. 1st.—Same state. The prescription now was natr. mur. 3x, to be taken every morning fasting, in a cupful of hot water. This treatment was continued till April 10th, when a considerable improvement was observable. The natr. m., in hot water, was continued till June 24th, by which time the patient was quite free from his eczema, and the hair had again grown on his head, not white, as it had been before he lost it, but dark brown.—Billig, *A. h. Z.*, Oct. 27th.

Epilepsy.—In a case of this malady of twenty-two years' standing, originating in a disappointment in love, the fits gradually increasing in frequency until—on coming under treatment—they occurred twice or thrice daily, Dr. Winterburn prescribed agaricus 30. The attacks at once became rarer, and after four or five months she had no more. The only symptom specially indicative of this medicine seems to have been "great flow of ideas and loquacity after the attack."—*Medical Advance*, Nov.

Dr. W. M. Houston relates a cure of this disease, of three and a-half years' standing, by cuprum met. 12, given because of the convulsions invariably occurring at night during sleep.—*Ibid.*

Mastodynia.—In a case of pain after nursing, of stinging character, commencing at the nipple and extending into the gland about fifteen minutes after the child had been to the breast, a number of remedies failed to relieve, but the tincture of sabal serrulata (the "saw palmetto") cured in two days.—*Am. Hœmæopathist*, Dec. 19th.

Metrorrhagia.—Mrs. O., aged 44. The catamenia, which she had not had for eight months, came on and had now lasted fourteen days. She felt particularly well to-day, and had walked out when a violent flooding came on. She was taken home in a carriage, and now lay in bed. Dark blood with large clots poured from her, especially at every movement; no pain. Yesterday had much flatulent distress. She got Lycop. 30, two globs. on tongue.

After this one large clot came away, but nothing more. The following day she was much better and rapidly recovered.—Waszily, *Archiv. f. Hom.*, i., No. 8.

Myxœdema.—Dr. Clarke reports, in the *Hom. World* for Oct., a case of this disease in which arsenicum, prescribed on account of the concomitant symptoms, proved curative.

Nails, Degeneration of.—Dr. Batault relates a curious case in which the nails of the fingers softened and stripped off in scales. The extremities of the fingers were so tender that the coat could not be buttoned. The patient had had syphilis seven years previously; but anti-syphilitic treatment was useless for this affection, which continued to increase during three and a-half years. Plumbum 30 was given night and morning, and after three weeks pain and tenderness had ceased. No medicine was taken for a month, and the nails improved in character. Under thuja 30, given because of perspiration of hands and feet, this improvement continued, but pain returned. Plumbum was now resumed, and in three and a-half months from the beginning of the treatment the nails were perfectly strong. After three years there had been no relapse.—*N. Am. Journ. of Hom.*, Feb., p. 87.

Nephritis.—Ernst Müller, farm labourer, aged 38, had been seriously ill for ten weeks under allopathic treatment. When seen on May 10th his whole body was cedematous and swollen to such a degree that he could not move an inch in bed without assistance. He got arsen. 30 every two hours. This was continued for ten days. The urine contained albumen to one-fourth of its volume. May 20th.—No perceptible alteration. Arsen. 5x every two hours. May 23rd.—Legs more swollen, but body and arms less so. Continue medicine. May 25th.—Marked improvement of all symptoms. Albumen in urine now one-eighth of its volume. Swollen much less. Patient was able to walk about and his appetite much improved. May 28th.—Only slight swelling at ankles, greatest towards evening. The urine only showed a slight turbidity on June 17th; the swelling had quite disappeared. June 26th.—Urine quite free from albumen. Appetite normal. His body appeared well nourished, only some weakness remained. In another fortnight he was again at his work in the fields.—Paul Lutze, *A. h. Z.*, Nov. 2nd.

Obstetric Practice.—Dr. S. P. Alexander has a paper in the *Monthly Hom. Review* of Feb., relating his experience with homeopathic remedies for the disorders of the pregnant, parturient, and puerperal states.

Pleurisy.—A boy, aged 6, had suffered since end of March

from fever which at first came daily at 10 a.m., now (June 30th) at noon. There is first rigor, with blue lips and earthy complexion, then heat with red face, then sweat. During the attack complains of pain in body and head. The sweat is greatest on head. The whole lasts one and a-half to two hours. Before the attack there is cough, with retching and vomiting of food. The cough lasts through the attack. After it is over the child wants to get up and eat. Appetite good. Bowels regular and sleep sound. Is emaciated, very irritable. There is pleuritic exudation in right side up to angle of scapula. Gastric region tender to touch. During the fever the whole abdomen is sensitive to the slightest pressure. Has been under treatment since end of March; was for several weeks in hospital, was tapped there, but as the effusion returned was dismissed uncured. Bryonia and apis were given in alternation. June 16th.—Mother reports that there has been no febrile attack for three days. The dulness still extends to the same height. The medicines were continued. August 8th.—No more febrile attacks. Effusion quite gone. General health normal.—Dahlke, *Zeitsch. d. Berl. Ver.*, xii. 51.

Pneumonia, Cavity of Lung, Pleuritic Exudation.—August O., aged 4, had been long treated by allopathic practitioners, who pronounced the case hopeless. His illness dated from April 5th, when he had pneumonia and pleurisy with effusion. When seen on May 29th he was very ill, had great dyspnoea, and could scarcely stand. He coughed much and expectorated much yellow sputa, with occasional vomiting. In the upper part of right lung, before and behind, the percussion sound for a hand's width was quite empty; respiration bronchial, with metallic sound; in the lower part of right lung, before and at the side, empty percussion sound and absence of respiratory sound; behind, moderate dulness and feeble vesicular respiration. Then the upper part of right lung was pneumonic, with infiltration, suppuration and formation of a cavity; its lower part was occupied by pleuritic exudation. Prescribed Sulph 30. June 4th.—Cough and general state improved. June 12th.—Pain much less, respiration in right lung more distinct, though there was still dulness, but anteriorly the pleuritic exudation was greatly increased, and the dulness on percussion extended from above to below; no respiratory sound perceptible. Arsen. 30 every three hours. June 30th.—Fever and cough less. The pneumonia was gone, but the pleuritic exudation had increased and extended up to the angle of the scapula; it had caused a marked scoliosis of the spinal column. Kali iod. 6x one drop every three

hours, and a teaspoonful of cod liver oil at night. Under this medicine the exudation diminished, the strength increased, the scoliosis declined. July 15th.—Exudation gone, but the scoliosis remained. July 31st.—Improvement continues, the exudation anteriorly diminished. September 5th.—Patient looked well, had gained flesh, no trace of the scoliosis, only slight dulness in lower part of thorax anteriorly. No trace remaining of pneumonic infiltration or cavity.—Amberg, *A. h. Z.*, Sept. 29th.

Pneumonia with Lumbrici.—A girl, aged 7, of robust frame, but with swollen, pasty, pale face. She had been treated for pneumonia for a week by a practitioner who gave acon., bry. and phos. But so far from improving, her malady had assumed a typhoid character. March 3rd.—She lies in a state of sopor with occasionally bland delirium. Wakes up now and then with a piteous cry and begins to cough. She then replies to questions in a low voice, plays with her doll for a few moments, then falls again into her soporose state and lies with half-shut eyes. When awake she picks constantly at her nose and lips, which are dry, rough and red. Complains of right frontal headache. Percussion shows dulness in right lung superiorly; auscultation reveals infiltration and fine râles. Temperature 40° at night; 38.9° morning. Complete anorexia, great dislike to sweets, tongue red. Stools pea-coloured and thin, several times a day, sometimes passed unconsciously. With the cough a little viscid, rust-coloured expectoration. Pulse small, quick. Urine turbid, frequently passed. Rhus 30 every two hours. Warm compresses to chest, cold compresses to head. Next night slight perspiration, which continued during the day. Cont. Rhus. 14th.—Cough seldomer, sleep quieter, skin moist, diarrhœa several times a day. Passed a lumbricus. Picking at nose and lips continues. She got cina 30x and acid phos. 30 alternately every two hours. Passed about twenty lumbrici. The resolution of the pneumonia went on steadily. Cough seldom, with a little sputum coctum. Has left off boring in nose, but still picks lips. Diarrhœa ceased. She sits up in bed and plays. Temperature steadily declined. She got Sulph. 30. 19th.—Was nearly quite well. All the functions normal.—Mossa, *Archiv. f. Hom.*, i., no. 8.

Psoriasis palmaris.—Dr. Cooper relates in the *Hom. World* for January a case of this disease of some years' standing. He gave Calc. carb. 3x, five grains to ʒij of water, five drops three times a day, and a local application of calendula and vaseline. Three weeks after finishing the medicine the hands—hitherto unchanged—began to improve, and gradually recovered their normal condition.

Pulmonary Tuberculosis.—In articles by Dr. E. E. Graham, in the Oct. number, and Dr. H. S. Stark in the Dec. number of the *Therapeutic Gazette*, much praise is given to kreosote in the treatment of this disease—both writing from a wide experience. The drug is given internally, in doses of four drops three times daily, gradually increasing to forty or more. By neither author is its germicidal power made much of, though it is recognised. Dr. Graham thinks its chief use is to reduce cough and expectoration; Dr. Stark attaches most importance to its “anti-fermentative power in the digestive tract,” by which it favours nutrition and assimilation. Curiously enough, in the same (Dec.) number of the *Gazette* appears a paper from Dr. Longstreet Taylor, in which he says of kreosote, that “it upsets the digestive organs in the majority of cases, long before it is being taken in sufficiently large doses to have any appreciable effect,” and that after a conscientious and extended trial he has given it (and guaiacol) up. This writer is, on his part, enthusiastic about the so-called “Shurley-Gibbes” treatment, which consists in the hypodermic injection of iodine and of the chloride of gold and sodium, with disinfectant inhalations. The testimonies he cites (in addition to his own) to its efficacy are sufficiently striking; and as the drugs used are in no slight homœopathic rapport with the disease, the treatment must command our interest.

Dr. Winterburn relates a case in which not only were there all the rational and physical signs of pulmonary tubercle, but the sputa revealed under the microscope the presence of elastic fibres of lung tissue. Under silicea, sulphur and lycopodium complete restoration to health took place.—*Medical Advance*, Nov.

Sciatica.—Mr. B., aged 45, robust and otherwise healthy, has suffered for some weeks from a pain extending from sacrum down through right lower extremity, following the course of the anterior branches of the sciatic nerve. Rhus 6, one drop every three hours, produced marked improvement in two days. The medicine was continued four times a day. Three days later the pain was only felt on moving. Caustic. 6, four times a day. After two days more no pain, only some weakness and difficulty of moving the leg. After a few days of caustic. 30 the affection was quite cured.—Amberg, *A. h. Z.*, Sept. 29th.

Trismus.—Dr. Owens reports two cases of this affection, of traumatic origin, in which physostigma 2x sufficed for the cure.—*Med. Era*, Jan., p. 8.

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**RHEUMATISM: SOME INVESTIGATIONS RE-
SPECTING ITS CAUSE, PREVENTION AND
TREATMENT.¹**

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THE great frequency of the disease is indicated by the fact that out of 15,552 cases admitted to St. Bartholomew's Hospital during a period of six years, no less than 1,137 were cases of acute rheumatism, *i.e.*, 7.31 per cent. This does not include the large number of sufferers from the chronic and acute forms of the disease, who were treated in the out-patient department.

The danger of acute rheumatism lies in its remote, rather than its immediate, effects. The mortality was only 1.32 per cent., but no less than 70.86 per cent. of these patients developed heart disease as a result of the attack.² It is

¹ Read before the Society, April 6th, 1893.

² In almost every case a blowing murmur was heard over the heart some time during the acute stage, but these disappearing murmurs are not included in the above statistics. The liability to heart complications increases with each attack; thus the percentage is 58.8 for first attacks, and this rises to 81.9 for third attacks.—Dr. Saml. West, *Practitioner*, 1888, p. 104.

when we consider the great frequency of this fever as compared with others, and the large share which an impairment of the heart's functions has in the mortality from all other causes, that its dangerous nature can be justly appreciated.

In its sub-acute and chronic forms, rheumatism is responsible for a greater amount of pain and physical disablement to the inhabitants of the British Isles than any other disorder. If an estimate could be made of the pecuniary loss which the country sustains as a result of the crippling effects of rheumatism on its working population, it would represent such a large sum that the consideration of means for its prevention and cure would be regarded as a social as well as a medical question.

The mortality and the suffering which attends it is infinitely greater than that of the combined effects of small-pox and cholera, in the prevention of which so much public money is very properly spent; but the preventive treatment of rheumatism is not at present regarded as a possible result of the advance of medical knowledge. In respect to its cure, I will only say that it was a study of the unfortunate results attending the ordinary methods employed which led me five years ago to a study of its nature and causes, with a view to finding some more satisfactory method of combating the disorder. As a result I was led to adopt measures for the treatment of rheumatic fever which are the reverse of those ordinarily adopted. While watching the results of my earlier cases, it became evident to me that there were methods by which rheumatism could be easily detected long before its actual development, and that by very simple methods of treatment the attack could not only be prevented, but that the measures used for prevention were themselves a cure for a large number of intractable disorders, due to the same conditions which produced rheumatism, but which are not generally recognised as associated with it. I have delayed the statement of the results of this investigation until the observation of individual cases had extended over a sufficient number of years to enable me, not only to test the results of treatment, but to examine the value of indications afforded by persons who, while in apparently perfect

health at the time the observations were made, exhibited signs which eventually led to the development of rheumatism or its allied disorders.

Acute Rheumatism.

The first question which suggests itself to us in the study of acute rheumatism is: What is the nature of the fever? Is it a continued fever, attended with swelling and pain in the joints as one of its most prominent symptoms, or is the fever produced by the acute inflammation of the joints themselves? The term "rheumatic fever" would properly represent the first condition, but "acute rheumatism" would be a more precise mode of expressing the latter.

The "Encyclopædia of Practical Medicine," published in 1834, tells us that "this disease is often designated by the trivial name of 'rheumatic fever,' which implies a constitutional disease as well as a local." The continued adoption since then of the term "acute rheumatism," to express what is commonly known as rheumatic fever, would indicate a general opinion in favour of the view that the fever is the result of the local symptoms. From this naturally follows the therapeutic induction, that if we cure the inflammation of the joints we can abate the fever, and that whatever reduces the fever will be likely to limit the rheumatic process and cure the disease. This view is not an unnatural one, but it gathers very little support from the results of clinical observation.

The following facts must be within the knowledge of every practitioner who has watched the course and progress of any series of cases of rheumatic fever:—

(1) The development of very high fever may take place before the joints become affected.

(2) There is no direct relation between the degree of fever and the number of the joints affected.

(3) Articular rheumatism may exist in a very large number of joints without the existence of fever, and it is not uncommon in rheumatic fever for the joints to remain acutely affected after the fever has subsided.

But further and very important evidence is afforded on

this point by the results of the use of salicylic acid and its salts in this disease. For many years the treatment of rheumatic fever in our large metropolitan hospitals has been synonymous with the use of salicylates; we have in consequence an amount of statistical evidence which proves the undoubted power of this drug in controlling the fever and in limiting the painful inflammation in the joints. But we have also learned that although it is a powerful anti-pyretic, cases of hyperpyrexia are as common under its use as they were under the older methods of treatment.¹ We find that convalescence is retarded, and that patients remain in hospital longer than before. That, according to various statistics, no less than 50 to 70 per cent. of the patients treated develop heart disease.

I have stated only the most prominent of the facts which may lead us to question whether the fever of rheumatism can be regarded as a result of the local inflammation of the joints, and this led me to consider whether remedies which act as agents for subduing the pain or controlling the fever, are of necessity the best that can be chosen for curing the disease which gives rise to them. If we seek for further guidance on the subject by making a study of the causes which give rise to this particular form of fever, we are brought into contact with many apparently contradictory phenomena.

(1) The attack is most often due to a chill or exposure to damp, but it may occur in persons who have for a long time been confined to their rooms or to bed, when such causes have not existed.

(2) It is common among men exposed to muscular fatigue, but it occurs among delicately nurtured girls, who are not placed under such conditions.

(3) It is commonest in youth and middle age, but it may occur at a very advanced age, and it is noticeable that in its chronic forms this disorder is most common among elderly persons.

¹ See paper by Dr. Donald Hood, read before Medical Society of London, Feb. 13th, 1888, in which the results of treatment of 9,850 patients at Guy's Hospital before the introduction of salicylate treatment were compared with 1,145 cases treated by salicylates at Guy's and St. Bartholomew's Hospitals.

The only condition amongst those usually stated to which it is difficult to find an antithesis, is the influence of cold and damp in combination in causing this disease. Even here we have to remember that out of a certain number of persons exposed to this condition only a small minority will develop rheumatism. To establish a connection between certain conditions and the symptoms to which we have given the name of rheumatism, leads only to paradoxical results, because we are working without a knowledge of the immediate causes from which these symptoms spring. If we except the "nervous theory" of rheumatism, ascribed to Canstatt and Seitz, but which is practically a modernised version of the views of Cullen, we may take it there is a general agreement in favour of the existence of a poison which is the direct cause of the symptoms of rheumatism.

Whether this poison is admitted into the blood in the form of micrococci (Hueter), or exists there in the form of a vegetable organism (Salisbury), or enters the system in the form of a miasm, which resembles the effect of malaria (Maclagan), or is lactic acid which has accumulated in the blood or the excretion of which is prevented by the effects of a chill—according to the views of Prout and adopted by Todd, Richardson, Fuller, and most modern writers,—it appears probable that we shall be guided to a clearer understanding of this subject by considering the relation of causes to this poison than by trying to directly connect them with the symptoms it produces.

The symptoms of rheumatism are of a very marked and definite character, and it appears a proper line of enquiry to seek some substance which, introduced from without or manufactured from within, is capable of producing symptoms on the healthy body resembling those of rheumatism. I will venture, at the outset, to throw aside the consideration of poisons introduced from without, as there is no clinical evidence to support the theories which adopt them.

We know that the chemical laboratory of the human organism is capable of producing poisons, instead of beneficial products, as a result of derangement of its functions. We can produce an impairment of function followed by

symptoms indistinguishable from a form of rheumatism, by causing a person unaccustomed to great physical exertion to undergo excessive muscular fatigue. On the next day we shall find that the muscles which have been especially exerted are swollen, tender to the touch, and that every movement causes sharp pain. We shall usually find also that the reactions of the saliva and of the perspiration have become acid instead of alkaline, just as we find them in rheumatism. These symptoms are more temporary than those which follow the effect of a chill in a "rheumatic subject," because the disturbance of function in the healthy subject more readily tends to rectify itself; but the character of the symptoms is the same in both.

From the familiar experiment of the effects of muscular fatigue on the muscle of a frog, we know that the result of the over-stimulation of the motor nerve is to produce an accumulation of lactic acid in the muscle, the effect of which is to prevent the muscle reacting to the stimulation conveyed from the nerve. Before this fatigue took place, each contraction of the muscle was followed by an act of perfect combustion, in which oxygen was used up and carbonic acid gas and water liberated. But under the conditions produced by exhaustion the combustion is incomplete, and lactic acid is produced as an intermediate product of oxidation. If this lactic acid is washed out of the muscle by means of a weak solution of common salt, the muscle again responds when its nerve is stimulated. It is usual to explain the defective oxidation by which the lactic acid is formed by saying that all the available oxygen is used up. This view is not entirely correct, because if instead of washing away the abnormal product we gently manipulate the muscle between the finger and thumb, we can complete the oxidation of the acid, and the muscle will again respond to stimulation. This tends to show that it is not the absence of oxygen, but of the power to liberate it, which is the cause of the imperfect combustion. This point is of considerable importance, because while it is demonstrable that the symptoms of muscular fatigue are due to the accumulation of sarco-lactic acid in its tissues, it is none

the less true that fatigue of nerve, by preventing the liberation of oxygen, may be, and is, a direct cause of the production of this acid.

There is, therefore, no direct antagonism between the nervous theories and the poison theories of this disorder. The fault of the former theory is that it does not take into account the many other causes which may produce defective metabolism. We should not be right in saying that the rheumatic pains from which a person who has undergone over-fatigue suffers are directly due to lactic acid; all that we know of the direct effects of the excessive accumulation of the products of tissue waste in the muscles is that they cause a feeling of fatigue and loss of power, and this is not of necessity followed by the pains I have described, as we may gather from the study of athletic feats which require the over-fatigue of muscles for many days in succession.

It is here that this enquiry brings us to the consideration of two sets of conditions and symptoms. The first has reference to the production of excess of products of the lactic acid type in the tissues, the conditions causing it, and the symptoms it produces. The second, to the manner in which this condition may lead to the symptoms of pain, inflammation and swelling of the affected parts, with or without fever. The increased manufacture of these products involves so slight a departure from ordinary function that the symptoms resulting may be so slight as not to attract attention; it is when this production is excessive and continuous that it causes definite symptoms. The conditions which give rise to the formation of lactic acid, instead of carbonic acid gas and water, and of uric acid instead of urea, are any which are capable of causing defective oxidation.¹

¹ The type of chemical change here indicated is well illustrated by Dr. Golding Bird. Starting with 1 atom of protein (which represents the ingredients of all muscular and fibrous tissue), and adding to this 91 atoms of oxygen, we obtain $1\frac{1}{2}$ atoms of uric acid, 33 atoms of carbonic acid gas, and 30 atoms of water. The uric acid from its insolubility may be the exciting cause of a pathological condition, but if we add 6 atoms of oxygen and 4 atoms of water to 1 atom of uric acid, we obtain 6 atoms of carbonic acid gas and 2 atoms of urea, both of which are readily eliminated.

There may be a defect in the supply of oxygen owing to the condition of the blood, or owing to impairment of its circulation in the tissues. In respect to the defect of circulation, it may be equally due to disuse or over-use of the muscle, to the influence of cold and damp, or to any cause which depresses the activity of the peripheral or central nerve centres. Thus the causes which appear conflicting when considering the symptoms of rheumatism are found to be acting in the same direction, when regarded as sources of imperfect oxidation. This condition is the cause of many troublesome ailments which the physician is called upon to treat, and which remain intractable because the nature of the ailment is not recognised. It is essentially a debility which leads to the production and accumulation of acids in the tissues.

Asthenoxia.

I shall speak of this condition as asthenoxia—a name derived from the Greek words *Ασθεveia*, debility, and *Οξυς*, an acid. It is not uncommon to find “an acid condition of the blood” described as an essential condition in gout and rheumatism, but this name does not imply the existence of this condition; on the contrary, I have examined the reaction of the blood in a wide variety of cases, including many of rheumatic fever, and the blood has been invariably alkaline. Acid products may be discovered in the blood in minute quantities both in health and disease, but the whole of my investigations go to show that the acids are not conveyed to the tissues by the blood, but are manufactured in the tissues themselves, and that their destruction *in situ* is both the ordinary physiological condition, and the one which should be the aim of treatment.

When there is excessive accumulation of acid in the tissues, symptoms are produced corresponding with the action of a depressant poison on the system. A feeling of weariness and indisposition to muscular exertion is a prominent symptom. This symptom may be due to physical debility or to neurasthenia, but in both these

cases exertion will be followed by exhaustion. In asthenoxia, vigorous exertion will most often give relief.

There is this peculiarity respecting exercise—an ordinary walk would cause fatigue, but cycling, riding or any form of exertion which raises the heat of the body, and causes vigour of circulation, temporarily removes the weariness previously complained of. In some cases mental depression is more marked than muscular inactivity. The patient either worries over matters which would not otherwise cause trouble, or recognises that there is no reason for depression, but is still profoundly depressed.

The skin commonly presents symptoms which point to defective circulation or disturbance of its innervation. Instead of its natural transparency, it presents a dull opaque appearance, and sometimes we notice that unhealthy pasty look which is associated with the formation of comedones. Irritation of the skin, especially about the eyes and forehead, which sometimes passes into a low grade of erysipelas, is invariably attributable to the condition of asthenoxia. Another very frequent symptom is a remarkable sensitiveness of the skin to cold. That chronic and oft-recurring skin eruptions are due to the condition of asthenoxia, and can be readily cured by removing this condition, is a fact worth noting, but I am not yet in a position to say more than that when these conditions are found in conjunction, measures should always be employed to remove the accumulation of acid from the tissues. Asthenoxia often occurs in association with anæmia, and renders this disorder very intractable; there is a reason for this to which I will presently allude, and which shows that the removal of the acids from the tissues should take priority over the remedial measures used for improving the condition of the blood.

The effect of an excessive accumulation of acid in the tissues sometimes causes dyspnoea which may be of a very urgent character. This may be proved by the immediate relief caused by methods used to remove the acid products. The relation of asthenoxia to asthma is of considerable importance in considering the treatment of the latter affection.

Before entering upon the study of the process by which the acid products of the tissues are converted into a poison capable of producing active inflammation, I will mention one or two symptoms connected with the digestive system, which, standing mid-way between asthenoxia and rheumatism, are not ordinarily traced to their cause, and which prove very intractable to ordinary medicinal measures.

There is a form of gastrodynia which is associated with a decided tenderness over the epigastrium, and which closely resembles the symptoms of gastric ulcer, but it will be found that the tenderness is more diffuse and more superficial. It does not readily yield to the treatment or dietetic measures used for gastric ulcer, or if it is relieved by the effects of careful diet it readily recurs. An examination will often prove that the patient is suffering from asthenoxia, and the rapid and permanent improvement which follows the removal of this condition will afford proof of the cause upon which it depends. It is not uncommon to find a localised tenderness over other parts of the abdomen, unaccompanied by symptoms which would enable us to name a definite cause, and sometimes accompanied by symptoms, such as vomiting, which might lead to a very grave diagnosis. It is the absence of symptoms associated with the graver disorders, and the detection of the condition of asthenoxia, which will enable a diagnosis to be made and rapid relief given.

The Cause of Rheumatism.

A very extended series of observations confirms me in the belief that the condition of asthenoxia invariably precedes the manifestation of rheumatism, but that it is a disorder which may continue for months or years without the production of symptoms which would be recognised as rheumatic. It is necessary, therefore, to consider the manner in which the acid products in the tissues may become changed so as to produce the rheumatic poison. If we refer to the results of overfatigue in the human subject, we find that it is not until some time after the actual exertion that the symptoms resembling rheumatism are produced, and then only in a marked degree in those whose muscles are

feeble. The conditions presented, therefore, are an excess of lactic acid in muscles reduced to a low state of functional activity by the effects of over-fatigue. It is obvious that the muscle is not in a condition to remove the excess of lactic acid by combustion, and that some chemical changes must take place. It appeared to me that the effect of lactic acid on tissue in a low state of vitality might be studied on the muscles of a recently killed animal. If a portion of such muscle be placed in a concentrated solution of lactic acid, we shall observe that it is capable of entering into chemical combination with the muscle without destroying its structure. The muscle becomes semi-transparent, and exhibits an almost gelatinous appearance. The complete chemical transformation which has taken place is rendered evident by the fact that if this muscle is kept for weeks exposed to the air in a warm room, it will not undergo putrefaction or any observable organic change. It will be observed that the transparency of the preparation is increased by exposure to the air, and that such exposure is almost necessary to complete the chemical transformation.

Two fish which have been treated in this way and afterwards exposed to the air in a warm room for two months well illustrate this. In one of them the process of oxidation was rapidly completed by immersion in a solution of peroxide of hydrogen, with the result that the tissues are preserved in their natural state and are permanently preserved. When the oxidation is left to the action of the air, the tissues become more friable and less adapted for preservation and anatomical preparations; but both specimens represent the fact that acids such as are formed in the tissues are capable of entering into chemical combination with tissues when their vitality is lowered, without alteration of the anatomical structure of the latter, and during this process oxygen is used up, although destructive oxidation with the evolution of carbonic acid gas does not take place.

It is of very great importance to a clear understanding of the phenomena of rheumatism, that the process of oxidation which takes place in animal tissue should be understood. We are apt to think of oxidation as a process of combus-

tion attended with the evolution of carbonic acid gas ; but there are conditions of incomplete oxidation, when any carbonic acid formed is not given off, but re-absorbed, so that the addition of oxygen serves to form a more acid product than before.

Thus, if a piece of muscle which has been combined with lactic acid be placed in a bottle filled with a weak solution of permanganate of potash, and this bottle is connected by a glass tube with another containing lime water, it will follow that if the process of oxidation which takes place is accompanied by the liberation of CO_2 , it will pass along the tube, and cause the formation of a milky precipitate in the lime water. But the experiment may be watched for hours, and it will be found that no gas of any kind is evolved by the chemical processes taking place, in fact, there is a greater tendency for the lime water to rise in the connecting tube, showing that there is some exhaustion of the air in the other bottle. The permanganate solution shows by its loss of colour that it has yielded up its oxygen, but neither this nor the CO_2 has passed away, and the only alteration observable in the muscle is an increase of its transparency.

While lactic acid in its pure state is rapidly oxidised in the presence of an oxidising agent, we notice that when it has entered into chemical combination with proteid matter it is capable of using up oxygen to form a body, which I show you, but into the complex chemical nature of which I will not enter, but which has a more intense acid re-action than lactic acid itself. While free lactic acid may be regarded as a depressant to tissue functions, its combination with proteid matter and with a quantity of oxygen insufficient to produce complete oxidation causes the formation of an intensely acid product capable of acting as an irritant to the tissue, and producing those symptoms which we associate with the name rheumatism.

It will be understood, that by continually adding even a weak solution of an oxidising agent we shall finally reach the stage of complete combustion ; but I shall not make too great a demand upon your imagination if I ask you to consider that under the conditions which tend to produce the

accumulation of lactic acid in the human body, and the causes which lead to the imperfect oxidation of this acid, with the formation of the more acid product, the destruction of this intermediate body may not proceed faster than its manufacture, and this may explain the condition presented in cases of chronic rheumatism.

The previous experiment may be performed in another way. The lime water is replaced by some coloured fluid, and is connected with the other bottle by a fine capillary tube. Here the coloured water will be seen to pass along the tube in the direction of the bottle where the chemical process is taking place. Its passage not only indicates that there is no gas passing off from the bottle containing the acid muscle and permanganate solution, but that there is *no increase of temperature as the result of the chemical action*. Because if the temperature of the solution was only raised by the slightest degree, the effect would be to drive back the fluid, which steadily rises towards it along the capillary tube. This can be demonstrated by placing the hand on the permanganate bottle, when the fluid in the tube will immediately flow back again, owing to the expansion of the air caused by the slight heat conveyed to the bottle.

But it is quite possible to cause complete combustion in this experiment by still further *raising the temperature of the bottle* in which the process is being conducted. The same result may be accomplished by adding a stronger solution of the oxidising agent. It is not only the *quantity* of oxygen, but the *energy* with which it is supplied which determines complete combustion. When we cause this energy in either of the ways I have mentioned, phenomena are produced resembling those of acute rheumatism. While the process is taking place, intensely acid products are formed which undergo combustion, and are given off in the form of CO_2 and water. But the process occupies some time, and it is only when it is completed that the acid products disappear. While it continues, there is a decided rise of temperature in the solution.

The Cause of the Fever.

If in the light of these investigations we again approach the question of the cause of fever in rheumatism, we have before us the following data:—

(1) A person suffering from asthenoxia, whose tissues are charged with excess of lactic acid, is exposed to a chill; the primary effect is to diminish the force of the circulation and the amount of oxygen to the tissues, the secondary effect is an increase of both.

(2) The result is to render chemical change in the tissues more rapid—to cause, in fact, the rapid oxidation of the products of tissue waste. It is known that active chemical change produces a rise of temperature, although it is a very slight one; thus if I add a solution of lactic acid to one of carbonate of soda, active effervescence takes place and the thermometer will show a rise of temperature equal to a fraction of a degree, but if, instead of using carbonate of soda, I employ a solution of permanganate of potash (*i.e.*, an oxidising agent), there is again brisk effervescence, and the thermometer will show a very decided rise of temperature. (The experiment was performed and the temperature of the solution rapidly rose from 60° F. to 140° F.)

It would be impossible to discuss here the relation of the constant oxidation of lactic acid, or it would be more correct to say, the chemical bodies which it represents, to the maintenance of the body heat, or the general relation which its more rapid oxidation bears to fever as a symptom; but this fact will be constantly observed: A patient who suffers from an ordinary chill, with no symptom but fever, or perhaps one of the forms of tonsillitis, or some other slight affection which enables us to give a name to the disorder, will usually exhibit (my experience is not sufficient for me to say invariably) an acid state of the saliva and perspiration, which will continue during the continuance of the fever, but which *will disappear when the fever abates*. The exception to this is that the acid reaction may continue after the fever has abated; in such cases it is my experience that convalescence is delayed, and I treat such patients for asthenoxia, and directly the acid reaction disappears they

make rapid recovery. The method of testing this point is so simple that I prefer to wait for the accumulated experience of others before asking that my view should receive a too extended application.

My own clinical observations leave no doubt upon my mind as to the fact that if four persons suffering from the same degree of asthenoxia each contract a chill, probably only one of these would develop rheumatic fever; and that while the other patients would show a degree of fever out of proportion to their inflammatory symptoms, that of the rheumatic fever patient would be comparatively lower, although the fever would be of longer duration. He exhibits the symptoms of rheumatism because the functional activity of the tissues is not sufficient to completely oxidise the acid product, but permits it to enter into that combination with the tissues which I have already explained.

The addition of permanganate of potash to lactic acid represents the first three cases—a process of rapid oxidation with a high temperature is produced. The addition of a weak solution of permanganate of potash to muscle treated with lactic acid represents the rheumatic case. With the addition of heat produced by fever, active changes take place which finally destroy the acid, but they are slower and less vigorous than the former reaction.

Treatment of Rheumatism.

From the experiments we have made it will be seen that the quantity of oxygen required to decompose the rheumatic poison is in inverse ratio to the amount of the heat supply. These facts bring us to an obvious conclusion. The fever which attends rheumatism, and the acute fevers from which an asthenoxic subject suffers, represent the destruction of a poison; and the result of such attacks should be followed by an improvement in the general health, if the process is helped by the physician, rather than that every effort should be made to check the salutary process. It is well known that all the ordinary antipyretic remedies, the salicylates and quinine, serve to diminish tissue metabolism. By offering a temporary check to the imperfect process of

oxidation by which the rheumatic poison is formed, they may effect an improvement in the external symptoms; they leave however the acid products undestroyed, and the vital powers in a worse position than before to complete their destruction. Convalescence is delayed, a greater tendency is shown for the disorder to pass into the chronic form, and relapses are frequent. This is precisely what our studies would lead us to expect, and from the results of the use of such drugs they receive their strongest confirmation. In respect to the deplorable frequency of heart complications under the use of salicylates, it appears probable that when the tissues are charged with the rheumatic poison, and the natural processes required for its combustion *in situ* are checked, the poison is taken up by the lymphatics and is thus conveyed to the heart.

While rheumatic fever is regarded as due to an acid condition of the blood, little importance will be attached to the necessity of its prompt removal from the tissues; but having proved that acidity of the blood is not a normal occurrence in rheumatism, and that the poison is formed and decomposed in the tissues, then the great importance which I have learned to attach to its active destruction and ready elimination will be appreciated.

Both in asthenoxia and rheumatism the presence of acid products in the tissues, by depressing their vitality, favours further production. Their removal, therefore, is the first indication for treatment. It is obvious that all methods which favour increased metabolism assist the destruction of the poison. The most rapid method of increasing metabolism is by raising the temperature of the body, by simulating, in fact, the process which occurs in fever. The effect of heat applied to the body is threefold:—

- (1) It directly facilitates chemical change.
- (2) It causes an active circulation, and therefore an increased supply of oxygen to the superficial tissues.

(It is worth noting that while a rheumatic patient may exhibit a very high temperature, the appearance of the skin usually shows defective circulation in the superficial tissues, which do not receive the full effect of the brisker circulation

caused by the fever. This explains why "natural" fever is less effective in increasing metabolism than the application of heat to the surface.)

(3) It aids the elimination of waste products by means of perspiration.

In reference to this point it is important to observe that the act of sweating is not in itself a cure for rheumatism. Continued sweats are common in both acute and chronic cases, and experience shows that they do not give relief. They are due to an almost paralytic condition of the vasomotor nerves, the result of the poisoned condition of the tissues; thus while it favours the elimination of waste products it also favours their production, with the result that no benefit results to the patient. The application of external heat in such cases gives immediate and appreciable relief, and its subsequent result is to *limit the amount of sweating*.

In cases of asthenoxia and the slighter forms of rheumatism, a wide choice of methods for raising the body temperature is open to the practitioner; but in acute cases, or when there is some debility, we are practically restricted to those which can be administered while the patient is in the horizontal position. Bearing in mind the fact that the secondary effect of heat is to diminish tissue metabolism, it is desirable to use no greater amount of heat than is necessary to raise the body temperature, and at the same time cause perspiration. The raising of the body temperature without the act of perspiration would cause discomfort to the patient. Hot water baths are inadmissible in acute inflammatory conditions, because they cause too much arterial excitement; they are valuable for the same reason in the chronic forms.

One of the most satisfactory methods, and one which need never be omitted because of a difficulty in obtaining appliances, is the "hot moist blanket pack." This differs only from the "cold sheet pack" in the fact that a blanket, wrung out of water at as high a temperature as possible, takes the place of the cold wet sheet. It is important that the blanket should be "moist" and not "wet," and it is an advantage to use a hot-water bottle to the feet, and another

(made of india-rubber) to the back. The only objection to this in the treatment of acute rheumatism is that it requires a certain amount of lifting the patient or his removal from the bed. The same objection applies to the other methods in ordinary use. To obviate this difficulty, and to remove that sense of restriction which many patients find unpleasant while packs are being given, I invented an appliance which I have called "the Vaporarium." It consists essentially of a metal cover, large enough to form an arch over the



patient while lying in bed, and to extend from the shoulders to the feet, at which end it is closed. This cover is double, so that a space of a little less than half-an-inch is left between the outer and inner surfaces. This space is filled with boiling water, and it is the heat radiated from the metal, in addition to that given off from the patient's body, which forms the means of raising the body temperature. As moisture is necessary, this is provided by simply wringing a piece of flannel out of hot water and enclosing it inside the appliance—practically it is laid upon the patient's body.

This appliance can be recharged without removing it from the patient's body, but this is never necessary, as it will retain its heat for a longer time than is required for any single process. For convenience it is made in two halves, and it is when these are used separately for a prolonged vapour bath to the upper or lower part of the body, that the advantage of being able to refill them, or keep a constant stream of hot or cold water circulating through them, makes itself apparent.

The effect of raising the body temperature in cases of asthenoxia and rheumatism differs from that which follows it in fever arising from other causes. Its use in such cases is usually followed by a marked fall of temperature, which can be made permanent if the process is repeated daily, or oftener if necessary. The effect is not that of an antipyretic, but that of an agent which checks the inflammatory condition, and the fall of temperature is accompanied by improvement in the physical signs. In cases of asthenoxia or rheumatism attended by a febrile condition but no actual pyrexia, the effect of artificially raising the body temperature is frequently to cause a permanent increase of temperature which may last several days. I do not mean by this that a single temperature is maintained, but that the daily rise and fall is higher than that of the preceding day, and under the influence of daily applications of heat this rise will continue for a certain number of days, when there will be a sudden fall of temperature after the use of artificial heat, and the temperature speedily falls to normal, at the same time the reactions which were acid become neutral.¹

No stronger indication could be afforded of the general correctness of the views which this investigation led me to adopt than the observation of one of these cases. The effect, so far as the temperature chart is concerned, is to produce a mild attack of rheumatic fever, but apart from

¹ It will be remembered that while the normal reaction of the perspiration and saliva is alkaline, the first is mixed with the acid secretion of the sebaceous glands, and the latter with the acid mucus of the mouth, and that therefore as we examine them clinically, the normal reaction may be said to be *neutral*. But when either of the mixed secretions leaves blue litmus paper unchanged, we may take it that the pure saliva, or pure secretion of the sweat glands, is *alkaline*.

the indications afforded by the thermometer there is nothing to show a febrile state, on the contrary the patient feels better each day, the symptoms formerly complained of abate, and the whole appearance manifests improvement.

Although the aim of the treatment I have adopted for some years is to convert all sub-acute and chronic cases of rheumatism into acute ones, the expression must be taken to represent the symptoms exhibited by the temperature chart, rather than those of which the patient is conscious. The pain in the joints or the feelings of general malaise are always mitigated from the first day of treatment. It would appear to follow from these results that in cases of acute rheumatism, attended with marked pyrexia, the same treatment would tend to increase the fever to a dangerous extent. But it does not happen to be so in practice. The reason of this appears to be, that as the fever is simply the product of a more rapid process of oxidation, and as there are limits to the degree to which this process can be stimulated, depending upon the supply of oxygen, a natural safeguard is interposed between excessive oxidation and the production of such a degree of heat as would endanger life.¹ While in the early stages of acute rheumatism the artificial raising of the body temperature is usually followed by a slight rise, and the reverse happens during the latter part of the attack, there is a variability in the temperature results which are only explained if this factor is taken into account.

Against this treatment, the danger of hyperpyrexia may be brought. But all pathological and clinical evidence points to the central nervous system as the origin of this symptom. Experience shows that antipyretics and the use of extreme cold, which check tissue metabolism, do not reduce the fever in these cases, and that it will continue to rise when all the vital powers are at their lowest ebb.

¹ Thus while the use of a hot pack will usually produce a rise of temperature of 2° F. in a person whose temperature is normal, the same application will rarely raise the temperature more than half a degree if given to a patient whose temperature is already 105° F. The first "pack" given to a patient with acute rheumatism may cause a rise of 3° Fah. during its application, but as the quantity of acid in the tissues is diminished, a rise of $\frac{1}{2}$ to 1° F. is all that is produced.

If it is due to the direct effect of the poison upon the heat-producing centres, this will account for its comparative frequency under the use of antipyretics, which arrest the destruction of the poison, and its absence in the 107 cases of rheumatic fever which I have treated by raising the temperature of the patient.

Another source of anxiety which the practitioner may have in adopting this method, is the propriety of doing so when the patient is very debilitated or has a weak heart. If this debility is due to the presence of unoxidised products in the system, or is maintained by them, I can affirm from the results of the use of this process many thousands of times, that it is not only free from risk, but that it will yield speedy and more permanent results than any tonic which could be selected.

It is time to mention that although I have spoken only of the use of heat, each of these applications is followed by the use of tepid water to the surface of the body. This consists in uncovering one limb at a time, sponging with water at 75° F., and rapidly drying with a towel, which is not wiped along the surface of the skin, but lightly and briskly rubbed to and fro over it. It is then covered up and another portion of the body treated in the same way, until the whole body has received both the application of water and friction to the surface of the skin. The object of this is obvious. Heat forces tissue metabolism, but its after effect is to diminish it. Cold¹ and friction of the skin stimulate the natural production of heat, and increase therefore oxidation in the tissues. It would be possible, when the vital reaction is good, to use no other agent but cold to obtain the object we have in view by the use of heat, but the result would be slower, and the great relief to pain which the method I adopt gives would not be obtained. But so soon as the neutral reaction of the perspiration shows that the acid products have been removed from the tissues or reduced to a low ebb, then the use of heat can be abandoned, and the "Cold

¹ As explained in my article on Thermo-therapeutics (*Medical Annual*, 1890), heat and cold are relative terms. The physiological effect of water at 75° F., following that of vapour at 105° F., is that of "cold," although it is "tepid" when considered in relation to the normal temperature of the air.

friction" which I have described, but carried out more vigorously, becomes the main treatment necessary. This is done by lowering the temperature of the water to 65° F., and finally to 50° F., and using more prolonged friction.

I attach immense but not too great an importance to this simple process, not only in the cure of asthenoxia and rheumatism but also in other forms of debility, and in none so much as persistent anæmia. By it all the good effects of cold baths can be produced, without shock, risk or danger, no matter how delicate the patient may be.

When the patient's cutaneous circulation is so far restored that ready reaction takes place, the third stage of treatment may be commenced. This consists in the use of exercise performed while the patient is in bed or lying on a couch, the principle being that devised by Ling, in which the effort made by the patient is resisted by the operator or nurse.

Results.

There is a natural difficulty attending the preparation of statistics bearing on the treatment of rheumatism, because the disease is naturally variable in its course and termination. In respect to the frequency of heart complications, in the 107 cases of acute rheumatism I have mentioned, by which I mean cases accompanied by continued fever, no cardiac complications have taken place.¹ I do not take this as evidence that such complications will never occur in patients treated according to the methods I have described, but that such a proportion as seven out of ten should have heart complications is quite impossible.

As regards the pain and inconvenience caused by loss of power during the acute attack, I think that the testimony of my nurses is more eloquent than any statement I could make. The treatment I adopt gives more labour to the nurses than the administration of medicines at stated intervals, but they are all of opinion that the actual labour of nursing a case of rheumatic fever is far less under my

¹ Since this paper was read the number has risen to 111, a record unique in the history of the disease.

method than in ordinary cases, because throughout the attack the patient is better able to assist himself, and suffers so much less pain.

In respect to convalescence and after effects, we have learned to expect that the patient will be in *better health* after the attack of rheumatic fever than before it. . . . When it is remembered that this acute attack is Nature's effort to free the system of a depressing poison, there is nothing extraordinary in this result, although it is contrary to ordinary experience. One point we are careful to impress on patients dismissed from the hospital, and that is to return for examination in six months. If the symptoms of asthenoxia are present, although the patient is in apparently good health, we give treatment to remove this condition, which usually occupies a week, and saves the patient from an attack of acute or chronic rheumatism.

I claim that rheumatism is one of the most preventable disorders as well as one of the commonest from which the inhabitants of this country suffer. It is only necessary that the physician should detect the very common condition of asthenoxia, and employ the simple method I have described for its removal. Let it be understood that I do not assert that the discovery of this condition indicates that the patient is "rheumatic," but it means that if this condition is allowed to continue, rheumatism is one of the forms of disorder from which the patient may be expected to suffer; but there are many others beyond those to which I have already alluded.

The removal of the excess of acid may not take more than three days, and in many cases the relief from its depressing conditions enables the *vis medicatrix naturæ* to assert itself, and the condition does not return; but when it depends upon a debility of circulation, of muscle or nerve, we must only regard the patient as cured when these conditions are removed.

While these investigations explain why physical methods which have been held in certain estimation in the treatment of rheumatism produce these effects by overcoming mechanical obstacles which hinder the cure of the disease,

they do not prove that remedies are useless—on the contrary, they make it the more clear that all medicinal agents which act as specific stimuli to the tissues affected by rheumatism, or act by augmenting the general metabolism of the body, must be of value in removing the cause of the disorder. No object is to be gained by claiming too much for one or the other. The method of physic and physical methods are most powerful for good when they act together, and both are useless unless properly selected and judiciously administered.

Dr. HUGHES said that he admired the ingenuity of Dr. Wilde's paper, and it was full of interest from the point of view of organic chemistry. He was at first dubious as to its bearing fruit, for whatever might be thought to be the chemical cause of the disease, it was probable that for all practical purposes it would be lactic acid under another name. As the paper went on, however, he found the method indicated one that promised a helpful way of treating rheumatic fever, which generally needed more than dynamic remedies. Dr. Wilde's method supplied the need of an extra-dynamic treatment, such as of old had been sought in alkalies, lemon-juice, &c., and he felt that we ought all to be disposed to try it. The action of our homœopathic remedies in rheumatic fever was very valuable, but hardly so much so as in other pyrexia, and hence the necessity of additional means of treatment.

Dr. EDWARD BLAKE said that to begin to understand the relations of the various forms of gout, of rheumatism, and of the allied joint affections, it is needful to remember that: (1) Neither gout nor rheumatism exists as a classic disease; that is to say, there are no such pathological entities. (2) There are no absolute anatomical characters to differentiate between the chondro-synovitis of gout and that of rheumatism, of puerperal fever and of the other arthropathies. It cannot be too often repeated that the difference is clinical. It is etiologic and not histological. Thus everyone admits that lead, alcohol and traumatism may lead to the development of gouty chondritis. He witnessed recently acute septic urethritis in a gouty old gentleman of 72 pave the way to the production of an undoubted attack of podagra.

He asked Dr. Wilde what evidence he could adduce that lactic acid alone has the power to cause rheumatism? It is more

likely that every agency which can abruptly arrest metabolism may lead to rheumatic fever. On the other hand, any agency which slowly modifies metabolism may cause chronic rheumatism or osteo-arthritis, the differences between these two being quite an artificial invention of the Bath School. Our pathogeneses teach us that every poison known to man, every drug in the pharmacopœia, may induce symptoms resembling those of rheumatism, and we ought to expect this, for they all modify metabolism, or otherwise they are not poisons at all. He said that he had previously drawn attention to the fact that the agencies—mental, moral and physical—which induce joint disease in man, cause nerve disease in women and skin disorder in children.

Dr. Blake was especially interested in the remarks made by Dr. Wilde on the skin-changes of rheumatism. We are all familiar with the erythema of rheumatic fever and of puerperal septicæmia, but in the chronic forms of rheumatism the dermatoses are just as constant and quite as important. The chondritic changes attract our notice, in that they not only impair movement, but seriously mar the symmetry of the body; but from the pathological standpoint the cutaneous changes are more significant and more important. All the arthropathies are preceded by variations of temperature and by modifications of sensation. The earliest change is a fall of temperature, associated usually with anæsthesia. The second is a rise of temperature, with hyper-æsthesia and erythema. The third is dysidrosis, or else hyperidrosis. The last is cutaneous atrophy—"satin-skin"—with certain changes in pigmentation, usually xanthelasma of covered portions and melanosis of exposed areas. A careful study of these modifications convinces us that in the gout and the rheumatism we have to do with a great variety of forms of peripheral neuritis, possessing fixed characters, and having each a distinct and definite toxic origin. The cartilage and the bone changes are mere late results of neurotic dystrophy. They bear no essential relation to the disease, therefore "osteo-arthritis" is an unfortunate and misleading term.

Dr. Cook said as long as Dr. Wilde contented himself with facts he was in agreement with him, but with his theories he entirely disagreed. When organic matter of any kind was brought into contact with permanganate of potash or peroxide of hydrogen, as an end product carbonic acid was always developed; in fact, there was only one organic product known which did not so oxidise, viz., acetic acid. But when Dr. Wilde attempted to

show that oxidation of fresh muscle produced extra acidity other than carbonic acid the experiment was fallacious—there was no extra acidity. The test was fallacious, for with the two pieces of litmus paper the one fluid had removed the opacity of the paper and the other had not, hence the tints appeared different and the transparent paper more acid, but that was because the background was different. It was well known that lactic acid injected into the body would not produce rheumatic fever—it is not the cause of the pains, but some subtle organic compound other than lactic acid probably operating in minute quantities produced the symptoms. Dr. Wilde's theories were pretty, but not borne out by facts. You may have lactic acid poisoning, but he believed ptomaine poisoning is probably a cause of rheumatic pains. Acetic acid as well as lactic acid causes muscle to become transparent, and this proves nothing. The removal of acid products is nature's remedy, and with this he agreed. Dr. Wilde's apparatus was nothing more than a Turkish bath, and an increase of nature's plan. In bad cases the hyper-pyrexia and the great perspiration was but nature's plan for removal of poison, the quantity present being greater the worse the case, and therefore the greater the effort needed to remove it. When the liquid perspiration was prevented condensing on the skin by outward application of dry heat, much more heat was removed from the fever patient than when it did so condense, and hence Dr. Wilde's appliances were good. He agreed with the treatment, but not with the suggested reasons for it.

Dr. DYCE BROWN agreed with Dr. Cook that lactic acid was not the cause of the symptoms known as rheumatism, and the theory led to no practical result. If lactic acid were the cause ought there not to be some symptoms before the explosion which terminated in an attack? If the elimination of the poison were effected by the fever he did not see why those cases with profuse perspiration and high temperature did not get well the quickest. If elimination were the only thing to be aimed at, these patients ought to have a short attack. He constantly tested the saliva of patients with abnormal rheumatic symptoms, and in nine cases out of ten he found it markedly acid. He could not agree either with the theory or the mode of treatment proposed by Dr. Wilde.

Dr. DUDGEON had seen cases of semi-acute rheumatism in which the symptoms were often of a lingering character. In these cases the perspiration was commonly very profuse, and the greater the perspiration the intenser the disease. When by the

action of medicines the perspiration is reduced the rheumatism lessens *pari passu*. The rheumatic pain would return with the perspiration and thus prove that relief came not through the elimination of the acid through the perspiration, but that the perspiration is developed along with the rheumatism.

Dr. CARFRAE confessed that he could not see the advantage of the Vaporarium described by Dr. Wilde over the ordinary bed Turkish bath, a cradle and a spirit lamp; he had followed this mode of treatment very successfully. He thought the condemnation of the salicylic acid treatment of rheumatic fever to be exaggerated.

Dr. MADDEN wanted to know whether the sweating treatment would be applicable in cases of hyperpyrexia.

Dr. WILDE replied that among his cases he had had none of hyperpyrexia.

The PRESIDENT (Dr. Galley Blackley) was sorry to have to confess that the theory of the lactic acid origin of rheumatism was proved in practice to be untrue. He said that if one examined with blue litmus paper a number of cases, in ninety-nine out of a hundred the moist surface of the tongue would be acid. The secretion of most of the mucous surfaces is acid. He had used the wicker-work lamp bath with benefit. Every modern investigation went further and further in the direction of the bacillar origin of rheumatism, and he looked forward to the time when the bacillus would be isolated and a toxine prepared from it.

Dr. PERCY WILDE, in reply, said that the discussion had clearly proved that he had failed to make his views intelligible to the meeting. He had tried to show them that lactic acid may accumulate in the tissues to a large extent without the production of any very definite symptoms, and when they did declare themselves they were not always those which we associate with the word rheumatism.

To explain the conditions under which rheumatism was produced in those who suffered from this accumulation of acid products in the tissues, he showed that lactic acid was capable of combining with muscle (or other proteid matter) without causing alteration of structure, and that no structural change followed the subsequent exposure of the muscle to an oxidizing agent too weak to produce complete combustion. But under such conditions an increase of the acidity of the proteid matter must take place. Dr. Cook distinctly denied this, but in doing so he must have forgotten that when oxygen was added to muscle in quantity

sufficient to liberate all the carbonic acid gas, there would be left behind uric acid and water, so that the residue would be intensely acid, although the original muscle was neutral. But in the experiment he had shown, the oxidation was not sufficiently complete to drive off the carbonic acid gas, and therefore so much as is formed goes to increase the acidity of the remaining product. Dr. Cook appeared to have forgotten that both lactic acid and uric acid were examples of acid produced by imperfect oxidation. Dr. Cook had also apparently forgotten that there are physical reasons why dry heat would not be used by any person acquainted with the principles of thermal treatment for raising the temperature of the body, and therefore when he said that the appliance he (Dr. Wilde) had shown there was nothing more than a Turkish bath, he made a mistake into which he hoped the others would not fall. The exposure of a patient to the fume of a lamp was not only the wrong way to obtain the result, but a prejudicial and dangerous method. As moist heat was required, and this could be obtained by the hot moist blanket pack, he trusted that this would be used.

In reply to Dr. Dyce Brown's query as to why, if the fever eliminated the poison, cases of rheumatism attended with high fever and perspiration did not get well the quickest, he could only express surprise that Dr. Dyce Brown doubted the fact. We all know that cases of acute rheumatism terminate naturally in a certain number of days or weeks, that sub-acute cases tend to run a slower and more lingering course, and that chronic rheumatism is interminable. He had shown how all cases of rheumatism might be made to take the course of acute cases, without the pain and discomfort usually associated with the word acute. The results proved that in acute cases instead of seven out of every ten becoming permanently affected with heart disease, 107 cases could be treated without this occurring once, and that it was a usual remark with patients that they felt better after the attack than before. If Dr. Dyce Brown could not agree with a method of treatment which accomplished such results, and the advantage of which could be proved by the effects produced on the first patient on which it was tried, he would be glad to have a better method pointed out to him.

Dr. Wilde concluded by thanking the members for the patience with which they had listened to a paper of such great length—a fact which he only recognised when he looked at the clock at its conclusion.

A CASE OF TRAUMATIC OSTEITIS OF THE
SKULL, SUBSEQUENT MENINGITIS WITH
DOUBLE OPTIC NEURITIS: TREPHINING:
RECOVERY.¹

BY C. KNOX SHAW.

Surgeon to the London Homœopathic Hospital.

FREDERICK W., an intelligent lad aged nine years, was admitted to the hospital on May 26th, 1892. About five weeks previously, whilst at play, he had a severe fall, striking the back of his head against a brick wall. He did not take much notice of this at the time, but a fortnight afterwards his mother noticed a swelling on the back of his head. He now complained of headache and of difficulty in reading. On the 16th of May, his headache continuing, he began to vomit, and on the 19th he presented himself with Mr. Dudley Wright's out-patients, when he was found to have a fluctuating swelling in the mid-occipital region, vomiting, headache and double optic neuritis. He had a slight convergent strabismus and his pulse was 80. The symptoms continuing, he was admitted to the hospital, when his condition was found to be much the same as when last seen, but he was listless and moping, his pulse was 84 and slightly irregular. Vomiting and headache were marked symptoms, but there was no paralysis nor twitchings nor convulsions. Though he still complained of his sight he was able to read. He was ordered belladonna 1x, three drops every four hours, and put on low diet.

The boy was kept quietly in bed for three days, and the vomiting ceased. On the 29th he was anæsthetised and an elliptical incision made over the swelling on the occiput. An abscess was opened: the pericranium was seen to be loosened and the bone beneath was bare and rough. On a sharp spoon being used to scrape away the rough bone, its texture was noticed to be very friable and the bone permeated with

¹ From notes made by Mr. Leo Rowse, Resident Medical Officer. Clinical Evening, March 2, 1893.

pus which seemed to come from the diploë. A little further scraping opened the cranial cavity, from which pus exuded. A large trephine was now applied, and the whole of the softened parts were removed. Lymph and pus were now found on the intra-cranial portion of the bone and the dura mater: the latter bulged slightly into the wound and pulsated freely. As the symptoms of the patient did not point to any localised collection of pus and were compatible with a diffused meningitis, it was not thought advisable to open the dura mater. The parts were very carefully antisepticated and the wound closed, leaving an angle open for drainage. The subsequent history of the case was eventless. He had no vomiting, and but little headache, and by June 7th the wound was quite healed. He was out of bed on the 14th, but was kept in the hospital till July 8th, by which time his optic neuritis had subsided.

After leaving the hospital he went to a convalescent home. At the present time he is very well and has complained of nothing but a little headache when at school, but this I find is due to a simple myopic astigmatism for which I have ordered him glasses.

Remarks :—This is a very interesting and instructive case. At the time of the operation the boy stood on the brink of a very serious and frequently fatal disease, and he probably owes his escape to the fact that his primary injury was unattended by a wound, so that the severity of his septicity was lessened. The first point we notice in the case is the slowness of the development of the symptoms; in injuries of this kind the first fortnight is often symptomless, as in this case, but then the headache, apathy, vomiting and optic neuritis are gradually followed by the more serious symptoms of convulsions, coma and death.

The sequence of events is accounted for probably in the following way: the blow injures the peri-cranium and bone and sets up a certain amount of osteitis, the inflammation spreads to the diploic veins and thence to the inner table. Lymph now forms between the dura mater and the bone: the lymph, being very prone to suppurate, soon extends the inflammation to the arachnoid, and a diffuse meningitis follows.

The case exemplifies the difference between a simple traumatic inflammation with the formation of pus and a similar condition where the pus has become septic. For in this case we were saved the terrible pyæmic condition which accompanies septic wounds of the skull. It further shows that in dealing with injuries of the skull we ought to treat them in the same manner as we should osteitis in any other bone, viz., by trephining to open the diploë, or even the cranial cavity if necessary, to give vent to pus or any inflammatory material. If we had waited for more pronounced symptoms to develop, the operation would have been delayed too long to have been of any real service.

Mr. Jacobson has written very interestingly on this subject in his work, "The Operations of Surgery," and this case typifies nearly all the points he raises there.

Belladonna was the only medicine given to the boy, and was continued the whole of the time he was in the hospital.

CASE OF ELEPHANTIASIS ARABUM.¹

BY J. GALLEY BLACKLEY, M.B.

Physician to the London Homœopathic Hospital.

THE patient was a woman, æt. 55, an Englishwoman born in Kent, who, having never been out of England, and during the greater part of her life having resided in or near London, had severe elephantiasis of the right leg. Her family and personal history were both good. She was in hospital with acute rheumatism fourteen years ago, but the enlargement had then been in existence about fifteen years. It began gradually and had gone on steadily increasing, although her general health had been quite unaffected. Beyond the difficulty of locomotion, the growth gave her no trouble. The girth round the knee was now twenty-nine inches.

¹ Clinical Evening, March 2nd, 1893.

Examination of blood and urine during her stay in hospital about two years ago, gave negative results. Hydrocotyle ϕ had been steadily given for months at a time, but without effect. Massage had also been tried, but with no permanent benefit. Photographs of the case taken by Mr. Spencer Cox, when she was in the hospital, were exhibited and showed that the progress since then had been but slight.

In reply to a question by Dr. Cook, Dr. Blackley stated that the blood gave no sign of the presence of filariae.

ON DENTITION.¹

BY GERARD SMITH, M.R.C.S.ENG.

THE whole of child life is a time when the organism is open to abnormal deviations, provided there be a causal influence at work, either originating outside the body, as in the case of chill or infection, or coming from within in the form of some upset of a physiological process. Such an internal causal influence is difficult dentition. (I am not concerned here with normal dentition.)

It may be as well to briefly mention the nervous connections of the teeth. Through the medium of the superior cervical ganglion of the sympathetic, the teeth have anatomical relations with the trifacial, pneumogastric, and glosso-pharyngeal nerves; this ganglion sends a branch direct to the jugular ganglion of the pneumogastric, and the ganglion of the root of the pneumogastric; also to the petrous ganglion of the glosso-pharyngeal.

The carotid and cavernous plexuses have intimate connections with this cervical ganglion, and through them this ganglion is connected with the ophthalmic branch of the fifth, and the ophthalmic ganglion. These are not the only ophthalmic relations of the teeth through the cervical

¹ Read before the Society, February 2nd, 1893.

ganglion; we have connections from the cervical ganglion with the middle meningeal plexus, and hence with the optic and inferior maxillary nerves; the otic and casserian ganglions also are in relation with the teeth *via* the sympathetic. These, although very imperfectly described, will be enough to lead us to expect reflex affections of the stomach and intestines, the salivary glands and glands of the neck; the eyes, ears, larynx, and respiratory mucous membranes, and the central nervous system, as the result of severe or abnormal dental irritation.

The affections due to teething may be either local or reflex; the local affections, due to direct irritation of the structures of the mouth and throat, are the well-known excessive salivation, which scarcely needs to be considered as a thing beyond a physiological process. But there is a sense in which it may be useful to treat it. A very humble nursery precaution may be taken in the shape of the application of a piece of waterproof material to prevent the constant chilling of the front of the baby's chest by the thin saliva.

But this process may go on to catarrhal stomatitis, accompanied sometimes by enlargement of the submaxillary or cervical lymphatic glands; and, more rarely, aphthous and ulcerative stomatitis may arise. The lesser trouble of ulceration of the frænum linguæ may also be troublesome; these affections are worth treating.

With regard to therapeutics, in my unregenerate days two drugs were always useful. They are used by our orthodox brethren on merely empirical grounds, and with success. Now I use them for better reasons; they are borax and chlorate of potash, and they will act well, as you all know, in far smaller doses than allopathy uses. In simple ulceration of the frænum, kali chlor. will cure in the 3x or higher triturations, and when there is aphthous ulceration, or more unhealthy conditions, borax in the same trituration seems to me to be useful. You will, of course, remember how borax suits nervous, screaming children, who clutch at their nurses and are afraid of falling out of their

arms. Loose, pappy, offensive stools seem also an indication for borax.

If the frightened state is due to active cerebral congestion, I think you will all agree that belladonna is better than borax, the absence of fever being the ground for selecting borax in these children.

In catarrhal stomatitis, kreasote and sulphuric acid are good remedies. Kreasote I find useful in rather high dilutions (high, I mean, for me), 6, for example; sulphuric acid I use lower, but this may be wrong, 3x being my usual practice. I confess to having been badly served by merc. sol., perhaps because I use it wrongly. I should be glad to hear some discussion as to this drug.

When enlarged glands are prominent symptoms, silica comes in. I have to make a confession here; I am fond of iodide of potassium in such troubles. This is not the similar, but it does good.

The more severe sympathetic or reflex affections of difficult dentition are, as you will agree, numerous, and in a short paper I cannot do more than touch on them. I speak more for the sake of starting a discussion than in the hope of giving any real information. I think that conjunctival blennorrhœa arises rather more frequently during the eruption of the canines than with other teeth; I think that this is the reason for the popular term of the "eye teeth." The popular idea that these teeth have longer roots than others, and go near the eyes, has been added as an explanation to the original reason for the term, and perhaps there is some ground for the idea in a sense, for probably the irritation may be felt first in the antrum of Highmore, and spreads thence to the nasal and ocular mucous membranes. The pain and photophobia, with non-purulent, or almost non-purulent discharge, leads us to bell. I have not used any other remedy, and shall be glad to hear of others. I like the drug strong, three drops of 1x every two hours. It is noticeable that the disorder is often unilateral, and it is non-contagious.

Otitis is common; the nervous connection with the otic ganglion, and thence to the tympanum, would lead us to

expect this. I think that you will generally find the membrane dull and congested. I have so much faith in aconite and pulsatilla here, that if they fail, and the pain is not abated, I always fear suppuration. I think that I have seen membranes destroyed for want of paracentesis during teething. I find a drop or two of a 10 % solution of cocaine in the ear a great reliever of pain. The applicability of hepar and silica in cases of threatened suppuration is a question worth discussion; I am not sure but that hepar may determine suppuration which otherwise might have been avoided.

As to whether respiratory affections are often directly due to teething is also a point on which I should like suggestions. My experience is that bronchitis during teething is so far more common in the cooler months, and in badly-ventilated rooms at all times of the year, that chill or foul air may be really the cause; but no doubt the primary irritation may be first felt in the larynx (I know children who have spasmodic croup with many of their teeth, quite apart from chill or unsanitary rooms, as do probably all of us), and the primary trouble in the larynx may set up the bronchitis. I have not time to enter into the therapeutics of respiratory affections in dentition. I do not think that the remedies are necessarily to be aimed at the special cause, since our well-known bronchial and respiratory drugs seem to act well, but no doubt I shall be corrected here. I believe that infants sometimes get bronchitis from the chill of a wet chest from salivation, and I know that they avoid such trouble if the chest is kept dry by waterproof sheeting.

With regard to diarrhoea, I have little time at my disposal. The yellow or greyish stools seem the most common, due to intestinal catarrh. I am sorry to have to desert mercury here; I fear that I use it ignorantly. As the children have generally many chamomilla symptoms, fondness for cold water; stools offensive, like bad eggs; child wanting to be carried about,—these lead me to a faith in that drug. This is not a violent straining diarrhoea, with often morning aggravations and occasionally prolapsus ani as symptoms, which podophyllin cures. Colocynth in the higher dilutions I have used for colicky diarrhoea. Calcarea

phos. 3x has served me well with flabby, shrunken children with flatulent, thin, green stools. I need scarcely mention merc. corr. and ipecac. in dysenteric diarrhœa, or arsenicum when gastric irritation with thirst and purging are present. Kreasote again is a favourite with me, and with many of us, when we have vomiting and dark brown stools. The question of diet I am glad to find I may leave to Dr. Neatby. It is, of course, of the very highest importance in these cases. I must apologise for the very short and scanty account of the therapeutics of the diarrhœa of dentition. I do not care to speak of more drugs than I have personal experience of, and I must therefore expose the febleness of my armamentarium here.

Alumina for constipation, when there is difficult voiding of even soft stools, I think we must all have used with success; bryonia, in rather strong doses, I rely upon for dry hard stools, but I am not sure of its homœopathicity; causticum is good for tough stools covered with mucus, and calcarea carb. for fat, fair children with large, chalky stools.

I shall be glad to hear your opinion as to the frequent origin of marasmus, with diseased mesenteric glands, from a primarily catarrhal intestine due to dentition. I think that the catarrhal irritation is often apt to pass into a condition of follicular enteritis, involving subsequently the mesenteric glands.

The most common affections of the skin are, I think, what is called "red gum," which seems to be a very mixed rash, prominent red papules, interspersed with patches of erythema; there is considerable variation in the size of the papules; they itch; and there is often some desquamation after their disappearance. I have seen a case in which the close crowding of the papules, with much erythema, along with trouble in the throat and foul tongue, rendered the diagnosis from scarlatina none too easy. I like rhus tox. as a remedy, and bell. if the erythema be greatly in evidence. Weak carbohc lotions to relieve the itching, both in this affection and in urticaria, are, of course, well known to all of us. I have reason to be satisfied with bell. even in urticaria; there is generally much erythema around the wheals.

If gastric troubles are prominent with these rashes, I think we do better to give remedies directed to them rather than to the rash alone.

As to the eczema of dentition, it is a large subject. It does not need much description; beginning with redness, induration and roughness of the cheeks, it would often stop here, but for the intense itching which causes the child to scratch the parts and make raw surfaces, which are then the seat of deeper mischief; it is over these raw surfaces that the vesicles seem prone to appear, and if the effused gummy fluid is allowed to dry and form crusts, which are subsequently scratched away, we soon have a serious condition to deal with. The pustular form of eczema gives rise to that profuse scabbing, forming sometimes a complete mask to the face, which comes away and leaves raw surfaces; the neighbouring lymphatic glands are often affected. The same remarks apply to the scalp eczema.

I think that we homœopaths are saved from giving in to the popular errors as to the advisability of not attempting to cure eczema during dentition; it is a very convenient error for those whose therapeutics are incapable of meeting the case, as is also that other error about leaving diarrhœa alone to run its course in teething. I am very fond of Unna's glyco-gelatine paint as an outward application, also of the well-known white precipitate ointment. I should be glad to hear of a soap which may be trusted here; for the want of one, I direct that only oatmeal water or linseed water shall be used. As to therapeutics, I can only mention my friends, and shall be glad to be instructed: arsenic, seldom; rhus tox, in the vesicular stage, graphites in dryer forms, also petroleum; rhus has always served me well in intertrigo. I should be glad to hear about tellurium; I have had a few cases where it has served well, and of course we must not forget antim. tart. in the purulent form.

And now for the serious affections of the nervous system. I think that we shall do well to be cautious in our diagnosis here. The time of teething is also that of the very rapid development of the nervous apparatus; and, though teething is often the determining cause, I think that we sometimes do

of the remedies directed to the spinal cord and the use of the sedating tooth drugs. We meet with spasms of the neck, spasms from affections of only single muscles, twitching of the limbs, or grimaces during the course of the convulsions and coma. I do not think that the treatment of these convulsions is generally so difficult to be as is generally supposed. These muscular twitchings and spasms often signs of importance, and, as such, require attention. I have generally been led to give belladonna in slight potencies at the appearance of these symptoms. In the course, there be more serious signs of inflammation or irritation, when bell. comes in. I have also have noticed that there is, even in the course of teething answering to the muddled mental state which is seen when a nerve storm is brewing; a dullness of perception, and the reverse, an acute hyperæsthesia; and in older children a tendency to incoherence or unfounded terror, which may serve to warn us of coming trouble. A warm bath and a few doses of hyoscyamus will give a quiet course.

I have not been able to recognise true "dental paralysis," but the infantile paralysis occurring during the second dentition may be classed under that title. In a few cases of paralysis during the first dentition which I have seen, there have been symptoms which I should put down to coincident polio-myelitis, and this could scarcely be due to the direct influence of teething. But I shall be glad to hear of other notes on this point.

As to therapeutics, the distinction between bell. and veratrum viride has been one which has sometimes perplexed me, when prescribing for the convulsions of teething. It is a point worth discussion. Hyoscyamus, also, is a drug often suggested, and I shall be glad to hear your opinions upon these three drugs. In less severe cases, not proceeding to convulsions, there being some pain in the head and evidence of giddiness, such as clutching at the nurse's arms, or in older children, staggering, gelsemium is a great remedy, opium met., where there is also vomiting; ignatia in paroxysms, kicking children, who wake from sleep with a

scream; and finally, *cicuta virosa*, where there is facial spasm and rigidity, whilst the limbs are relaxed, or not convulsed. These are a few out of many, and again I must explain that I am aware how small a list this is, but I do not care to speak of drugs which I have not used.

I have sometimes found that the diagnosis of worms has been overlooked in cases of convulsions at this age; it is a point worth attention.

As to the question of lancing the gums, since so many of the abnormal symptoms pass off when the tooth emerges, it would seem that to lance the gums is common sense. I am strongly in favour of lancing, if thereby it is certain that the tooth can be set free from pressure; and to secure this, deep crucial incisions over the molars, and equally deep linear incisions over the incisors, must be employed. The lancet should, I think, feel the whole surface of the tooth, and the lancing must be repeated if the cuts tend to heal before the teeth emerge. I am open to correction in this opinion. I know that many, to whose opinions I owe all respect, oppose lancing.

I should put the determination of the question of lancing as of prior importance to therapeutics, in practice.

The local affections due to primary dentition may be repeated in the second dentition, and demand similar treatment; but, as the child is now taking solid food, we find a good deal of constitutional upset due to the fact that eating is painful. I have several times found cases of loss of appetite and consequent debility, being treated by what are vaguely called "tonic medicines," which were due simply to the child not being able to explain that food was objectionable because biting was painful; indigestion from bolting the food is also not rare under these conditions. The treatment is obvious, coming under the head of dietary, with which Dr. Neatby will deal.

I am persuaded that in the press of general practice, we often pass over many little troubles, due to the eruption of the permanent teeth; we find children irritable, weary, and unwilling to play as usual; sleeping badly, with a temperature slightly above the normal, and perhaps some sore throat,

and tenderness of the submaxillary and cervical glands. Examination will often prove that the permanent teeth are giving trouble. Lancing the gums over the new molars, extraction of loose milk teeth and the application of a touch of cocaine to the tender gums, with the administration of chamomilla, gelsemium, kreasote, or ignatia, will often greatly relieve these conditions. Bad temper and general contrariness in a naturally gentle child is often due to the irritation of permanent teeth. Follicular tonsillitis, hypertrophy of tonsils, are also sometimes due to the same cause.

The intestinal catarrh which is sometimes the accompaniment of second dentition, is the analogue of that of the primary dentition, and, I think, tends more to take on a chronic course, or at least, is more obstinate than that of the primary dentition. I think that "Chronic gastro-intestinal catarrh" or the "Mucous flux" of childhood, may be traced back sometimes to the second dentition as its origin; the digestion and absorption of food is seriously interfered with, and we cannot be too careful in our attention to the apparently trivial signs of ill health during the second dentition. In view of these possibilities, the primary intestinal catarrh is treated much on the lines of that of the first dentition, but if there be a more chronic state, I have found hydrastis, nux and pulsatilla my friends, though, of course, calcarea carb. will often come in, and arsenicum for acute attacks during the chronic illness. Again I am glad to leave the diet question with Dr. Neatby.

I think that many cases of obstinate cough are due to reflex laryngeal irritation from dentition, specially the second dentition: indeed, you may have known such cases of incurable coughs in adults from the presence of carious teeth. I have seen several such cases; the therapeutic treatment of such coughs is of little use unless the origin of the trouble is removed; in any case, drugs with both symptoms will act better than those for the laryngeal symptoms only.

The headache, often with ocular symptoms, of the second dentition I have found to be greatly relieved by gelsemium.

Time fails me to deal with the question of infantile paralysis, which, I think, may be sometimes due to second

dentition, and in this opinion I expect to be contradicted, and I have not enough clinical proof to bring forward to support it; but it is one of those ideas one gets from the impressions of cases in busy work. I like conium very much as a remedy, and in later stages I have gained great success from galvanism scientifically applied (if we may yet dare to speak of therapeutic electricity as scientific).

Time also fails for dealing with chorea, and many other affections which occur during the period of child life covered by the second dentition, whether they be caused by it or not. I must now conclude with my apologies for what is, I fear, but a meagre account of a great subject: which I have treated in a not very scientific way, though I hope that a useful discussion may arise from the fact that my paper is thus imperfect.

NOTES ON TEETHING.¹

BY EDWIN A. NEATBY, M.D.

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EXTREMES of all kinds are usually founded on error, and this is not less true with regard to the views which have obtained respecting dentition than in other spheres. At one time almost every ailment occurring between the fourth or fifth month and the third year of life was attributed to teething. From this a not unnatural re-action took place, and it was denied that *any* illness was due to the eruption of the teeth. The truth lies midway between these extremes. It would probably be more correct to say that dentition may modify almost every disease, may excite attacks of ailments to which the patient is constitutionally or otherwise predisposed or is frequently subject, or may predispose to attacks which other circumstances excite.

¹ Read before the Society, Jan. 5th, 1893.

It is not my purpose to enter into any detailed account of the subject which has been so fully and so ably discussed in the paper we have just heard.

Mr. Gerard Smith has drawn attention to the nervous connections of the teeth. I need not remind you that they, the skin, and the mucous membranes of the alimentary canal, are all derived from the same embryonic layer, the epiblast.

The "feverishness"—speaking clinically—associated with teething is of two kinds. The acute variety occurs when the teeth are already piercing the gums, and precedes the completed eruption by a few hours or days. The slighter degrees have no special symptoms, while the more severe cases are accompanied with, if not due to, cerebral hyperæmia. The little patient lies almost unconscious, with flushed face and occasionally jerking of the limbs. The temperature may reach 104°, remaining at this height for 36 or 48 hours. The whole attack lasts from three to seven days. These cases occur oftenest in rickety subjects. The chronic cases begin and end without any tooth immediately appearing, and last from two to three weeks. There are night exacerbations and morning remissions of irregular amount. A week or two after the subsidence of these attacks a batch of three or four teeth may be "cut" close together.

That pyrexial attacks, both during teething and at other times, often have a local and tangible cause, which is liable to be overlooked, is well known. In children, amongst the most common of these causes (as Dr. Edward Blake has often reminded us) is "sore throat." I allude to this only in order to refer to a circumstance which I have not seen mentioned in books. There is clearly some connection between throat inflammations and the skin—possibly one of septic poisoning—as seen in some exanthems. Following sore throats, chiefly of the variety termed by Trousseau "pultaceous," I have during the last two or three years repeatedly met with desquamation of the epidermis, very suggestive of scarlatina. This desquamation may be either on the face and upper part of the chest or on the hands. In the former situation the flakes are

much finer than in the latter. That these cases are not exanthematic I hold to be proved by the course of the malady, and still more by the fact that the same attack may repeatedly recur in the same individual both during and after teething.

One of the most painful ailments associated with dentition is ear-ache; it is not infrequently followed by otorrhœa. I imagine that this is often associated with inflammation of the middle ear, which may either be due to extension of inflammation of the fauces, or may be reflex. Perhaps some of our members having a knowledge of otology can tell us more of these cases, and of their prognosis. In my experience the prospect is good. Even when repeated attacks of otalgia, followed by otorrhœa, have occurred, as often happens, hearing may be perfectly restored.

Besides the catarrhal and inflammatory conditions of the intestinal tract, which I do not propose to dwell upon, there are two other conditions occurring, of course, equally often independently of teething, but which are materially influenced by the presence or proximity of that state. I refer to vulvitis and nocturnal incontinence of urine. Both of these influences are reflex.

The association of rickets and dentition is very close, but it is rather the rachitic condition which modifies the course of teething than the converse. That rickets causes retardation of dentition is universally recognised; the other frequently-made statement that the first teeth of rickety children also decay early has recently been called in question. My own observations lead me to agree with recent writers, who state that decay is not early, but I still regard this question as *sub judice*. To arrive at a correct conclusion, we need carefully to exclude the presence of scrofula, which certainly does cause premature decay.

The skin eruptions common during the period of dentition form a subject full of interest, too wide to be entered upon now.

“Convulsions” occurring during teething are, in my experience, much less common than most other ailments. In deciding upon their frequency and relations, it is necessary

to exclude—when one depends upon the testimony of mothers—a number of contortions (due to pains of flatulence, &c.), which are termed “inward convulsions.” On the other hand, it is important to differentiate the serious form of eclampsia due to the syphilitic poison acting on the surface of the brain or on the cerebral vessels. Convulsions deserve always serious attention and care. Whether *post* or *propter*, convulsions in infancy are more frequently than other ailments followed by neuroses in after life. A large proportion of epileptics have suffered from convulsions in infancy.

I can only briefly refer to the most important part of my subject. A table I am drawing up from observations on some 300 cases is, unfortunately, unfinished. This table will show the frequency of various teething ailments in relation to feeding, to family history, and to other ailments of the patients. I may state that I have been surprised to find what a paramount influence upon dentition does feeding appear to have. Too great care and precision in every detail cannot possibly be adopted to secure appropriate feeding. Only a year ago Mr. Gerard Smith, in his admirable paper on “Feeding,” pointed out that even breast-fed infants may be very improperly fed, through irregularity and over-frequency of meals. I pass round two papers which have been to me of great service in securing precision in feeding. One of these is issued by the staff of this hospital and the other is drawn up by myself. As might be expected, diarrhœa is frequently the result of this ill-feeding: not less so is bronchitis; and of cases of convulsions, not less than 75 per cent. have been obviously improperly fed, and probably the proportion is much higher.

Respecting family history, the parents of patients suffering from convulsions have quite frequently suffered from convulsions, or other nervous symptoms. My observations suggest a possible relationship between rheumatism in the parent and intestinal disturbances in the child. This is not yet established. I have been unable to discover any relationship between the health of parents and skin affections during teething, eczema, urticaria, prurigo, &c. Nor does feeding appear to have so conspicuous an influence on this condition as on many others.

As to after or separate ailments of the patient, the most prominent lesson my incomplete table conveys, is that in a very large proportion of cases, dentitional bronchitis is followed by bronchitis in after years. Every attack of infantile bronchitis is of importance, both from its prognostic significance and its actual gravity. Eczema occurs quite as frequently amongst children who have had no difficulty of teething as amongst those who had suffered at that time. It more often is associated with bronchitis than with any other tooth-trouble. The alternation between bronchial attacks and outbreaks of eczema is familiar to you all.

Therapeutics.—There are just three remedies which, in conclusion, I should like to ask you to notice. For the simple irritability, fretfulness, and restlessness of teething children I have found agaricus 1x and 2x of marked service. The presence of pruritus from urticaria or prurigo will heighten the probability of the prescription being successful.

Passiflora incarnata for sleeplessness in the same subjects, unless due to skin irritation, when no other remedy is indicated I have found a most valuable empirical aid. It is given in doses of 2-5 minims repeated at intervals of half an hour or longer.

For some of those intractable cases of skin irritation due to urticaria, &c., I have found $\frac{1}{2}$ drop doses of nux vomica θ more successful than almost any other remedy, and I have tried, after careful choice, a good many. Perhaps this is another instance of the fact, interesting from a developmental point of view, that many of our great nerve medicines are also skin remedies, *e.g.* arsenic, bromide of potassium, and borax.

I may add to the remarks of Mr. Gerard Smith, that lycopodium (12 or 3) has been of more service to me in constipation than any other single remedy. I have found incision of the gums entirely unnecessary.

Dr. MADDEN asked Dr. Neatby whether he had ever noticed any tetanic symptoms after using the material doses of nux vomica he had recommended.

Dr. NEATBY replied in the negative.

Dr. HUGHES said that Mr. Gerard Smith's paper had raised several interesting pharmacological and therapeutic questions.

Mr. Smith had mentioned the fear of falling downwards. Was that any real indication for borax in stomatitis? He could hardly imagine that it would have any relation to such local affections. Schreter had noticed that a child, while borax was applied to his mouth, showed a fear of downward motion. It was quite possible that it had an incidental effect upon the nervous system; and this might be a good indication for borax in nervous disorders in children. But the affection of the mouth from borax was purely local, as might be seen in the first number of this JOURNAL. In the instances given by Mr. Smith, borax cured local and pathological symptoms without any effect on the nervous system generally. He could not think it would be more suitable because a child showed a dread of downward motion. He thought the reason why Mr. Smith had found borax more useful than mercurius was that the whole blood and nervous system was affected by the latter. When children had ulcerous stomatitis the first decimal trituration of Kali chloricum acted beautifully. He thought creosote was homœopathic to stomatitis. The long-continued use of creosote affected the mucous membrane of the mouth and tongue. Its effects in this respect are to be found in the *Cyclopædia*. A homœopathic remedy iodide of potassium was proved to be in enlarged glands by Cartwright in a paper which he had written on the subject. The cervical glands had swelled in three weeks under its influence. Mr. Smith said that he had been disappointed in mercurius in the diarrhœa of teething. That was because it was a reflex affection. That was why chamomilla acted much better. It was his experience that constipation had been best acted upon by the 30th dilution of bryonia. He did not think hepar could induce suppuration. If that were the case they could not go on using their remedies. One of the greatest comforts homœopaths had was that their remedies could not do any harm. When suppuration was natural and inevitable the lower triturations of hepar would forward it, whilst the higher triturations would every now and then check it. But he thought it very unlikely that it would cause suppuration where otherwise suppuration would not supervene.

Dr. DYCE BROWN said with respect to the use of mercurius in the stomatitis of children, if there was no other disorder it did not succeed, but if there was any other disorder, say diarrhœa, he found the value of mercurius. If there were stomatitis and nothing else chlorate of potass was the only remedy. He could not agree with Dr. Hughes that borax had only a local effect.

Dr. HUGHES explained that he did not mean "local" to exclude dynamic.

Dr. DYCE BROWN said that in older children stomatitis and active diarrhœa had been cured by chlorate of potass, which had more than a local action on the whole mucous membrane. Mercurius in skin irritation, eczema, dried, rough skin, and in pustules during teething irritation, was of immense value. As to hepar, he quite agreed with Dr. Hughes, that not even the low dilutions would produce suppuration. But the rule was a correct one, that if you wish to promote suppuration, begin with a low trituration; but if you wish to prevent its going on, the higher triturations were more successful. It was necessary, in the case of bronchitis, to keep in view the reflex character of that from teething: one should use medicines which either given with others or given alone tended to relieve the reflex irritation, such as belladonna or chamomilla. The latter he found of immense benefit. As to bryonia in constipation he had acted on a hint from Dr. Bayes. In children where the fœces were hard and painful to pass, bryonia in the higher dilutions answered beautifully. In eczematous irritations on the head and face, "red gum," chamomilla and viola tricolor were extremely useful. Gum lancing ought to be discarded out and out. If the tooth was so close as to be actually visible, there was no harm in lancing. But when that was not so, harm rather than good was done in cutting down deeply. The wound had to be kept open, and an unjustifiable amount of irritation was continued. If a cicatrix was formed it became more difficult than ever for the tooth to emerge. Homœopathic treatment would be found to answer beautifully, instead of lancing, to allay the irritation and enable the tooth to come through.

Dr. MADDEN thought that sometimes when a tooth wanted extraction the irritation was caused by the food being swallowed whole and not digested. The trouble was sometimes caused by the organs of secondary digestion. Sometimes the suffering proceeded from the auto-infection of toxic material. Taking away a decayed tooth or getting a new set of teeth would sometimes put an end to a whole series of dyspeptic symptoms. He had always lanced gums when he had been asked; he had never known it produce pain or do harm.

Dr. BLAKE remembered a Scotch lady coming to him who had suffered pain in the great occipital (second cervical) nerves for many years. He requested a dentist to remove from each side a square piece of gum: this revealed beneath a completely elaborated pair of wisdom teeth, and the long-established pain

disappeared. All absolute rules as to lancing gums were wrong. There was often a little gastric catarrh with every tooth worry; colic and green diarrhoea being common accompaniments of the trouble. He objected to the word "reflex," which, like "hysteria," covered a multitude of sins. Mr. Gerard Smith had asked about petroleum. The late Dr. Blake, of Taunton, relied on it for post-aural eczema. All skin diseases were primarily neuroses, secondarily invasions. When the internal ear suffered it was due to an extension from the throat. An infinite number of bacilli were to be found in the Eustachian tubes. He had known a fit of epilepsy connected in the case of a little child with a carious state of teeth and sequent tonsillitis. He did not agree with Dr. Hughes about the local action of borax. He had cured stomatitis with borax 12 without local application. On this point he agreed with Dr. Dyce Brown.

Mr. WRIGHT, observing that Dr. Blake had alluded to the extension of inflammation along the eustachian tube, said that the possibility of its occurring from reflex action was shown by Dr. Cook's experiment. Undoubtedly the majority of cases occurred from inflammation and direct extension. Glycerine would serve as well as cocaine, which would be unlikely to have any local action, whilst glycerine with carbolic acid exercised a soothing influence and relieved otalgia. Aconite tincture with warm water would also relieve pain, and still more, veratrum viride lotion. With regard to skin diseases, Mr. Smith had not referred to sulphur applied internally and externally. Hyoscyamus was also useful in children's cases. Enlarged tonsils and glands in children were often due to carious condition of teeth. The eye tooth was connected directly with the antrum, which might be affected by suppuration round the fang.

Dr. DUDGEON recommended the use of belladonna and chamomilla, as well as the aconite and pulsatilla which Mr. Smith had mentioned. In otitis no remedy was better than belladonna.

Dr. MORR thought many diseases ascribed to the teeth were due to rickets and improper feeding. Much, too, depended on how the child was nourished in the uterus. The bib-bronchitis mentioned by Mr. Gerard Smith was due to a mechanical cause. There was generally some active influence besides reflex action. There was not much use in lancing gums, nor did he think there was any benefit from pricking gums. If one looked into the milk teeth of the children of the present day, there were often large cavities which tended to produce sore throat.

Dr. DAY insisted on the necessity of a minute examination of details. If they were neglected, the most carefully selected

remedies would fail. Many remedies are quite pernicious to children, many of whose sufferings were due to errors in diet. Adjuvants to medical practice were essential, and occupied as important a place as purely medicinal treatment.

Dr. BLACKLEY agreed with Dr. Dyce Brown and other speakers in condemning the use of the lancet. It did, perhaps, no serious harm, but it did not do much good. As a student he had been brought up to use it freely, but had not used it professionally for the last 20 years. During the last three years he had had several cases of exanthemata with throat symptoms. He had put them down to influenza. The ill-defined exanthem was no doubt a form of influenza. There could be no question that iodide of potassium was very efficient in inflammation of the cervical glands. With regard to bryonia in constipation, he had generally taken as his key note whether the child dribbled or not. If there was previous dribbling it would not do much good. Mercury was useful in skin affections. But there were two drugs which had not been mentioned. Antimonium tartaricum and crudum and sulphur were drugs which he used every week. Sulphur in the form of ointment was serviceable in serous effusion. He did not quite follow Dr. Blake's explanation of diarrhoea. He could not give Mr. Smith any definite indications for the use of petroleum and tellurium, as he rarely used them. He had tried them, and found little encouragement to do so again.

Mr. GERARD SMITH, in reply, said he was thankful for the many hints which he had received, and was glad that so many had been down upon him for the use of the lancet. He supposed that he had not been emancipated long enough, and the trail of the serpent was over much that he did. Lancing he found to relieve pain, whether by local bleeding or local pressure. He had followed precedent in using merc. sol. and borax. With regard to irritation of the antrum extending to the eye, he meant that suppuration about the root of the tooth would extend to the antrum as the nearest mucous membrane. The same condition which led to convulsions might give rise to epileptic symptoms. But he doubted whether one was the cause of the other. The teeth probably decayed earlier in rickety than in healthy children. He did not know whether nux vomica was homœopathic to urticaria.

A CASE OF TERTIARY SYPHILITIC ULCERATION OF THE TONGUE.¹

BY DUDLEY WRIGHT, M.R.C.S.

Surgeon for Diseases of the Throat and Assistant-Surgeon to the London Homœopathic Hospital.

THE patient, John D—, aged 70, first came to the Hospital in December, 1892, complaining of a sore on the tongue, which had, so far as he knew, been present some eight months. He gave the following history:—Fifty years ago he contracted syphilis, having a well-marked chancre and bubo. For the past 40 years he has had some soreness of the inside of the right cheek, but never had any trouble with the tongue until the present one.

He had been an excessive smoker up to 30 years ago. He is a father of a family of 26 children, nearly all of whom are now alive and healthy.

Eight months ago he had a very bad cold, and at this time he noticed some soreness of the tongue. He received medical advice for it, and, since it did not heal up, he was advised to have the tongue removed both by his own private physician and by a surgeon of St. Bartholomew's Hospital, whither he had gone on the recommendation of the former gentleman.

This he refused to have done, and he then came to the London Homœopathic Hospital, and was placed under my care.

When first seen, there was deep and extensive ulceration of the right side and tip of the tongue; on the right side there was also some scarring.

The parts around the ulceration were swollen and slightly indurated, and there were one or two slightly enlarged glands in the neighbourhood of the angle of the jaw. The breath was foetid, and there was considerable pain shooting up into the ear. Iodide of potash $1x$ η v. t.d.s. was ordered, together with a lotion of chromic acid gr. ii. ad ζ i.

In a week's time there was no improvement, so nitric

¹ Clinical Evening, March 2nd, 1893.

acid ℥x ℥ii. t.d.s., and a lotion of eucalyptus of the strength of ℥i. ad ℥i. were prescribed.

This was on December 5th, and from that time to February 27th the medicine was continued, each week showing a marked and rapid improvement: the ulceration cicatrising, the pain abating in intensity, and the fœtor disappearing. After this date the patient caught a bad cold from sitting in wet clothes, and a fresh induration and ulceration of the tongue was the result. The pain also returned, and these symptoms still remain active (March 2nd). At Dr. Pope's suggestion, the patient will receive fluoric acid 6, in the place of the nitric acid.

MYXEDEMA.¹

BY ROBERSON DAY, M.D.LOND.

Assistant Physician to the London Homœopathic Hospital.

THIS case is very typical of the disease, and as it shows nearly all the symptoms, I will briefly state the leading features of the disease, which was first described by Dr. Ord:

Always adult females affected.

Excess of mucous tissues, "solid œdema."

Absence of thyroid.

Anæmic condition, from absence of this hæmopoietic gland.

Hands spade-like (Gull).

Mental hebetude, slow speech.

Voice monotonous, leathery.

Tardiness of co-ordination, difficulty of walking.

No albumen.

Mrs. H., aged 36. Dates her illness from birth of last child, ten years ago. But since then she has had two premature confinements.

¹ A Case presented at the Clinical Evening, March 2nd, 1893.

The illness began with feelings of chilliness and indigestion. The feet and legs swelled and the breath got short, she turned faint and giddy, and began to talk with thick speech. She staggered about when walking as if from drink, and her friends said she had dropsy in the face. Soon the legs got very weak, and now it is a great effort for her to go up and down stairs. The menses became profuse and continue so; now are very irregular, lasting a week or fourteen days, with perhaps only three weeks interval. At the menstrual period she has an aggravation of symptoms: the puffiness of the face increases very much, she passes very little urine, and all the tissues get swollen and her weight increases, she becomes burdened with her weight. The menses are quite painless and come on suddenly; also at this time the teeth get loose and she cannot clean them. She bleeds very readily and wounds heal slowly. A burn on the arm recently took a long time to get well.

During the illness, she has had a very dry skin, and cannot perspire. The hair from being light, soft, and curly, has become coarse, fallen out, and now is very scanty. Hearing also became dull, so that she could not hear the carts in the street, but hearing has improved now very much. The eyes also got bad and she had to wear spectacles, but sight is better now. She used to wake up numbed in the night and could not feel her hands. She is very awkward with her hands, in buttoning up clothes, &c., and she cannot sew or wash.

She has got very stout and heavy—fingers enlarged so much that she has been obliged to have her ring filed off. The calf of the leg is $15\frac{1}{4}$ inches round, and the wrist very big. She feels such a lump and so weak, she can scarcely turn over in bed at times.

The teeth have decayed very much, and after going to the dentist on one occasion the gums bled so much that they had to be plugged.

Her memory is very bad, and she cannot read as she used to do, will read the same passage over and over again. She cannot repeat things from memory, gets confused. She is very sleepy, and could sleep all day. She is never hungry.

She can take a message but 'cannot think quick enough to answer, and is very irritable in temper, but she used not to be so.

There is no history of the disease in the family, and she has four children, three healthy; one has congenital heart disease.

On some future opportunity I hope to show this patient again, after she has been under treatment.

Dr. CLARKE drew attention to a case of myxœdema lately published in the *Homœopathic World* cured by arsenicum in high potency. Homœopathy was capable of curing these cases if properly applied. Thyroid feeding or injection was not a cure.

A FEW HINTS ON THE MECHANICAL MANAGEMENT OF INFLAMED KNEE.¹

BY JOHN W. HAYWARD, M.D.

Consulting Physician to the Hahnemann Hospital, Liverpool.

IN diseased joints mechanical treatment is as much called for as is medicinal—perhaps more. It is especially needed in inflamed knee. Of the truth of this maxim I have myself had personal experience, and experience is, perhaps, the best teacher.

Of course, the main objects in view in the mechanical treatment of inflamed knee are to keep the joint still and free from pressure—that is, to procure rest to all the parts and structures connected with the joint; without this, medicinal treatment is almost useless. Now, these objects cannot be attained by simply keeping the patient in bed, for even whilst there the body itself must be moved occasionally, and every such movement causes motion in the knee, and pressing together of its parts; besides, it is very un-

¹ Read before the Liverpool Branch, April 13th, 1893.

desirable that such patients should be kept in bed, because this confinement is injurious to the general health; some rest in bed is, however, both necessary and advisable.

The knee is susceptible of two kinds of motion—flexion and rotation—the latter to only a very limited extent; and to two kinds of pressure—longitudinal by the weight of the body, and antero-posterior through the patella, both to a severe degree.

The usual way to attain the objects in view is, of course, to fix the leg in a Thomas's splint. This, when properly adjusted, not only prevents all motion by flexion, but it keeps off much of the pressure by the weight of the body, and when nicely fixed and strapped, with a well-fitting boot and the moulded stiff pads above and below the knee, even rotatory motion is reduced to a minimum.

If the avoidance of flexion and rotation, and the pressure by the weight of the body, were the only objects to be attained, Thomas's splint leaves very little to be desired—it accomplishes these ends almost to perfection; but, unfortunately, these are not the only objects in view, for it is quite as necessary to prevent motion and pressure by way of the patella—perhaps more.

Now, however carefully applied, Thomas's splint does not entirely prevent the motion and pressure by way of the patella, which are produced by the extensor muscles in front of the thigh. This is made evident by placing the patient on his back and causing him to attempt to lift the leg without the help of his hands; when, by placing one's palm upon the knee both motion and pressure by way of the patella are distinctly perceived. Every time, therefore, that the leg is raised—as in placing it on or taking it off a rest, or getting into or out of bed, or it is carried forwards—as in walking or sitting down on a low seat, this motion and pressure by way of the patella are, to a certain extent, produced, notwithstanding the wearing of a Thomas's splint; and if Thomas's splints cannot prevent them no splint can itself do so. Now, motion and pressure by way of the patella are not much less in themselves, and not much less likely to keep up inflammation in the knee, than are flexion and

rotation and pressure by the weight of the body, and seeing that they are of very frequent occurrence—that, in fact, the leg cannot be either lifted or carried forwards without their being produced—and that on each occasion the articular surfaces of the patella and femur and tibia are moved upon each other, and pressed together by the weight of the whole leg and foot, it seems imperative that means shall be provided for their prevention, quite as much as for the prevention of flexion and pressure by the weight of the body. Without such means, in fact, the mechanical management of inflamed knee is only half provided for. How shall this be done? Can it be effected by an addition to, an alteration in, or a re-adaptation of, Thomas's splint? I cannot myself see that it can, for the splint has no fulcrum on the pelvis, or independent of the thigh; indeed, it is itself lifted by the very muscles that produce the motion and pressure complained of, aided by, of course, those coming from the pelvis; nor can I see any way of applying automatic power. The motion and pressure by way of the patella are produced by the mass of powerful extensor muscles on the front of the thigh, acting through the patella as a fulcrum or pulley over which they act every time the leg and foot are lifted or carried forwards. If, then, this motion and pressure are to be prevented it must be by some means for lifting and carrying forwards the leg and foot independently of the muscles of the thigh, and such as will leave these absolutely quiescent. This means, too, must be always present, always at command; and, as it cannot be effected automatically, it must be under voluntary control, indeed, it must be voluntary muscular power; it must, in fact, be by the muscles of the arms; the leg must be lifted and carried forwards by the muscles of the arm instead of by those of the thigh. Can this be done? I think it can; it can, in fact, be easily and effectually accomplished by having a piece of narrow webbing passed under the forepart of the foot—say in the form of a stirrup—and hung from some convenient part of the dress in front, perhaps the brace button, or it may be passed over the neck—the former for use in the day time and the latter for the night—for it must

be used in the night as well as in the day—or, as making it less an eyesore, it may be carried up inside the trouser and through the pocket. It must have a small crosswise handle opposite the top of the thigh—perhaps in the pocket—to lay hold of and lift and carry forwards the leg every time these motions are required. By thus using the arm for lifting and carrying forwards the leg and foot whenever these have to be done, all motion and pressure by way of the patella will, of course, be prevented, because the muscles in front of the thigh will then not be called into action. If the prevention of this motion and pressure be attempted by tightening the pads above and below the knee in Thomas's splint, the articular surfaces of the patella and femur and tibia will be so pressed together as to be very likely to aggravate the inflammation of the knee, at least, in recent acute cases. In such cases every possible means should be adopted to avoid pressure on the knee itself, either directly or through the muscles. With this webbing, then, in addition to Thomas's splint, not only flexion and rotation and pressure by the weight of the body, but also the motion and pressure by way of the patella are prevented; in fact, all the mechanical requirements of inflamed knee are effectually provided for, and rest to all the parts and structures connected with the joint is secured.

Now, Thomas's splint requires to be very carefully and accurately adjusted and fitted in each case. The ring round the thigh must fit so that the ischium rests nicely on it, and it must fit the thigh itself firmly. Unless the ring fits the thigh itself nicely the pressure and chafing of the fork will be very annoying, and even if ever so nicely adapted, some time is required to become accustomed to the inconvenience, and for the skin to become sufficiently hardened to bear the pressure and friction. At least some weeks' rest in bed should be allowed for these, and during this time the boot and pads must be left tolerably slack, and the leg always lifted by means of the webbing. The total length of the splint must be such that when resting on it the heel shall not press on the boot; if the splint be even a very little short so that the weight of the body presses the

heel down upon the boot, then, at every step, the jarring and pressing together of the articular surfaces of the femur and tibia are all the greater in consequence of the knee being kept absolutely stiff, and these are especially felt in descending stairs and in walking quickly. If it be a little too long the pressure of the boot on the instep will cause intolerable pain, and perhaps inflammation of the foot. Extension should on no account be attempted by traction *viâ* the foot. Also, the pads above and below the knee must be sufficiently wide apart to avoid their bearing on the extensor tendon and on the ligamentum patellæ; and the straps must be sufficiently slack, otherwise the pressure will be very likely to aggravate the inflammation of the knee. Also the pad below the knee, as well as that above, should be made stiff and shaped so as to keep all pressure off the ligamentum patellæ. Again, as the splint has to be worn both night and day, the straps and the boot should be slackened for the night (at least, for the first few nights), otherwise the swelling of the leg and foot brought on by the heat of the bed will cause intense pain—absolutely unbearable and unnecessary suffering—and may indeed induce inflammation of the tendo Achillis, and perhaps of the instep. On these points, gentlemen, I speak from personal experience. When, however, the above-named points are attended to, Thomas's splint, assisted by the webbing, not only meets all the mechanical requirements of inflamed knee, but it produces, perhaps, as little inconvenience and suffering as such an apparatus must of necessity involve. The using of a stick to bear part of the weight of the body when descending and ascending stairs, and when walking quickly, will further diminish the pressure by the weight of the body, and thereby assist recovery. When first applied the patient should spend some weeks in bed, in order that he may become accustomed to the inconvenience and to prevent any injury or accident from awkwardness in its management.

When the whole knee is implicated—the cartilages and bones as well as the surrounding structures, in deep-seated structural disease of the knee—Thomas's splint is abso-

lutely necessary, and recovery can scarcely be looked for without its use, but when it is more the surfaces and surrounding structures that are inflamed—in recent mild cases—though excellent, it is not essential. In these cases a less heavy, less inconvenient and less expensive apparatus may be used. It may possibly be sufficient if the knee be kept (only) tolerably still, and pressure be (only) to a great extent prevented, whilst appropriate medicinal treatment is pursued. Motion by flexion can be fairly well prevented by the use of a nicely padded, light, long wooden splint reaching from the heel to the top of the thigh, and carefully and firmly bandaged the whole length, *except at the knee*. Every possible care must be exercised to avoid pressure on the knee itself. To allow of this the knee should not be included in the bandage. Two bandages should be used—one to reach from the heel to just below the knee, another from just above the knee to the top of the splint. Two broad leather straps, shaped to the leg and nailed to the splint, one just above the malleoli and the other at the top end of the splint, to pass round the ankle and the thigh—the former about three inches wide, with three buckles, and the latter about four inches, with four buckles—will not only give firmness and steadiness to the splint but will also prevent the bandages slipping down. The lower end of the splint must be well padded in order to protect the tendo Achillis. A walking stick should be used to bear part of the weight of the body, especially when ascending and descending stairs, and when walking quickly. Motion and pressure by way of the patella may be very effectually prevented by the webbing already mentioned, used carefully and both night and day whenever the leg has to be lifted or carried forwards. This will also assist greatly in the prevention of motion by flexion.

Provided the patient can remain mostly at home and at rest, in mild cases, the above arrangements will keep the knee sufficiently still and free from pressure to allow proper medicinal treatment to cure the inflammation within a reasonable time; otherwise—that is, when the patient must go about—it will, of course, be safer to fix the leg in a

Thomas's splint and keep it there until all inflammation has been subdued.

Dr. GORDON SMITH thought that in all serious cases the patient should be kept in bed, in addition to wearing a Thomas's splint, so that the knee can be kept absolutely still. He considered Dr. Hayward's device very ingenious, and likely to prove very effective.

Dr. GORDON said that he believed in applying a carefully fitting Thomas's splint, and getting patients on their feet as soon as possible. He considered Dr. Hayward's suggestion a very good one.

Dr. CAPPER said that as far as he was able to judge from experience, Thomas's splint always acted practically with admirable efficacy. At the same time he thought Dr. Hayward's improvement a very ingenious one, and likely to prove of great service.

Dr. J. D. HAYWARD thought that Dr. Hayward was inclined to exaggerate the effect of the pressure on the knee joint by way of the patella. Any pressure exerted by the patella must be at considerable mechanical disadvantage. The leg is raised rather by means of the psoas and iliacus, than by the extensor muscles. The extensor muscles do contract on raising the leg, but that is chiefly due to an effort on the part of these muscles to fix the knee. He thought the device might prove of some service as an aid in the treatment of diseased knee joint.

Dr. J. MURRAY MOORE mentioned a case in which jerking of the hamstring muscles was met by the exhibition of ignatia. He thought that Dr. Hayward's sling was likely to prove very useful in the treatment of fractured patella.

Dr. ELLIS said that he agreed theoretically with Dr. John Hayward's remarks with regard to the recti muscles, but muscles are so accustomed to act in unison, that doubtless the recti act at the same time as the psoas and iliacus in raising the leg, and Dr. Hayward had probably found that this was practically the case. Speaking without this personal experience of the splint, he hardly saw the necessity for Dr. Hayward's improvement.

Dr. CHARLES HAYWARD said that acute cases of inflamed knee seldom came under the surgeon's notice, but in his opinion such cases should be always kept in bed, wearing a Thomas's splint. With the long splint Dr. Hayward recommended, it might be an advantage to have a slightly thickened sole on the sound foot. When a patient is fit to go about on a Thomas's

splint, the slight pressure exerted by the patella would not be deleterious. In cases so acute that such pressure would be deleterious the patient should be kept in bed.

Mr. W. D. HAYWARD drew attention to the fact that as with Thomas's splint the leg is kept straight, the traction by the extensors is in nearly a straight line, which, of course, diminishes the pressure by way of the patella.

Dr. HAWKES brought in two cases illustrating the treatment of inflamed knee by means of Thomas's splint. The first was a case of old synovitis, the patient being a plumber who had to kneel a good deal; and the second a case that had been diagnosed as tubercular disease of the knee joint. The latter had worn the splint for six months, and was comparatively cured. Dr. Hawkes said that in such cases he usually made use of a Macintyre splint to straighten the limb, before the application of a Thomas's splint.

In reply, Dr. HAYWARD thanked the members for their remarks, especially Dr. John Hayward for drawing attention to the fact that the leg is lifted and carried forward not only by the extensor muscles of the thigh, but also by the psoas and iliacus, which do not act through the patella. Also Mr. W. D. Hayward for his reference to the fact above stated with regard to the traction being nearly in a straight line. He also remarked that some of the most important points had not been taken up in the discussion, viz., these referring to the tight straps, pads and boot, especially when left so during the night. These were points he wished decidedly to emphasise, because of the absolute and unnecessary torture they cause.

A CASE OF TUBERCULOUS PHTHISIS CURED
MAINLY BY TUBERCULINUM (HEATH.)¹

BY JOHN H. CLARKE, M.D.

Physician to the London Homœopathic Hospital.

JAMES K., a carman, aged 40, was admitted into the hospital October 17th, 1892. The following notes are taken from the case book of Dr. Vincent Green, junior resident medical officer. The family history is excellent, there being no history of phthisis. The patient's present illness dates from an attack of influenza three years ago, the attack being followed by cough, expectoration, night sweats and emaciation. These symptoms continued for a year until the patient could hardly get out of bed on account of weakness. He was in the North London Hospital six weeks, where he improved, but during the next six weeks he became rapidly worse, having two sharp attacks of hæmoptysis. When admitted to the Homœopathic Hospital he was emaciated, suffered much from dyspepsia, and had a poor appetite. He had an irritative hacking cough, but not much expectoration, but the sputum contained tubercle bacilli. At the apex of the right lung there was a cracked pot note, tubular breathing and abundant coarse crepitations. In the infra-clavicular region there was some dulness, with prolonged expiration and fine crepitations; posteriorly, there was audible prolonged expiration, with crepitations all over the lung. At the apex of the left lung expiration was prolonged, but there were no accompaniments. The heart sounds were clear; pulse 110. The patient complained of a feeling of weight in the right chest, sleeplessness, and cough for several days, and then he began to improve; constipation was one of his chief troubles.

On November 9th, as he still complained of the weight in the chest, he was given Tuberculinum (Heath) 100, gr. iii., on the tongue, and this was repeated the following week.

By November 20th he had gained one and a-quarter

¹ A case presented to the Society February 2nd, 1893.

pounds in weight; the sensation of weight in the chest was better, there was very little cough, no expectoration, no night sweats, but he was troubled a good deal with flatulence. Tuberculinum was repeated on the 30th, and again on Dec. 10th; by this time he had gained another pound and a-half in weight.

December 19th.—He complains of pains in the joints without swelling; there is a return of the sweats and cough, with frothy white sputum. Under merc. vivus 12 the rheumatic symptoms perfectly subsided.

Tuberculinum was repeated on January 4th and 25th.

On February 2nd it was noted that he had gained four and a-half pounds since January 18th; he had no cough and felt quite well. There was a prolonged expiratory murmur and increase of vocal fremitus and resonance at the right apex, but no abnormal physical signs at the left apex.

CHLOROFORM ANÆSTHESIA: ITS "ACCIDENTAL ASPHYXIA" AND MEANS OF PREVENTION.¹

BY T. G. H. NICHOLSON, M.R.C.S.

Anæsthetist to the Hahnemann Hospital, Liverpool.

IN engaging your attention for a short time on the above subject, you will, of course, as I proceed, take it for granted that I accept as far as it goes the pronouncement of the Hyderabad Chloroform Commission, and look upon their Report upon this question as something approaching finality; and considering that the faculty has not got beyond speculation, you will, I fancy, acquit me of blame, the more readily, may be, if the fact of my doing so should result in any further elucidation of the cause of the trouble which has engaged its attention for some years past. The Indian Commission

¹ Read before the Liverpool Branch, Feb. 2nd, 1898



has done much to enlighten us upon the subject of deaths from chloroform, but I think we must look even further than the Commission for the first cause, for I look upon the cause assigned by them as really an effect, as I shall presently endeavour to shew. Having then detected the real cause, let us do the next best thing, viz., seek a remedy for a trouble that *is*, and will *continue* to be, forced upon our attention and that of the public, with unpleasant frequency until it is found. Now the better to enable you to form an opinion as to the appropriateness of a method of prevention which I am endeavouring to introduce, it may assist you if I submit to your notice a few leading facts in reference to the order in which chloroform exerts its influence. We are told first of all, "that the vaso-motor system is very soon involved," 2ndly, "that the fall of the blood pressure becomes dangerous if pushed to the point of paralysis of the respiratory centre," and lastly, "that if the poisoning continues, the fall becomes much more rapidly dangerous, the nutrition of the heart is profoundly interfered with, and the deprivation of oxygen, produced by paralysis of the vagus, causes it (the heart) to gradually cease to act." This quotation refers to the inhalation of a poisonous or overdose, which the Commission tell us is the invariable cause of deaths from chloroform, producing as it does narcosis of the vagus and interference with the respiration, culminating in spasmodic constriction of the pulmonary and systemic arterioles, a back rush of unaerated blood into the cavities of the heart, and ultimate paralysis of its walls from over distension, assuming that artificial respiration has not been resorted to in time to re-establish the respiration and circulation through the lungs. Seeing then that an overdose is practically synonymous with asphyxia, it would seem that our efforts should be directed to the prevention of the possibility of an overdose being taken, and this suggests the question "What is an overdose? is it from the chloroform, or the chloroform plus something else?" and then how best to prevent it. As to the first division of the question, let us keep in view the fact that there are three factors that contribute to bring about the condition that the Commission designates as

“*accidental asphyxia* :” 1st. A slowing of the circulation with consequent partial arrest of the process of aeration, corresponding perhaps to oppression of the vagus as distinguished from absolute narcosis. 2ndly. An abnormal accumulation of carbonic acid and hydrogen in the system, to which presumably we are adding at each inspiration. 3rdly. Complete arrest of the function of the vagus and lungs, followed by asphyxia through the deprivation of oxygen. To the second division of the question, how to prevent it, I would suggest that whatever will prevent undue slowing of the circulation (which signifies a fall of the blood pressure, and more or less interference with the normal rapidity of aeration), without adding carbonic acid and hydrogen, must tend to prevent vagus narcosis with its attendant asphyxia.

Now as a cardiac and respiratory stimulant we have in oxygen a restorative of the first order, one that we should never be without; indeed, that we should seldom need in the latter capacity alone, by adopting the method of inhalation that I have initiated. It may be said of oxygen that while it plays the part of a physiological antidote to a condition liable to be induced during anæsthesia, viz., asphyxia, it does not chemically antidote chloroform. If oxygen were a chemical antidote to it, we should not get as far as to produce anæsthesia, let alone asphyxia, because being an incompatible it could not be given at all. That it may, under certain conditions, delay anæsthesia I am willing enough to allow, but the reason of its doing so will be found in an excess of either air or oxygen. If too much air be given the chloroform is diluted too much, while, on the other hand, an excess of oxygen excites a patient and delays the action of the anæsthetic. The question, therefore, resolves itself into a mere matter of determining the quantity by or with which we can obtain the best effect of each; in other words, by which we may limit the action of our chloroform to the suspension of consciousness (which is all that we require), at the same time maintaining the respiration, circulation and aeration as near as may be at the normal. From the very commencement of our anæsthetic operations we absolutely, but unconsciously,

court disaster, safety seeming to depend entirely upon the degree of nicety with which we can, as it were, poise our patient between safety and danger, owing to the indefinable character of the line dividing the two states. We must bear in mind that not only is there, as we are told, a fall of blood pressure due to ordinary chloroform inhalation, but that a further fall, please note, results from any interference with the respiration, showing the necessity that exists for limiting as far as possible the action of our anæsthetic. If we must have slowing of the circulation, with all that it means, let us have it from one source rather than two, and to effect this, we must give oxygen to keep up the blood pressure, to stimulate the heart and vagus with aerated blood, and to prevent that abnormal retention of carbonic acid and hydrogen in the system, which leads up to the condition of asphyxia, and so greatly depresses the nervous systems of our patients, as we see in the length of time it takes them in many instances to come round. Now, if there was no other advantage in the use of oxygen in this connection, it is a distinct gain to be able to counteract the depressing effect of our anæsthetic, and to facilitate the recovery of our patients, and that it does so, I think scarcely admits of doubt; but such an effect can only be by virtue of its anti-asphyxial and general tonic action upon the nervous, respiratory, and circulatory systems. The extreme potency of pure oxygen must be taken into account when crediting it with retarding anæsthesia. As a powerful excitant it merely suggests the moderate use of it, or of just such a quantity as will antagonise asphyxia, without interfering with the action of the anæsthetic. As regards the length of time a patient takes in getting "under," it has not by any means been proved that a person would not be just as long in getting under without oxygen, for we all know that the time occupied varies in different cases according to susceptibility, idiosyncrasy, and other circumstances, such as struggling, vomiting, hysteria, or what not.

There is just another point in the Report of the Hyderabad Commission to which I would like to direct your attention, viz., "That irregularity in the fall of the blood pressure is

always due to irregularity of, or interference with, the respiration," but that this is not dangerous, "if" not excessive. It is then added, "How this asphyxia is produced is for physiologists to determine." Now, unless I am altogether wrong, an elementary knowledge of physiology will enable one to understand how it is, and I think the explanation will be found in an uncounteracted or unneutralised deposit or accumulation of carbon and hydrogen in the system, and that mainly, for what is this but an interference with the respiration of a most active kind? It is fortunate for us that the system tolerates at all the presence of an excess of carbonic acid, and it is because it would appear to do so, that we are able to get through any cases with safety, and here (our various methods notwithstanding) comes in the unsatisfactory aspect of the question—we never know the moment we may cross the line of safety. Insensitiveness of the cornea (corresponding to full anæsthesia) is said to be our guide to stoppage of administration; it may even represent the limit of safe tolerance of the drug, but then we cannot stop it altogether; we have to go on piling up, so to speak, carbon and hydrogen, watching the respiration meantime, and for what? only to see it slow off or stop altogether! until, indeed, asphyxia threatens or is upon us. What says Dr. Laurie? He says, "Administration should not be pushed beyond full anæsthesia, because, if it is, the essential condition, observe, which is normal respiration, cannot be maintained;" and this is true enough, for we continue the full anæsthesia, as I have said before, without neutralising the carbonic acid we are generating in excess, and he practically admits that after corneal insensitiveness there is danger; now what but oxygen can maintain normal respiration after this stage is reached? It would seem as though we could not realise that there can be anything wrong until the respiration gives out, but from what I have said I think it will be seen that very much is wrong, commencing not only when asphyxia sets in, but from the very initiation of our anæsthetic proceedings. Now I claim for oxygen all that is claimed for nitrite of amyl, and more, inasmuch as, unlike nitrite of amyl, it does not merely help to circulate blood already loaded with

carbonic acid (by paralysing the muscular coat of the containing vessels), but aerates and carries it along by virtue of its own inherent stimulating and invigorating effect upon the arterioles. It benefits the whole organism, it nourishes the heart, raises the blood pressure, stimulates the vagus with healthy blood, keeps the breathing regular, and does away with a certain feeling of impotence that one is conscious of while concentrating, as we are told to do, "all our attention upon the respiration." It is said that our aim should be to give chloroform in such a manner as that the blood pressure shall fall regularly throughout the whole period of administration, and that this can only be done by absolute regularity of the breathing, but this absolute regularity is just what we cannot command, and is the source of our trouble. Now what will better contribute to absolute regularity of the breathing than oxygen? It cuts at the root of the trouble, and prevents the condition that calls for the battery, nitrite of amyl, and artificial respiration. Oxygen in a room is not enough; were we to empty a cylinder of it, a patient would be little the better for it, so long as it could pass away through ventilators, or be otherwise exhausted. It seems to me that we are generating carbonic acid in excess, and that we should give oxygen in excess to neutralize it, and to do this it should be brought to the very nose of the patient, if we are to feel sure that it is being inhaled in any appreciable quantity, or to any purpose; the inference from all which is, the necessity of maintaining normal vagus stimulation, as distinguished from irritation, because while the former, as with oxygen, raises the blood pressure, the latter, as from an excess of carbonic acid, lowers it. There is, to my thinking, something confusing in the interchangeable use of the terms "*stimulation*" and "*irritation*," as though they meant the same thing; and I am of opinion that it would tend to a clearer understanding of the whole subject, if we were to think of "*stimulation*" in the sense that is attached to it in the dictionary, viz., "as a quickly-diffused and transient increase of vital energy and strength of action in the heart and arteries," or, as I put it, a normal amount of nerve influence, contributing to healthy function. Again, let us think of

"*irritation*" as of something which produces an opposite condition of things ; in other words, as signifying an abnormal degree of nerve stimulation or influence, leading or tending to unhealthy function or result, as, for example, asphyxia. We are told that electrical "*irritation*" of the vagus lowers the blood pressure, and that asphyxia (produced by a poison, and therefore an irritant) *stimulates* the vagus, slows the heart, retards the circulation, and lowers the blood pressure ; that it does, in fact, precisely the same thing that electrical irritation does. In quoting the above, I do so by way of illustrating the ambiguity alluded to.

Just a few words upon the subject of the heart, seeing that it is with this organ that danger is in many minds still primarily associated. The Hyderabad Commission tell us that it is never affected by chloroform, except by over-dosing, and that safety is guaranteed by regular breathing, and this goes to prove the correctness of my theory, for I have shewn how this over-dosing may occur, and be prevented, as also the only method by which regular breathing can be guaranteed. Where death occurs from pure nervous shock inducing fatal syncope, or from valvular lesions, it cannot be said to be due to, or as arising from chloroform, but as occurring under it, which is quite a different thing, and would suggest that a patient dying under such circumstances was not a fit subject for operation, and should not have been placed in the position of incurring the risk.

Now as to the mode of administration. There is no method (other than one which will ensure absolute regularity of the breathing), that can assure immunity from accident. It is not the inhaler, it is not the dilution of the chloroform, it is not boldness, it is not even any amount of experience and caution, because the trouble has its origin altogether outside of these considerations ; and by way of explaining what I mean, as also of affording food for reflection, I may say that of my three all but fatal cases, one occurred at the beginning and the other at the end of an experience extending over many years, as if to shew how very little even experience and caution avails to avert this particular form of danger. It cannot reasonably be supposed

that in all the cases of death that we have heard of from time to time, that there was timidity of administration, and I have not been told that this was the cause of our two "accidents" in this hospital, and in making use of this term I would not have it go forth that they were fatal accidents. Had they been, I should have alluded to them as deaths from, or deaths under chloroform, as they may have occurred; but the term "accidents" I apply to those cases of asphyxia in which we are successful in resuscitating our patients, and this it is said "can invariably be done." But I think that this admits of some doubt, for artificial respiration has failed at the hands of presumably very competent men, and the cause of death has been pronounced to be asphyxia, and to say that it was not might well be considered a piece of impertinence. Nevertheless, I believe that our efforts at artificial respiration would in all cases be successful if we could bring pure oxygen to bear upon the case. And here will be seen the advantage of the method of inhalation I am advocating. An inhaler of some kind must be used, and the best form is that which will liberate the chloroform vapour uniformly and steadily, rather than in gushes (as with a napkin), and I was going to say admit of a sufficiently free admixture of air, but experience has convinced me that this is not enough, at least under the atmospheric conditions which too often obtain in our large cities. We need therefore hyperoxygenized air, for it is the absence of this, or at any rate a deficiency of oxygen, that lands us in the difficulty in which we every now and then find ourselves.

I will now pass on to explain the method by which I hope to prevent rather than meet the asphyxia that is in most cases sprung upon us so suddenly. It consists simply in an admixture, during inspiration, of chloroform vapour with hyperoxygenized atmospheric air, the oxygen being regulated at the will of the manipulator as the condition of the respiration and state of the pulse may indicate. The advantages of the method are various and important, and may be summed up as follows:—1. That oxygen, by maintaining perfect aeration, can alone assure regularity both of

respiration and circulation. 2. That the function of the lungs being uninterfered with, narcotism of the vagus and asphyxia cannot occur. 3. That the proper dilution of the chloroform is effected by a steady and uniform rate of evaporation. 4. That the action of the anæsthetic is limited to the suspension of consciousness. 5. That watching the respiration (in the sense of anticipating danger), is unnecessary. 6. That the use of nitrite of amyl and artificial respiration is superseded. 7. That a patient is rendered independent of his atmospheric surroundings, however adverse. 8. That the quantity of chloroform used is of little consequence, regular respiration measuring the dose. 9. That by the method a feeling of confidence and security takes the place of one of impotence (familiar under the old system), and moreover greatly facilitates the recovery of the patient. 10. That the accidental element in chloroform anæsthesia is eliminated.

It may be objected that the foregoing are merely assertions of mine, that cases should be adduced in support of them. Well, I will cite a few, roughly jotted ones it is true, because to concentrate all the attention upon the respiration, and take notes at the same time, is not exactly an easy matter, but the last case (my own) was carefully noted, and I will for the present refrain from any comments upon it.

Case 1.—Gertrude Jones, age 7. Carious disease of bones of the foot. Chopart's operation. Was slow in getting under owing to admission of too much air, inhaler being large for the face and too freely perforated with holes. Gave oxygen at intervals. In half an hour after the operation the child was sitting up in the bed and playing with its toys. No vomiting.

Case 2.—John Barton, age 50. Fistula in ano. Took the chloroform slowly and was rather excited, the oxygen seeming to increase the excitement and counteract the effect of the chloroform. Gave the anæsthetic alone, when he finally got under. After a time noticed lividity of the lips and commencing pulmonary oppression. Gave a few whiffs of oxygen, when this quickly passed off, giving place to the proper florid hue. After the operation, said he felt as well as he did half an hour afterwards, and though there was a little bilious vomiting corresponding

with the period of pulmonary obstruction, he subsequently complained of neither nausea nor headache. In this case the chloroform from the same cause was too much diluted.

Case 3.—John Howden, age 31. Exploration of supra-pubic sinus. Had had chloroform a week previously and said he tasted it for three days afterwards. Took it again this time with oxygen and said he felt no nausea whatever, nor had he a headache afterwards.

Case 4.—Lena Hennessey, age 11. Removal of necrosed maxillary bone. Gave oxygen and chloroform. Was under in about ten minutes. Pulse full and regular; breathing ditto, though very deeply under.

Case 5.—W. D. Walley. An anæmic infant of six months. Removal of eyeball. Got under in about four minutes with oxygen.

Case 6.—Woodderson, Walter, age 24. Got under in ten minutes with oxygen at intervals. There was some little excitement, but got under thoroughly. Pulse and respiration regular and full. Case, hæmorrhoids.

Case 7.—Hales, Richard, age 18. Incision of deep femoral abscess. Got under in ten minutes with oxygen and chloroform. Pulse and respiration normal. A little bilious vomiting but no headache.

Case 8.—Thompson, Mrs., age 38. Rupture of perinæum. Gave oxygen and chloroform together. Was "under" in about twelve minutes; respiration regular and full, pulse steady and full. Was of a bilious and nervous temperament. Was under about half an hour; a little vomiting but very slight headache.

Case 9.—Ainsworth, Eleanor, age 19. Extracting eight upper stumps under oxygen and chloroform. Pulse and respiration good. Some little headache after, and some vomiting, which was worse the next day, and was attributable to a generally disordered condition of the system. Consciousness returned quickly.

And now for my own case, No. 10. Two or three important alterations had been made in the inhaler. Commenced with inhalation of oxygen. Pulse varying from 84 to 90, acceleration accounted for in part by previous violent muscular exertion. In three minutes it rose to 108 but was softer. Respiration 14. In ten minutes pulse 90 to 94. Vomiting for half a minute, preceded by a fall to 70, after which pulse returned to 96. In fourteen minutes vomiting again preceded by a fall to 60. In 21 minutes vomited for third time. In 30 minutes pulse varied from

66 to 80. In 33 minutes stopped the chloroform and gave oxygen only. In seven minutes later conscious, but some further vomiting; oxygen continued for five minutes longer. Respiration throughout regular and full, 13 to 16. Took about ziii . of chloroform. It will perhaps be noted that the fluctuations in the pulse were somewhat eccentric, 84 to 90-108-90 to 94-70-96-60-66 to 80, which I can only attribute to the immediate response of the heart to the oxygen given, and not as indicating danger, for as if to prove that regularity of the respiration is the main thing to be aimed at, and is assured by this method, it was remarked that "the respiration was regular and full throughout." Now what more can we want? As to the time a patient takes to get "under," none can be fixed; we are not supposed to work against time, nevertheless, I see no reason why a patient should not be got "under" as rapidly when oxygen is used as he can without it, because its inhalation need not be commenced until full anæsthesia is induced, the period at which, according to Dr. Laurie, danger commences, and as it is under the perfect control of the manipulator it need not be given too freely.

Having now placed before you, illogically it may be, and even incoherently, a few thoughts upon a subject which I think you will agree with me is worthy of every consideration, I have of necessity drawn upon the Report of the Indian Commission by way of shewing the fitness of the remedy that I have been directing your attention to, but how far the notions put forward will commend themselves to your judgment I cannot of course say. If you can explain them away, well and good; but if you are of opinion that there is a modicum of truth in what I have said, that it even has a basis of physiology and common sense, I cannot think you will do otherwise than encourage one to go onward and forward, and as a body share with me any credit obtainable from the inception of the method within the walls of this institution.

Dr. CHARLES HAYWARD thought that the best use of oxygen was in cases of emergency, and in rousing a patient from the effects of chloroform. He mentioned a case, reported from Paris, where a mother and daughter were saved by artificial respiration with oxygen, after three hours' hard work. They had been pronounced past help by the surgeon at the hospital; but the house surgeon made the successful attempt.

Dr. GORDON SMITH thought that Mr. Nicholson's method would be useful in the case of old topers, and in similar cases in which the organs were in such a state as to give no physical signs on examination, but yet where chloroform could only be administered with considerable risk. It would also be of benefit in cases of prolonged administration.

Dr. MURRAY MOORE said that some patients took chloroform well during parturition, even when they ordinarily suffered from palpitation. Mr. Nicholson's method would be useful in such a class of cases. After effects of chloroform pass off more easily than those of ether. Oxygen ought to prove of service in decomposing the carbonic acid in the lungs.

Dr. MAHONY was glad that Mr. Nicholson accepted the conclusions that the Hyderabad Commission had adopted, as he felt convinced that they were the right ones.

Dr. HAWKES said that chloroform is an intoxicant, and does not act by causing asphyxia. The anæsthesia is not due to the accumulation of carbonic acid in the lungs, but to the specific effect of the chloroform.

LIVERPOOL BRANCH MEETING.

THE usual monthly meeting was held in the Hahnemann Hospital, on Thursday, March 9th, Dr. Hawkes (*President*) occupying the chair.

The meeting was devoted to the consideration of clinical cases, medical reports, &c.

Dr. HAWKES showed under the microscope some well-marked granular casts in the urine of a pregnant woman suffering from acute nephritis, for which no reason could be assigned. He also exhibited four cases of considerable interest.

(1) Mary E., aged 16, a patient who had just recovered from purpura. She had taken a severe cold some weeks previous to admission to the hospital. Spots came out all

over her body about February 16th, and on admission were found to extend from head to foot. The spots were slight on the forehead and chin, absent from other parts of the face, but very well marked on the chest. Prior to the appearance of the spots there had been profuse menorrhagia. Hamam. 1 was given, and then phosp. 6, the profuse menorrhagia having returned, but while the purpuric spots rapidly declined the menorrhagia did not yield till secale ϕ (mii.—v. doses) was given every few hours. Secale 1x. was of little service. The girl's family history was unimportant.

(2) Isaac M., aged 50, who, besides suffering from gout, was the subject of multiple fatty tumours, which existed in each submaxillary region, on either side of the ligamentum nuchæ, and in each deltoid region.

(3) Thos. A., aged 50. This patient had a stroke on August 15th last. He did not lose consciousness, and was able to get home himself. In addition to paralysis of the right arm and leg and the right side of the face, the right leg was thrown out in walking. The patellar reflex was exaggerated on the left side, and markedly so on the right. After being in hospital about a month he complained of pain in the hand, and decided symptoms of late rigidity developed. These were manifestly helped by the interrupted current with massage, and the patient had much improved generally.

(4) Edward T. P., aged 48. Three years ago this patient was thrown from a bicycle. A week after he had a slight stroke, and kept his bed for a month. Some time after he became aware that his arm and leg were powerless. The leg improved, but the arm was still useless, and the hand the seat of late rigidity. He walked at the time he appeared before the meeting with a swinging gait, and the patellar reflex was much exaggerated on the affected side, but nearly absent on the other. He was improving under electrical treatment.

Dr. Hawkes quoted Bastian to the effect that in lesions of the cortex involving the whole thickness of the grey matter, or this together with a portion of the subjacent

white matter, it has been found that secondary degenerations occur only when such lesions implicate some portions of the cortex within the Rolandian area. Lesions of any portion of the internal capsule between the two nuclei of the corpus striatum may give rise to descending degeneration. Lesions in any part of the centrum ovale may give rise to such degenerations.

Dr. CHARLES HAYWARD brought in a young man upon whom he had performed amputation through the thigh some months ago. The patient was in good health, and had grown considerably since the operation. He was wearing a wooden leg that could be flexed at will by means of a spring. The artificial limb was made slightly shorter than the sound one, in order to prevent the habit of sweeping the leg outwards in walking—a habit once contracted not easily remedied when a more elaborate appliance comes to be worn.

Dr. CAPPER brought before the meeting a little girl, 4 years of age, whose mother stated that she had complained during the last few weeks of pains in the abdomen, which were accompanied by vomiting, and alternating constipation and diarrhoea. The abdomen was enlarged, and upon percussion a large area of dulness was manifest, extending over the hypogastric region, the left lumbar and both iliac regions, but more towards the left side. No tumour could be made out on palpation, and there appeared to be no liver or splenic enlargement. The child had been very delicate soon after birth, and had suffered a good deal from diarrhoea. Dr. Capper had had the case under observation only for a few days, but inclined to the opinion that the dulness was due to the presence of a parovarian cyst, and this was the general opinion of the members present.

Dr. HAWKES suggested that it might possibly be due to a cystic kidney.

Dr. CAPPER also exhibited a very good specimen of intussusception of the bowels, which had occurred in a child 5 months old. A considerable portion of the small intestine had slipped into the cæcum, which was almost involuted upon itself, the vermiform appendix forming part of the intussuscepted bowel.

A CASE OF PEMPHIGUS IN A CHILD.¹

BY J. ROBERSON DAY, M.D.LOND.

Assistant Physician to the London Homœopathic Hospital.

F. K., age 15 mos., was admitted under my care at the hospital on January 28, 1893. Both parents apparently healthy. There are two other children in the family, and both are healthy. The patient is the youngest. She was brought up on the breast and bottle, and has only just been weaned. She has always been delicate, but born healthy, and not till six weeks old did she show any rash. Has had boils and snuffles since that time. On admission she had a well-marked pemphigus rash scattered over nose, face, neck, legs, hands and arms. The eruption always comes out first as a bleb, and then leaves a raw surface. The voice is hoarse, and marked snuffles are present.

Merc. v. 1, gr.j. every two hours, was ordered, and equal parts of calomel and starch used as a dusting powder.

On February 4 it was noted that the dusting powder had dried the blebs up, and only a few more had appeared.

More rash out on February 11. Merc. sol. 1, gr.j. t.d.s., was substituted for merc. v., and as the child was distinctly worse this was on the 18th changed to canth. 3x mij. every three hours. Notwithstanding treatment it was noted at the visit on February 25 that more rash was out, and the blebs were numerous. She was then ordered rhus 1x.

On March 4 she was admitted to hospital, and now is improving under ars. a. 3x.

Remarks.—This case I do not regard as syphilitic, because there is no family history and no evidence in the parents; also because this is the youngest child, and the other two are healthy, and not syphilitic. Lastly, since the specific mercurial treatment failed to cure.

DR. HUGHES said that these cases in children were very rarely not syphilitic, and he was inclined to suspect this was the cause of this case. He should otherwise have thought of arsenicum as the first remedy for pemphigus.

¹ Clinical Evening, March 2nd, 1893.

NOTES OF A DISCUSSION ON TYPHOID FEVER.¹

DR. HAWKES introduced the subject, especially referring to its etiology and pathology, quoting from Parkes, Blythe, Allen and other authorities. He stated that Eberth and Gaffky had isolated a bacillus from fæculent discharges of typhoid patients. He exhibited a slide showing the bacillus described by Klebs. Soils impregnated with filth afford suitable localities for development. He referred to the ground water theory and pointed out that sheets stained by the urine or fæcal discharges of the patient might become dangerous on drying. It was stated that milk, the water used in its adulteration, and ice long unmelted might contain the germs of the disease. It was remarked that the prognosis becomes more grave as the age of the patient approaches 50, when the mortality reaches 34 per cent. The diseases simulating typhoid were referred to and briefly characterised. "Not typhus if 102°F. be not reached by fifth day" (Blythe). The ulceration was described and sections of ulcer at tenth and twelfth day shown under the microscope. Although Budd's dictum as to the appearance of the intestine remains true, the spleen, heart and kidneys are involved, and death from cardiac failure without other serious lesion may occur. A slide showing section of fibroid heart after enteric fever was exhibited. Blythe's view as to the cause being a vegetable parasite, capable of completing its cycle independently of the body, was referred to.

As to prevention.—Urine and fæces to be received into vessel containing corrosive. Fæcal and urinary stains to be dealt with similarly. Discharge to be buried away from wells, or mixed with sawdust and cremated.

Treatment.—Dr. Hawkes employs hydropathic measures for high fever. Baptisia in early stage, arsen. later. For glandular trouble (intestinal) iod., merc. cor. For hæmorrhage, tereb. 3x. He never obtained better results than when in early dispensary days he used bapt., then liq. arsenicalis ($\frac{1}{2}$ -1 drop doses), and tereb. when needed.

¹ At the Liverpool Branch, April 13, 1893.

Dr. HAYWARD said that in proposing a discussion on typhoid fever, his object had rather been to elicit the results of experience in the recent epidemic. He brought forward three points: (1) As to whether a patient can take infection through the respiratory organs? (2) Whether typhoid stools were infectious before decomposition? (3) Whether a relapse was due to a re-infection with typhoid germs, or to other causes.

As to treatment.—He asked for suggestions as to the best treatment after the usual febrile symptoms in the early stages. For example, when the glands are affected specially, such a medicine should be used as would be likely to have a specific action on the glands, such as mercury. If it is probable that the decomposing products of ulcers passing off are likely to set up further infection, would not some antiseptic treatment be thoroughly scientific? He also asked whether the members considered that benefit might be produced by local treatment, such as abdominal compresses.

Dr. GORDON SMITH said that with regard to the treatment of the morbid condition in Peyer's patches, Dr. Hughes suggests iodine as homœopathic, as it has produced similar conditions. In hæmorrhages he had found tereb. in sensible doses most valuable. With regard to relapses, he did not think it necessary to have a re-infection, and mentioned a case in which the whole train of symptoms recurred after eating a currant bun. He questioned any decided effect, by means of compresses, upon the morbid processes involved, but said that they certainly reduced fever, diminished delirium, and tended to give the patient ease.

Dr. ROWLAND WILDE said that next to the importance of diet, he believed in that of thorough ventilation. With regard to Dr. Hayward's suggested treatment by antiseptics, he mentioned the successful use of quinine in some cases, after the trial of carefully selected homœopathic medicines, the efficacy of which might be explained on the antiseptic theory.

Dr. GORDON referred to the anti-pyretic treatment, especially by means of the cold bath, as practised largely

on the Continent and in New York. He instanced the good results of this treatment, a death-rate of only four per cent. occurring in some hospitals where it was used. He spoke of the use of koumiss, and said that he continued the restricted diet well into convalescence.

Dr. BERNARD THOMAS considered the nursing the chief matter of importance. He had found cold sponging of great benefit, and referred to a case recently under his care, where the temperature fell from 105.6° to 102.5°, with subsequent improvement.

Dr. JOHN HAYWARD said that he relied on bapt. followed by arsen. in ordinary cases. He dilated on the symptoms and cases benefited by arsen. He had seen more serious cases recover in typhoid than in other cases in his experience, and referred to the frequency of diphtheritic throats during convalescence.

Dr. MAHONY mentioned Valentine's meat juice. He asserted the importance of differentiating our cases, and of treating them with the remedy which agreed most with the general symptoms and conditions of the patient.

Dr. J. MURRAY MOORE referred to his colonial experience, and stated that he had great confidence in arsenic, and used it more frequently than any other drug in typhoid. He believed that relapses were always due to indiscretion in diet.

Dr. ELLIS said that he thought rest so essential that he would hesitate to allow a cold bath. He looked upon arsenic as his sheet anchor, and agreed with Dr. John Hayward's reflections on the relationship of this drug to the disease.

In his concluding remarks Dr. HAWKES spoke of crotalus in relation to typhoid, and of lachesis and merc. cyan. in the treatment of diphtheritic cases.

NOTES ON TWO CASES OF AMPUTATION.¹

DR. GORDON showed a female patient, aged 20, upon whom an amputation of the foot had been performed. The patient was of markedly strumous constitution. Six years ago strumous disease manifested itself in the scaphoid, and gradually extended to the os calcis and astragalus. She was advised to have the diseased bone removed, but declined operative interference, which was not permitted for four years, during which time the lower ends of the tibia and fibula became involved. Two years ago the foot and the lower ends of the tibia and fibula were removed by Dr. John Hayward, and since then the patient has done very well, and is walking about without a stick or any aid, wearing a specially adapted surgical boot. During her illness she was treated with calc. carb., silica, aurum 1x., as indicated.

DR. JOHN HAYWARD showed a patient upon whom he had performed amputation through the lower and middle thirds of the femur for suppurating disease of the lower end of that bone, of three or four years' standing. The femur was considerably implicated, but the operation was successful, and the patient progressing well.

SOCIETY NEWS.

ON March 13th, 1893, at the ripe age of 84 years, and after a few days' illness from bronchitis, Charles Hills Mackintosh, M.D. St. And., passed peacefully away. He had been a member of the Society since 1868, and in active practice at Torquay for nearly fifty years. Dr. Mackintosh never held office in the Society.

ON Thursday, April 5th, 1893, the following gentlemen, having been duly nominated as candidates, were elected members of the Society by ballot:—Henry Arnold Eaton, M.B., C.M.Edin.,

¹ Liverpool Branch, April 13th, 1893.

39, Surrey Road, Norwich ; George Reginald Jones, L.R.C.P. Lond., M.R.C.S.Eng., 3, Iden Villas, Eastbourne ; William Theophilus Ord, L.R.C.P.Lond., M.R.C.S.Eng., Lansdowne Villa, Bournemouth ; James Call Weddell, M.D., C.M.Edin., 9, Park Terrace, Sunderland.

In consequence of the rebuilding of the London Homœopathic Hospital, in whose Board Room the meetings of the Society have been held for many years, the Hospital authorities have placed their temporary Board Room, at 35, Queen Square, Bloomsbury, W.C., at the disposal of the Society. Henceforth the monthly meetings will be held there.

At the April meeting Mr. Dudley presented some beautifully preserved specimens of Cephalopodæ (including Sepia), and Coelenterata (including Corallium), obtained from the Gulf of Naples.

On Thursday, May 4th, 1893, the following gentlemen, having been duly nominated as candidates, were elected members of the Society by ballot : — Samuel Brewer Brooks, M.R.C.S.Eng., L.R.C.P.Edin., Peachey Terrace, Nottingham ; Andrew Mossforth Neatby, L.R.C.P., L.R.C.S.Edin., Mulgrave Road, Sutton, Surrey ; Carl F. Fischer, M.D.Halle, L.R.C.P.Lond., M.R.C.S.Eng., St. George's Club, Hanover Square, W.

At the May meeting the President showed for Dr. Proctor (Birkenhead) some specimens of carbo-sublimatus, obtained by burning camphor and submitting the result to a red heat, the specimen showing finer division of the particles than ordinary carbo-vegetabilis. The result is a very pure form of carbon.

Dr. John Murray Moore, Liverpool, has resigned his membership of the Society.

On Thursday, June 1st, John Christopher Staley, L.R.C.P.I., The Mount, St. Anne's-on-Sea, having been duly nominated as a candidate, was elected a member of the Society by ballot.

SUMMARY OF PHARMACODYNAMICS AND
THERAPEUTICS.

“GATHER UP THE FRAGMENTS, THAT NOTHING BE LOST.”

MARCH—MAY, 1893.

PHARMACODYNAMICS.

Acidum fluoricum in Thyroid Disease.—A lady, aged about 30, complained of one side of her neck being larger than the other. The left half of the middle lobe of the thyroid contained a cyst the size of a walnut; it felt firm and elastic, and the structure of the gland was everywhere thickened. I thought I would divide the treatment into two parts. First I would bring down the swelling of the gland tissue, and then endeavour to promote the absorption of the cyst. But this unhomœopathic manœuvre did not succeed, for under the action of a daily drop of ac. fluor. [dilution not stated], from Feb. 2nd to the middle of March, by April 19th the swelling of the gland and the cyst had both disappeared.—Villers, *Arch. f. Hom.*, ii. 156.

Acidum picricum.—Albuminuria had persisted, in a woman of 27, for ten days after her confinement. It was accompanied, from the second of these days, by a peculiar headache. She woke every morning with a dull pain in one or both eyes, and a creeping sensation inside the skull. The pain increased in severity gradually, extending through whole head and down nape, and lasted all day. It was, at its height, pulsative, and was aggravated by the slightest exertion of mind or body, even by turning the eyes. It passed off in the evening, and she slept well. After several useless prescriptions, picric acid 12, four doses, aborted it at its onset, and it never returned. The albumen disappeared without further treatment.—*Hom. Physician*, Feb.

Agaricus.—Dr. Shadle communicates a series of cases of poisoning by different members of the family amanita—“the

only mortal toadstool foe of man," according to Mr. Julius Palmer—which seem to show that atropine is their effective antidote. The antagonism of muscarine and atropine is well known.—*Therapeutic Gazette*, May.

Agraphis nutans.—In the *Hahn. Monthly* for March, our own Dr. R. T. Cooper communicates his experience with this plant—the common bluebell of the woods. He finds that a tendency to free discharge from mucous membranes is a main indication for it in throat and ear troubles; that enlarged tonsils with post-nasal growths may be reduced by it; and that it is unrivalled as a remedy in the mutism of childhood unconnected with deafness. He gives single doses of the mother tincture.

Ammonium.—Dr. Clarence Payne finds stoppage of the nostrils to be a valuable indication for ammonium carbonicum, and coldness between the shoulder-blades for ammonium muriaticum, in catarrhs of the respiratory organs.—*N. Amer. Journ. of Hom.*, May, p. 282.

Antipyrin.—Moeller took 15 grains of antipyrin for headache. Next morning he was surprised to find the joints of his fingers swollen and, together with the backs of the hands, occupied by erythema. The lips, the orifices of the nose, the auditory canal and the conjunctivæ were also reddened, swollen, and somewhat painful. Moreover, there was a sharply circumscribed erythema on the skin of the scrotum and glans penis, and on the corona of the latter an ulcer developed, which healed without scarring in fourteen days. The rest of the exanthem disappeared in three to four days. On repeating the experiment a month later, in ten minutes he felt burning pain upon the lips and glans penis, and an erythema speedily developed, with much itching and pain. On the following morning ecchymoses had formed upon the dorsum of the first phalanx of the thumb, and on the scrotum and the folds about the anus were several excoriated spots. On the corona glandis was a blister in folds similar to that of a burn, and in spite of a protective dressing an ulcer formed, and was slow in healing as before.—*Therap. Gazette*, April.

Apis.—Dr. Julia C. Jump was stung by a bee on the helix of the left ear. There followed, in this order: (1) Sensation as though a thick stick was stuck through head from left to right. (2) Swelling all over. (3) General urticarious eruption. (4) Severe rigor, without sensation of cold. (5) Pain in kidneys and bladder, without any urine being passed. (6) Dull pain in the entire head, with weary and stupid feeling. She had now a gill of

hollands and was put to bed. After a restless sleep she woke with pain and soreness in region of kidneys, bladder and ovaries; only after some hours was urine passed, scanty, hot, and red. Eruption had disappeared, leaving skin white, waxy, and puffy, with extreme sensitiveness to touch and soreness on deep pressure. There was stiffness of joints and soreness of muscles as in rheumatism. It was a week ere she was restored to her normal condition.—*N. Amer. Journ. of Hom.*, May, p. 319.

Arsenic in Psoriasis.—The *Clinique* of April contains an interesting article by Dr. Halbert on experience gained in the cutaneous department of the Hahnemann Hospital of Chicago. In the discussion which followed when it was read as a paper before the Clinical Society of that city, Dr. C. H. Evans related a cure of a patch of psoriasis on the leg, of seventeen years' standing, during which time the patient had suffered many things of divers physicians. The one subjective symptom was that the spot burned night and day, and on the strength of this, arsenicum 6 was given, four doses daily. By the end of the third week the heat was reduced by one half, by that of the fourth it had gone. A week later the scales began to fall off, and a perfect cure soon followed. After seven years there had been no recurrence of the affection.

Arsenic in Cancer of Skin.—Lassar, at a meeting of the Berlin Medical Society, presented two cases, and reported a third, in which carcinoma of the skin had been cured by the use of arsenic. Fowler's solution was used either subcutaneously or internally, without any local treatment. Tonton (?), of Wiesbaden, reports a similar result by the same treatment in a case of general sarcomatosis of the skin.—*Münchener Med. Wochenschrift*, Jan. 24, 1893. [This is the reference for Lassar's observation; the other (which we copy from the *Hahn. Monthly* for May), we cannot trace.—ED.]

Aurum in Ozæna.—Dr. Delap relates a case of this disease—"atrophic catarrh" he calls it—in the *Southern Journal of Homœopathy* for January (p. 961). It began with a common cold from exposure, but had gone on to necrosis of the bones. There was no syphilitic history. Cleansing local applications were used, and aurum muriaticum 2 given internally. A severe headache which was present, greatly aggravated by stooping, yielded rapidly to the medicine. Dead bone came away, and the patient became quite well.

Aurum in Sarcocoele.—A man had a hard enlarged testicle on the right side, painful, particularly to touch. Clematis 1x aggravated. The 6x dil. of the same drug, and iodine 3x, had no effect, and castration was recommended. Aurum met., 15th trit., was now given three times daily; the testicle gradually took its normal size and became softer, and in six weeks patient was discharged cured.—*N. Amer. Journ. of Hom.*, April, p. 249.

Calcarea in Polypus Narium.—Dr. Milton Hammond relates a few out of (he says) "scores of cases" of this growth, which he has cured with calc. carb. 30.—*Southern Journ. of Hom.*, March, p. 1029.

Calcarea fluorica in Throat Troubles.—In some "Suggestions founded on experience in the use of the Schüssler Remedies," contained in the *N. Engl. Med. Gazette* for April, Dr. T. M. Barton commends calcarea fluorica to relieve the tickling of the throat, exciting cough, which is caused by elongation of the uvula.

Calendula.—Dr. Wilson Dods has experimented with this drug, and finds that it is not germicidal. What good it does must therefore be otherwise accounted for.—*N. Am. Journ. of Hom.*, March, App., p. 39.

Camphor.—Dr. J. T. G. Emery communicates to the *Amer. Homœopathist* of March 1st four involuntary provings of camphor, two from chewing the crude substance, two from tea-spoonful doses of the tincture. Vertigo, drowsiness, sense of approaching death, and subsequent nervousness, marked the first case; convulsive attacks, with hysterical delirium, the second; loss of consciousness, followed by that of memory, and by impaired sight for distance, the third; violent cramp in the stomach, the fourth.

Cannabis indica.—Two more poisonings by this drug may be read in the *Monthly Hom. Review* for March, p. 169. The patients, one a recent graduate in medicine, the other a dentist, give a vivid account of their mental disorder.

Carbo vegetabilis.—Dr. Pullar relates some experiences confirmatory of the value of this remedy in adynamic bronchitis, with threatening paralysis of the lungs. He gives the 6th cent. trituration.—*Monthly Hom. Review*, April.

Cicuta in Convulsions.—Dr. Stonham follows up his case of cicuta poisoning, recorded in the *Monthly Hom. Review* of September, 1892, by one of cicuta cure in the same journal of April, 1893; the convulsive symptoms being so similar as immediately to suggest the remedy.

Creosote in Tuberculosis.—Dr. Sommerbrodt praises creosote in the treatment of scrofulous glands as warmly as do some others in phthisis. He gives it in increasing doses, beginning (in children) with a drop three times a day. It must be given after meals, as the empty stomach will not tolerate it.—*Therap. Gazette*, March.

Dr. Albu, who has used the drug in pulmonary phthisis for five years in the Moabit Hospital of Berlin, considers that it has no effect upon the tubercular process in the lungs, but is a useful remedy in the symptomatic treatment of consumptives—perhaps the best we have.—*Ibid.*, May.

Dr. Quint praises it in tubercular iritis.—*Ibid.*, p. 305.

Dioscorea.—Dr. Gentry finds bending head and shoulders backwards a characteristic indication for this remedy in colic. [He speaks of it as “the very picture of the provings.” The only trace, however, we can find of such a feature is in Allen’s S. 1021, and here it was lumbar, not abdominal, pain which caused the backward flexion.—ED.]—*Amer. Homœopathist*, March 15th.

Diuretin.—This is a patent preparation, but no secret is made of its active ingredient being theobromine, the alkaloid of cacao. Dr. Aldubalbe has tried it in all forms of dropsy: in those of hepatic or renal origin its effects were slight, if any at all; but in cardiac dropsy the results obtained were excellent. About five grammes must be given daily.—*North Am. Journ. of Hom.*, May, p. 326.

Physiologically, theobromine seems to have no such action as digitalis and its congeners. Cohnstein, who has experimented much with it, concludes that it belongs to the group of drugs which act by direct irritation of the secreting elements of the kidney.—*Therap. Gazette*, May, p. 309.

Dolichos pruriens.—Dr. Jean de Wée, of Brussels, has found this medicine curative in two instances of the distressing itching which so often accompanies jaundice. In the first case he gave the mother tincture, in the second the 3x dil.; either seemed equally effective.—*Revue Hom. Belge*, March.¹

Duboisine.—Recent observations appear to show that in duboisine we have a drug which may be of considerable value in

¹ Dr. de Wée laments that he can find no article on this plant in the *Cyclopædia of Drug Pathogenesis*. If he will look at No. 6 of our rules of working he will see that the scanty pathogenetic material we possess concerning it was inadmissible.—R. H.

hystero-epilepsy. Cases have been recorded by Samuely and Belmondo, in which it produced good results when no other treatment did any good. Professor Pietro Albertoni has recently recorded three similar cases in which the same treatment was adopted with success. He gave from .0004 gramme to 0.5 milligramme, and thinks that, judging from his own cases and those of the observers mentioned, duboisine may be considered almost a specific against hystero-epilepsy.—*Therap. Gazette*, May.

Dulcamara.—A case of poisoning by this plant, medicinally administered, is recorded by Dr. Kranz, of Wiesbaden, in the *Hom. World* of April.

Exalgine.—A case of poisoning by this substance is related in the *Monthly Hom. Review* for March, p. 172.

Glonoin.—An unusual case of acquired tolerance for this drug is contained in the *Therapeutic Gazette* for May. It was given, to induce its physiological effects,¹ in a case of interstitial nephritis (?). These were at first caused, as usual, by a drop of a 1 per cent. solution. As they wore off, the number of drops, and then the strength of the solution, was increased, till in less than a year the patient was taking a dose equivalent to 6 gr. of the pure drug. With the consentaneous use of the chloride of gold and sodium—gr. $\frac{1}{10}$ to $\frac{1}{20}$ —the general symptoms, of which vertigo and dyspepsia were the chief, had disappeared, and the sp. gr. of the urine had risen from 1002 to 1018. [We have queried the diagnosis here, because it seems to have been based solely on the phenomena mentioned above. There was no albumen present, and nothing is said as to casts.—ED.]

Granatum.—Dr. T. Hart Smith, having prescribed somewhat substantial doses of tincture of pomegranate bark for worms, found it produce (the patient was a child) spasms of the glottis. He has since used the drug, in about the 2nd dil., as a remedy for such spasms occurring in whooping-cough or elsewhere, and has found it very effectual.—*Hahn. Monthly*, April.

Heloderma horridus.—This is said to be a poisonous lizard, found on the banks of the Gila river, in New Mexico. Dr. Robert Boocock communicates some provings with the 3rd and 30th dilutions of the venom. It seems to be very virulent.—*Hom. Recorder*, March and April.

Hydrastis.—Some fresh experimentation on the lower animals with this drug and its derivatives is summarised in the *Monthly Hom. Review* for March, p. 173.

¹ For illustrations of its use in this way see *Monthly Hom. Review* for March, p. 174.

Hypericum.—Dr. E. P. Colby mentions a case of moniform neuroma with consequent neuritis, rendering the whole hand useless and very painful. Hypericum was the only internal remedy administered, and after three weeks' use the tumours upon the nerve-trunk could hardly be found. The neuritis had also perceptibly diminished. The patient was seen again later, and was found so much improved that he was able to use a shovel in gardening for several hours.—*N. Engl. Med. Gaz.*, March.

Kali iodatum.—In the *Lancet* of March 4th is a case in which grain doses of the iodide; taken three times a day, caused after six doses irritation in eyes, nose and throat, and after six days a rash on the arms. On the seventh day this was found on the legs also, and was ascertained to consist of irregular-shaped blood extravasations.

Kalmia in Cardiac Headache.—Dr. Proll relates the case of a boy of 13, who suffered from headache and weak memory to such an extent that he was obliged to leave school. The cause was found in an insufficiency of the cardiac valves, and kalmia 1 was given three times a day. In three days there was slight improvement. The remedy was given twice daily in the 2nd dil. The headache then occurred occasionally only. The 3rd dil. was now substituted, and continued for seven days, when the headaches had wholly disappeared. Seven months after the boy was found to have been studying without interruption.—*Hom. Monatsblätter*, No. 1, 1893.

Lappa major.—Dr. G. M. Ockford relates a case of chronic prolapsus uteri, cured by this drug in the 3x dil. A pessary had been worn for years, and in its absence the uterus would protrude from the vulva. After a fortnight of lappa it was removed, and the uterus remained in position. The remedy was continued for some weeks, and a year after there had been no return of the trouble.—*N. Am. Journ. of Hom.*, March, p. 177.

Provings of this drug, conducted by Dr. S. A. Jones, are related in the *Hom. Recorder* for Feb., March and April.

Menyanthes.—Dr. S. A. Jones quotes a saying of the late Carroll Dunham's:—"If a woman ever tells you that she feels as if she was crowded into a skin that is several sizes too small for her, look up menyanthes, and you will probably find the rest of her symptoms in that remedy."—*Hom. Recorder*, March.

Enanthe crocata in Epilepsy.—Among his patients in the Middletown Asylum, Dr. Talcott has many chronic epileptics.

He has tried several homœopathic remedies on these in the past, but has obtained no definite amelioration save with silica, which has done real good in cases where the attacks recur not oftener than once a week, and are apt to be specially severe about once a month. Since using *œnanthe*, however,—which he has done on a large scale—he has noted much more decided results. The attacks have become less frequent (by 40-50 per cent.) and less violent, and the mental state before and after these, and in the intervals between them, has been notably improved. The drug was given in the mother tincture, 1-6 drops a day.—*Report of the Middletown Asylum, Jan., 1893.*

Phosphorus in Purpura.—Dr. A. Speirs Alexander communicates to the *Monthly Hom. Review* of May a case of purpura, with hæmatemesis and hæmaturia, in which rapid cure ensued on the administration of phosphorus in the 6th dil.

Piper methysticum.—By the long-continued use of this drug as an intoxicant, the skin of the inhabitants of the Sandwich Islands is said to assume, particularly in the extremities, the appearance of ichthyosis, associated with a certain degree of atrophy, such as is observed in senile skin. There is an absence of inflammatory symptoms.—*Brit. Med. Journ., Jan. 28th.*

Pulsatilla.—A schoolmistress, aged 30, thin, pale, with scanty hair, complains of restless sleep, accumulation of saliva in mouth, distended abdomen, occasional diarrhœa. She is growing thinner, is always chilly and tired, the eyes are particularly weary. When 17 she had an Italian malarious fever, with rigors coming on at 2 a.m. The influenza of 1890, which attacked her, made her ill. She was treated for a month without benefit with nat. mur., sulph., cham. and nux v. She was not the least better, and she had in addition bulimia with great yawning, and, in consequence of her weakness, palpitation of the heart on any exertion. From the moment when she began to take puls. 30, a dose every day, she steadily improved, and there remains nothing of her malady except some sensitiveness to open air.—Villers, *Arch. f. Hom., ii., 156.*

Ratania.—Dr. A. M. Cushing, taking some heavy doses of the tincture of this plant to stop an obstinate mucous diarrhœa (which it did), found it cause severe itching of the rectum. He has since used it with rarely failing effect when threadworms cause this trouble. *Sanguinarinum nitricum*, also, he finds beneficial in itching and burning of the rectum unconnected with ascarides.—*Med. Century, March, p. 90.*

Spigelia.—A woman, aged 32, of robust frame, suffered from a spasm of the stomach, coming on every evening at 8 o'clock; after great exertion it comes on during the day. It goes off when she goes to bed and falls asleep. She has also a sensation as if the left side of the chest were larger and wider than the right; this she only feels when lying down. Auscultation reveals an obtuse murmur with the diastolic heart's sound. This murmur is strongest under the third rib, near the anterior axillary line, and in the supraclavicular space of the same side. She got for a fortnight daily one drop of the 30th dil. of spigelia. On seeing her two months afterwards she told me that she had only had one more attack of spasm of the stomach. Auscultation showed perfectly pure heart's sounds without any murmur.—Villers, *Arch. f. Hom.*, ii., 159.

Stannum.—Dr. W. A. Campbell reports a series of cases of irritant poisoning, resulting from the ingestion of canned tomatoes. Tin was found in large quantities in the contents of the cans. A notable feature was the number of threadworms passed in the stools, suggesting, as the reporter says, that the salts of tin, and not only the powdered metal, are anthelmintic.—*Therap. Gazette*, March.

Thuja in Osteo-sarcoma.—In a paper entitled "Without the Knife," published in the April number of the *Hahnemannian Monthly*, Dr. Wallace McGeorge relates a case in which a large tumour of the thigh, diagnosed as osteo-sarcoma, was treated by an old-school physician with the "fluid extract of arbor vitæ (Americana)." He gave at first one drop, then two drops, three times a day, and after six months the tumour had completely disappeared. (At the International Homœopathic Congress of 1891, Dr. Helmuth spoke of several cases of sarcoma, which, an operation having been declined, he had succeeded in curing with thuja similarly administered.—See p. 797 of the *Transactions*.)

Tuberculinum in Phthisis.—In the *Hom. World* of April, Dr. Clarke relates a case of pulmonary phthisis in which "the consumptive process was completely arrested, and the patient practically cured" by a course of treatment in which tuberculinum, prepared and given as Dr. Burnett recommends, seems to have been the pre-potent agent. A partial proving of this preparation ("bacillinum," "tuberculinum Heathii") is extracted in the same number of the *World* from the *Hom. Recorder* of Nov., 1892.

Zincum.—Dr. d'Amore, of Naples, has experimented with

the oxide upon dogs, giving it in doses of grm. $\frac{1}{2}$ —1 per diem. Death occurred after 10—12 days. The animals presented the following symptoms:—Repeated vomiting without apparent effort; extreme weakness; incomplete anæsthesia; very pronounced emaciation; scanty urine; hæmoglobinuria, albuminuria, and glycosuria; hypoglobulæmia and leucocytosis, the hæmoglobin also being lessened. Zinc was readily found in blood and urine. The tissue-changes ascertained by necropsy were of two kinds—lesions of vascular origin, and those due to various degenerative processes. They may co-exist in the organs with more or less predominance of one or the other, depending on the time and the parenchymatous resistance to the drug. In general it may be said of zinc, that its action is similar to that of phosphorus and of arsenic. The chief points of attack are the blood, kidneys, and general nutrition; in the liver and pancreas, as well as in the kidneys, fatty degeneration is found.

THERAPEUTICS.

Achillodynia and Gonorrhœa.—Professor Albut, of Vienna, announced in the *Wiener Med. Presse* of January 8th, 1893, that he had lately met with six cases of severe pain in the insertion of the tendo Achillis. These cases were attended by a small swelling at the insertion of the tendon. The pains are very obstinate, and are not alleviated by warm baths, cold compresses, iodine or mercurial ointment applied externally. Professor Albut inquires if others have observed this affection. Dr. A. Welsch, of Augsburg, replies that he has seen three cases of it, and they all occurred in patients who had suffered for a long time from gonorrhœa. A swelling of the point of insertion of the tendon was always present. The pain was not always alike or constant, but increased as the gonorrhœa progressed, and remained long after the discharge had ceased. "These pains," says Dr. Welsch, "may either belong to those reflex phenomena which sometimes occur in remote parts of the organism during catheterisation of the urethra, or they may be referred to the so-called gonorrhœal rheumatism, confirming the opinion of many of the older physicians that gonorrhœa is not merely a local affection but a general malady (gonorrhœal dyscrasia). Which of these is the correct view I am unable to decide. In some cases the gonorrhœal infection may be merely a local disease, in others it may become a general malady, owing to the wandering of the cocci to distant parts." The remedy employed by Dr. Welsch is

the tincture of *thuja occidentalis* externally and internally. He applied compresses to the affected part moistened with a lotion made with one part of the tincture to eight parts of water; and he gave internally four to six drops of the tincture three times a day. He prescribed the same treatment in cases of pains in the knee and hip of gonorrhœal origin. "Thuja," he says, "acts like copaiva balsam specifically on the mucous membrane of the urethra, bladder, ureters and kidneys, but has a much larger sphere of action, as it relieves the accessory symptoms of gonorrhœa, which are chiefly localised in the joints and sheaths of the tendons. Boerhaave and Hufeland saw good effects from thuja. Now-a-days its use is almost confined to our homœopathic colleagues, who give it in diluted form. This is almost enough to deter many from the employment of this plant, but my motto is: 'prove all things and employ the best.' The patient seeks relief from the physician, and if the physician cannot help him he goes to Pfarrer Kneipp. *Sapienti sat!* The good effects of this tincture when applied to the base of warts are well known; it is also useful in condylomata and *ulcus molle*. Very good results have been observed from its application in erosions and ulcerations of the vaginal portion of the womb. I have seen better and more rapid cures of cases suspiciously like cancer from thuja than from any other remedy." This is a brilliant testimony to the truth of Hahnemann's therapeutics from an adherent of orthodox medicine.—*Arch. f. Hom.*, ii., 150.

Diarrhœa chronica.—A clergyman, age 64, had suffered for two years from diarrhœa. It came on after any exertion, after eating bread or cake, and without any ascertainable cause, betwixt 2 and 4 a.m. Urging to stool came on with great intensity, with rumbling in bowels and some pressure towards the right groin. He has great difficulty in resisting the call, particularly when it comes on in the early morning; it streams out, is very liquid, inodorous, and contains a few ragged bits of fœces. He has slight piles, and previous to this malady his digestion was very regular. *Rhus 30*, one drop twice a day, caused such an alteration in three days that his bowels became quite regular, and remained so for fourteen days, when, after drinking too much white wine, the diarrhœa returned. The same medication for five days cured him completely.—Villers, *Arch. f. Hom.*, ii., 155.

"Funk."—To *anacardium*, as a remedy for this mental condition, Dr. Jones, on the authority of Carroll Dunham, adds *argentum nitricum*.—*Hom. Recorder*, March.

Gonorrhœa.—Two series of 150 cases of this disease were treated at the venereal dispensary of the Hospital of the University of Pennsylvania. In the first series mild injections (zinc and hydrastis) were employed as soon as the disease had entered upon the stationary period, and stronger ones later. In the second, no injections were used until the subsiding period (*i.e.*, about the end of the third week), and then only the milder ones. The number of cases in which posterior urethritis developed was, in the first series, fifty-two; in the second, twelve; while epididymitis presented itself thirteen times in the first, but four times only in the second. The moral is plain.—*Therap. Gazette*, March.

In the May number seven cases are related in illustration of the new method propounded in the *Lancet* of Feb. 27, 1892. They show it to be worse than useless. "It only adds one more to the long list of impracticable and visionary methods of treating gonorrhœa, so much in vogue at the present day."

Leucorrhœa.—Dr. Southwick, who is well known as a gynæcologist, gives—in the *Medical Century* for April—indications for belladonna, calcarea phosphorica, helonin, kreosote, sepia and stannum, as the leading internal remedies for this trouble. The belladonna leucorrhœa is recent; thin, odourless, bland, not very abundant; increased by any cause producing pelvic congestion. That of calc. phos. is profuse, milky and bland, with scrofula as its basis. Helonin is indicated by a profuse yellow discharge in anæmic subjects, causing much itching. Kreosote comes in when the leucorrhœa is profuse, watery and offensive, with much itching and burning; sepia when it is milky, much worse before the menses, and there is bearing down with enlargement of the uterus, the complexion sallow, the skin unhealthy. Stannum is much praised for profuse bland discharge of yellowish or white mucus, with great debility and aching in the back.

Migraine.—Dr. H. Möser has a paper on the treatment of this malady in the *Hon. Monatsblätter*, No. 2 of 1893. His experience is, that one can never hope to cure a case without getting the patient to give up coffee entirely; that sanguinaria and iris are the leading remedies; and that niccolum, when indicated, "will surprise." Its pain is most severe in the forenoon, from 10 to 11, and may be so intense then that the patient cries out in anguish. It appears first on the left side, then possibly jumps over to the right. In the evening it disappears.

Myxœdema.—Mackenzie finds that much less of sheep's thyroid than was at first administered will suffice for these cases.



The gland, or half a drachm of the extract therefrom, twice a week, is as much as it seems advisable to commence with, and the same amount once a week suffices to keep patients in good health, after their primary recovery.—*Lancet*, Jan. 14.

Tuberculous Joints.—Dr. W. L. Morgan sends six cases to the *Hom. Physician* for March, which, being diagnosed as tuberculosis of joints, recovered under homœopathic treatment. Calc. carb. and phos., 30 to 200, were the leading remedies.

Varicose Ulcers.—The *Hom. Recorder* for March translates in full Dr. Windelband's article on the value of *carduus marianus* here (*Zeitschr. des Berliner Ver. Hom. Ärzte*). He has "records of 145 *bonâ fide* cures out of 196 cases." He gives small doses of the tincture or first dilution.

Dr. Jousset, in *L'Art Médical* for the same month, speaks as warmly of *clematis vitalba* in this disease. He gives the 3rd trit. internally, and uses locally an ointment made with the 1x.

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*All communications and exchanges to be sent to DR. HUGHES,
36, Sillwood Road, Brighton.*

PRESIDENT'S ADDRESS.¹

BY J. GALLEY BLACKLEY, M.B.

GENTLEMEN,—Since the last annual assembly, when you did me the honour of electing me to the post which I fill to-night for the last time, many events of the first importance to the well-being of this Society and of homœopathy generally have come to pass. It is well on occasions of this kind that we should attempt a kind of scientific stock-taking; and as the events of this session have been of surpassing interest, and will doubtless be destined to have a far-reaching influence upon the future of this Society, I propose to put before you as succinctly as possible what these events have been.

Firstly, then, your Council met in July for the election of a secretary and of an editor of its Journal. For the first of these posts I had the pleasure of recommending to the Council a gentleman whose name had occurred, I make no doubt, to all those who had the pleasure of listening to his paper upon the "Future of the British Homœo-

¹ Delivered June 29, 1893.

pathic Society," a gentleman in every way fitted to infuse new life into the post which I now feel had been somewhat perfunctorily filled by your late secretary—I allude to Mr. Knox Shaw. The reception given by the Society to his paper, and the discussion which followed it, were sufficient evidence that we were ripe for reform of some kind—or rather, I ought to say, for the bursting out into vigorous growth of the little plant, which had for a good many years been only waiting for the fertilising showers which the presence of an unusual amount of young blood in the Society would sooner or later be sure to give. That this choice has been in every way a fortunate one you hardly need to be told, and the result is, that we have now our Journal, with its supplement containing a full list of members with their addresses and appointments; we have, at least, one vigorous and healthy branch of the parent Society; and we have a real live Council, which has held no less than five meetings, and has transacted a large amount of important business.

For the post of editor of the Journal there was one name also which stood out pre-eminently from all the rest, if only the bearer of it could be induced to add another to the long list of burdens he carries on his shoulders. I allude, of course, to Dr. Hughes, and I am sure it must be a source of the liveliest satisfaction to us all that Dr. Hughes was once more ready to place his time and his boundless energies at the service of the Society and of the cause which he loves so well.

From the very first it became evident that the tide of new members which commenced to flow at the end of last session would be maintained, for at our first meeting we had no less than 28 new petitions for admission to the Society; at the second, 15; at the third, 7; at the fifth, 3; sixth, 4; seventh, 3; and one each at the eighth, ninth, and tenth; and all these gentlemen, 63 in number, have been duly elected members. The affiliation of the Liverpool Homœopathic Medico-Chirurgical Society, as a branch of this Society, added three more members.

The new corresponding members you have just elected will also help to confer lustre on our muster-roll.

It is rarely that a session goes by without our having to lament the loss of familiar faces, but it can be but seldom that we have to lament the loss of such a power amongst us as John James Drysdale. Although resident at such a distance, and but rarely present in the flesh, he was in very truth, to the last, with us in spirit. With the extent of his work on behalf of homœopathy, as well as in the domain of pure science—with his many-sidedness, the copious biographical notice in the *Monthly Homœopathic Review* of last September has made you familiar; but it is only those who have lived in Liverpool, where he lived and worked to the last, who can fully appreciate the loss we have sustained by Drysdale's death. He was a power amongst us who will not be replaced in our time. Over and above his individual medical and scientific work, brilliant as it was, he did, if possible, greater service to the cause of homœopathy by his unique gift of exciting an enthusiasm for honest painstaking work in all those about him. It was impossible to be long in Drysdale's company without having promised to devote some of one's leisure to the scientific exposition of homœopathy. Not the least, too, of his services to homœopathy in Lancashire were due to his gifts as a genial host, and (where once the ice had been broken) as a thorough-going and trusty friend.

Dr. Mackintosh, though living in retirement at Torquay, and not often present of late years at our meetings, was well known to the older members of the Society. On the rare occasions when he came up to the Annual Assembly, his chief desire was to make the acquaintance of the younger members of the Society, to whom he was always especially kind and genial.

In Dr. Blumberg, of Southport, who died on the 5th inst., we have lost a representative man, and one, moreover, who might be reckoned as amongst the most scholarly amongst us. He will be missed both in his local sphere, and as being one of the few remaining members of that gallant band of patriots from various countries who sought and obtained an asylum on these shores after the general upheaval of 1848, and most of whom, having adopted medicine as their profession, have left their mark behind them.

Dr. Carl Fischer was a new member of the Society, having been elected only at the May meeting. Immediately after his election he went out to Chicago to attend the World's Homœopathic Convention, and died there last week.

Of corresponding members, one of the best known thirty years ago has disappeared, in the person of Dr. Chargé, a man who, perhaps more than any other, had done good service for homœopathy in France by his vigorous combative nature coupled with skill and acquirements of the very first water.

The attendance of members at our monthly meetings has given undoubted evidence of awakened interest in the Society; on one occasion no less than 36 were present, and the average for the first nine meetings was 24. This, for a small Society like ours, the majority of whose members are men living at great distances, is more than creditable. Visitors have not been very numerous, the average being 1.1.

Besides the specimens shown on the occasion of the clinical evening in February, some very interesting ones have been exhibited at our ordinary meetings. Perhaps the most interesting were Dr. Burford's specimen from a case of ectopic gestation, and Dr. Moir's patient with paresis of left sixth nerve and soft palate, and anæsthesia of left side of face and gums.

The list of papers brought before the Society this session will be found second to no other session both in their character and the tone of the discussion, as well as in the extent of ground covered by the various essayists. Dr. Dudgeon's paper on stammering heart was a fitting prelude to the others. Perhaps the second evening of the session was on the whole the most interesting—an evening devoted to a discussion upon the medical and surgical treatment of empyema. Opened by men of such experience as Dr. Herbert Nankivell, Dr. Midgley Cash, and Dr. Wynne Thomas, one is not surprised to hear that the attendance was the largest of the session, namely, 36; and that 14 members spoke in the discussion. Dr. Cook's paper, on the ovary and endometrium as a glandular structure, was, like

everything proceeding from Dr. Cook's pen, marked by strong originality.

An excellent paper, of a thoroughly practical kind, which we should be glad to see more frequently, was Dr. Moir's on the "Diuretic Action of Apocynum;" short as the paper was no less than 13 members spoke in the discussion.

Dr. Blake's subject "Habitual Constipation" was handled in a novel and somewhat original fashion, and in addition to purely medical treatment of this troublesome condition, placed the members *au courant* in all that is new in the way of modern adjuvants, massage, electricity, movements, &c.

Mr. Frank Shaw, in his short paper on "The Attitude of the Medical Profession towards Infant Life Assurance," gave an excellent example of the advantage there is for medical men to step aside from purely medical work and give the world the benefit of well-directed efforts for the benefit of the species, beginning, of course, very appropriately, with infant life preservation.

The clinical evening I have already referred to.

Dr. Percy Wilde's paper on the "Pathogenesis and Treatment of Rheumatism" was a somewhat ingenious attempt to revive the half-forgotten theory of the lactic acid causation of acute rheumatism. In the discussion which followed, whilst giving the author full credit for his success in the way of treatment, the general feeling was that the hypothesis concerning the cause was what the Scotch would call "not proven."

Dr. Alexander's paper, in May, was another of the practical papers devoted to a single medicine, "Thuja in relation to Aural Polypus and Allied Growths," and gave rise to an interesting discussion.

Mr. Wright also read, on the same evening, his short paper on "Roaring in Infants," destined to be read in the section of Pædology at the World's Homœopathic Convention in Chicago.

Dr. Cook's second paper this session, on "Antiseptics, with especial Reference to the use of Ozone," was a most fascinating lecture, and had the advantage of being extemporaneous. All present will look forward to an early oppor-

tunity for investing in an ozone generator, and so giving their patients the full benefit of the virtues which lie in allotropic oxygen.

Carrying out the line of policy adopted by the last annual assembly, the first two numbers of the new Journal of the Society, edited by the master hand and mind of Dr. Hughes, are now in the hands of members. The Journal tells its own tale, and has been pronounced on all hands an unqualified success. Men who refrain from joining the Society now, because they get nothing for their money, must indeed be hard to please. The very complete classified Supplement, containing names and addresses of members, &c., is also very useful, and in the opinion of an influential minority of the members of this Society fulfils nearly all the purposes of a homœopathic directory without having its distinctive title. Whether this is really the case or not remains to be seen. Some at least amongst us are of opinion that a rose by any other name will surely smell as sweet. Is it not the thing itself, rather than the name, that the dominant school objects to? I have always thought it is. So long as we let it be known that we prescribe even partially according to the law of similia, so long shall we be ostracised; and it matters little, then, whether we appear in a distinctive directory or a List of Fellows and Members of this Society. Those of our allopathic colleagues who are disposed to be friendly do not stop to inquire whether our names appear in the Homœopathic Directory or not. Whilst on the subject of publications, I might direct the attention of all members who have joined since 1886 to the *post-scriptum* on their notice paper, concerning the republication of Part I. of the Cyclopædia. As more than a hundred members have been elected since 1886 there must be a great many whose sets of the Cyclopædia are incomplete. I would urge upon all to send their names at once to the Secretary, so that the republication may proceed forthwith.

Outside the Society, and what immediately concerns it, the events of the year, with two exceptions, have perhaps been below the average in point of interest, but these two

events deserve special notice as being what is called epoch-making. The first of these was the World's Homœopathic Convention, which commenced in Chicago on Monday, May 29, and lasted a whole week. The choice of so early a date acted naturally as a barrier to the presence of very many Englishmen, but our Society was after all represented by three of its members, viz., Drs. Molson, Hawkes, of Liverpool, and Fischer. Several papers written by members were also sent over and discussed, and will, in due time, appear in the Transactions of the Convention, amongst them being one by Dr. Hawkes upon the "Position and Progress of Homœopathy in Great Britain and Ireland since the last International Convention."

The second event, which happened as recently as Friday last (June 23), is, so far as homœopathy in England is concerned, of far greater importance than anything which has occurred for a generation past. I refer to the laying of the foundation stone of the new London Homœopathic Hospital, which is at last a *fait accompli*. Graced by the presence of the Patroness of the Hospital, that most genial and deservedly popular of Princesses, who is not ashamed even now *coram populo* to confess her faith in the method of Hahnemann, and strengthened by the ever-needful sinews of war, with an insignificant sum of £10,000 remaining still to be raised, everything looks bright for the future of the Hospital. Before two years are out we hope that all will be in working order. With everything in the way of construction, furnishing, and appliances of the very newest and best, it will be strange if we do not attract students and do more in the way of teaching than has ever been possible in London before.

I see it has been the custom with most retiring Presidents in their annual address to make suggestions as to the future of the Society, and I would fain follow their example in one or two respects. It has been frequently said that to us members the British Homœopathic Society is *the* medical society, the only possible one, and that therefore our proceedings should embrace all that is usual in a medical society's life. This I heartily endorse, but at the

same time let us not forget that the Society was founded originally for the cultivation and spread of homœopathy, and that an exposition of the practical application of homœopathy in the cure of the sick should continue to be kept well in the forefront. Let us not say we love surgery or gynecology less, but that we love medicine (homœopathic medicine) more. It is also, let us not forget, our only medico-ethical society, and although, speaking for myself, I am agreeably disappointed at the very small amount of such work which has devolved upon me as President, let us always, by strengthening the hand of our President and Council, enable them, where necessary, to put the foot down and administer rebuke where it is merited. Let us not be content merely to follow our allopathic brethren in such matters, but let us ever set them an example in rigid application of those first principles of medical ethics which should come instinctively to the mind of all true lovers of their profession.

It has frequently been suggested from this chair, almost, I think, from the very foundation of the Society, that we should endeavour, as far as possible, to give opportunities in our discussions for settling in some wise the all-important question of the dose. This is a question which crops up from time to time, is warmly discussed, and is then laid to slumber for another spell. We do not seem to make much progress. Perhaps I might suggest that one of our discussions at an early date might be devoted to a consideration of the treatment of different cases of the same disease at the hands of different medical men by different dilutions of the same drug. There is, I feel convinced, more in this than appears on the surface, for the first questions which assail the teacher are invariably the same—"How do you determine the dose?" and the next one, "How far can we depend upon homœopathic medication alone?" On these questions, and a few points which hinge upon them, I will quote the remarks of one of my predecessors in this chair, the late Dr. Bayes, merely remarking in advance that though nearly twenty years have gone by since these words were uttered, they remain as true and as much needing our practical attention as they did in 1874 :—

“The solution of the much vexed question of the dose is included in the proper appreciation of the great law. It is a part of the art of therapeutics so accurately to adjust the dose that the depressed and paralysed nerves shall be stimulated exactly up to the health-point; any dose which goes beyond this retards cure by leaving a corresponding depression. The working out of this enquiry affords a most interesting field for careful experiment on the part of our members, and it can only be satisfactorily carried out by the conjoint efforts of many men and by the free comparison of many individual experiences.” Again: “It would tend greatly to the advance of the legitimate influence within the profession were we in a position to define its exact value in the realm of medicine. The experience of many active workers can alone enable us to prove the full extent of its healing powers, and the limitations by which homœopathy is bounded in the treatment of disease. It may not be premature to indicate that experience points to the two following propositions. Firstly—that homœopathy enables us to restore the balance of functional action both to the organs, to the circulation, to the nerve force, to cell growth, and to metamorphosis of tissue. Hence the homœopathic method is applicable to all diseases where loss of balance between functional actions constitutes the disease, or is the prominent cause of suffering. Secondly—by restoring functional balance the homœopathic method enables us to arrest and destroy many morbid growths and many parasitic diseases in an indirect manner, for if we are able to restore perfect health to the containing or surrounding tissues, we may, so to speak, starve the morbid growth or parasite. The illustration of these two propositions affords much scope for experiment. It will probably be found that surgical interference, or the adoption of the antiseptic method in the treatment of morbid and parasitical growths, in toxæmic conditions, pyæmia, &c., will enable us to restore the sick to health with a still greater facility and in a direct manner, but nevertheless, a combination of the homœopathic method with those others will even here enable us still further to expedite the cure.”

One point more connected with the near future of the Society and I have done. Some months ago I approached our secretary with a suggestion that as the termination of next session would complete the fiftieth year of the Society's existence, we ought not to let the occasion go by without some special effort being made to celebrate the Society's jubilee in a fitting manner. This idea was at once warmly taken up by our energetic secretary, who immediately suggested that for an occasion of the kind we should certainly endeavour to get one of the original members to accept the presidency for next year. We looked over the list of members, with the dates of their elections, and found, alas, that there was but a single one left of all that compact little band who helped Quin to found the Society in 1844; but this one was our dear old friend Hugh Cameron. Him we now approached with a request that he would consent to serve as president for next year, promising him all possible assistance at the hands of two young and vigorous vice-presidents. By this time you know the rest. Our dear old friend has consented to sacrifice some, at least, of the well-earned leisure of a green old age, and I think I may venture to promise on behalf of all here present that it will not be our fault if the session 1893-4 is not head and shoulders above all its predecessors in the enthusiasm, at least, with which we devote our energies to being, first physicians, then homœopaths.

And now, gentlemen, before I say good-bye, let me thank you for your unvarying kindness and consideration for myself whilst presiding at your meetings. I am proud to say that I have been present at every meeting this session, and that only on one or two rare occasions has the meeting had to begin without me. Finally, let me thank officers and council, who have one and all done so much to make my post, if not absolutely a sinecure, at least a bed of roses.

THUJA IN RELATION TO AURAL POLYPUS
AND ALLIED GROWTHS.¹

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ONE of the advantages claimed for homœopathy is that by its means surgical operations can sometimes be averted. In the experience of most practitioners, cases from time to time occur, where a surgical operation, though presenting the readiest means of affording relief, may for some reason or another be counter-indicated. Among such opposing circumstances may be mentioned, the situation of a new growth, as rendering an operation dangerous or impracticable, or perhaps the nervous or debilitated condition of the patient, which may induce both him and his attendant to gladly accept the alternative of some less drastic method of treatment than that of the surgeon's knife.

It is with the object of illustrating such an alternative that I venture to address you this evening on the merits of the well-known drug, *Thuja occidentalis*, as an agent for the treatment of aural polypus and other allied or analogous neoplasms. I also hope to elicit some expression of opinion on the part of my hearers as to the probable action of the remedy in the few cases about to be related; or, better still, the history of any experience they may possess in the same direction.

There is a disposition on the part of perhaps the majority of aurists to regard polypus of the ear as a merely local disease, and therefore to treat it solely by local measures. Hence it is usual to remove these growths by some suitable surgical proceeding, such as the application of the cold or galvano-cautery snare. That such treatment is often the most rapid and effectual that can be adopted is doubtless true; yet if, as Hahnemann taught, "affections of external parts proceed from an internal morbid state,"² it would be

¹ Read before the Society, May 4th, 1893.

² "Organon," Sect. 187, p. 148.

more scientific, more true to our principles, and more likely to give a permanently satisfactory result, to treat the patient, and not the disease.

Whatever merits surgical measures may possess, it will be manifest that they were impracticable in the first case I have to narrate, the anatomical relations of the parts involved preventing the introduction of any form of snare. Moreover, such measures were unnecessary, and the case affords a proof that correct homœopathic treatment may, in certain instances, obviate the need of surgical operations.

CASE I.—Mr. C. N., age 38, applied for treatment on Sept. 2nd, 1892, on account of deafness and noises in the left ear. He stated that a week or two previously, the ear had been exposed to a blast of steam laden with coal dust, after which the above symptoms had developed.

Examination revealed the presence of three masses of exostosis springing from the anterior, the postero-inferior, and the superior aspects of the meatus, and projecting into the latter to such an extent as to leave only a small triangular chink of its lumen patent. In consequence of this obstruction, no view of the membrana tympani could be obtained. The cutaneous lining of the canal was slightly hyperæmic and swollen; but the circumstances above mentioned prevented any very accurate diagnosis being formed of the changes that might be in progress internal to the exostosis.

Various palliative measures were adopted while waiting for developments, but the case remained much *in statu quo* till Sept. 13th, when a slight discharge of pus was observed exuding from the chink between the bony tumours. Hepar sulph. was now given internally, and suitable cleansing measures instituted.

Here I pause, to observe that such treatment, though it is the kind of rule-of-thumb means of dealing with many cases of otorrhœa, cannot be commended as generally useful. Many other drugs beside hepar have otorrhœa in their pathogeneses, each no doubt possessing its own peculiar and distinctive assemblage of symptoms. Where it is possible to match one of such groups of symptoms to those of the given case, the corresponding drug would probably be

the simillimum, and might therefore cure, irrespectively of the pathological condition giving rise to the symptoms. In ear cases, however, the discovery of the pathological condition is generally of the greatest possible assistance in guiding to the appropriate treatment, and may lead to the choice of the correct remedy, when symptoms alone are unavailable, or insufficient for that purpose. In other words, it is desirable to take the entire *objective*, as well as *subjective* aspect of the case into consideration, for the purpose of diagnosing not only the malady, but also its remedy. That such observation is necessary for the sufficient comprehension of a given case, is well illustrated by that now narrated. Hepar sulph. had been prescribed chiefly because it is known in a general way to control or modify the suppurative process; but that such a principle was an inadequate basis for its selection in this case, the sequel will show. On Oct. 15th, the ear was again inspected, and now for the first time a small polypus was seen pushing its way through the triangular chink between the masses of exostosis. It was bright red in colour, and bled easily when touched with the probe. The subjective symptoms of deafness, roaring and commotion in the head persisted, and were extremely distressing to the patient. These latter were of course merely effects of a cause, and did not constitute the disease itself, any more than jaundice is a disease *per se*. They did not of themselves afford any such distinctive drug-picture as to indicate the simillimum, and inasmuch as they are common to other abnormal aural conditions beside polypus, it was necessary to recognize the existence of the latter before the appropriate remedy could be selected. But just as the subjective symptoms did not constitute the disease, neither did the polypus do so. As *nasal* polypus is not a disease of itself, but the outward expression of one, viz., *necrosing ethmoiditis*, so aural polypus is but that of the diseased process that gives rise to it—in the present case *otitis externa acuta*. The subjective symptoms, then, *plus* the purulent discharge and polypoid growth, were the full external expression or totality of the symptoms and signs of that internal disease

which had to be cured, and, without that complete picture, the weapon that should successfully contend with, and completely conquer the enemy, could not have been chosen. To find the simillimum, then, these had to be matched by a disease-picture producible in the healthy body by some medicinal agent. Here a difficulty arose; for, while several drugs are accredited with the *cure* of aural polypus, none, so far as I am aware, have yet been found to *produce* that condition. An appeal had therefore to be made to clinical experience—a resource whose value few will deny, and of which most of us habitually avail ourselves. Such a proceeding may be open to censure by some, as savouring of empiricism; but the selection of a remedy for a given case, on the ground that it has been known to cure a precisely similar case, is not empiricism in the obnoxious sense of the term, if it can be shown that the drug acted beneficially in virtue of its response to a recognised law. The drugs, then, that have been accredited with the power of curing aural polypus are calc. carb., lycopodium, mercurius, phos., sanguinaria, thuja and teucrium. Of these, thuja perhaps possesses the weight of evidence in its favour; though in the strumous diathesis, calc. carb. would doubtless be the more appropriate drug. Dr. Hughes reports a case of aural polypus (to which I will refer more fully farther on) cured by the internal administration of the former; and others have obtained a like result in polypus of the uterus, larynx, etc. On Oct. 15th, thuja, in the 30th dilution, was accordingly given to the patient before alluded to. On Nov. 4th, the condition was unchanged, except that the polypus appeared to have bulged out a little more through the opening. Patient was directed to continue the medicine. On Nov. 18th, he returned, and reported that a few days before, after a great increase of the noise and turmoil in his head, he had suddenly felt something “go off in his ear,” to use his own expression, the sensation being accompanied by a slight discharge of blood from the meatus, that thereafter the noises had entirely ceased, and that hearing power had at the same time returned.

Examination of the meatus showed that the polypus had

disappeared, some black, dried-up blood occupying its place. The meatus was then syringed, and what appeared to be the shrivelled remains of a small polypus were washed out. Hearing was found to be equal to that of the other ear, and all subjective symptoms were gone. The chink between the bony processes was too small to allow of the membrana tympani being examined, but, as there were no signs suggestive of perforation, it was concluded that the polypus was of extra-tympanal origin.

CASE II.—Gertrude S., aged 11, was seen on Sept. 6th, 1892, on account of deafness and purulent discharge from the right ear. The discharge was of long standing, but no definite history of its development could be elicited.

After the meatus had been cleansed by syringing, a small pale polypus was found lying in the floor close to the membrana tympani, which was intact. The child being excessively nervous, shrinking even from the touch of the speculum, it was decided to try the effect of medicinal treatment, before resorting to any operative interference. Thuja 30 was therefore given internally, while boracic acid was used locally for the purpose of cleansing the meatus. Under this treatment the discharge gradually ceased, hearing improved, and in two months' time, on Nov. 8th, inspection showed that the polypus had entirely disappeared.

This case may be taken as typical of others of a similar character, in which I have found thuja useful. The situation of the growth in these cases has not seemed material, in some being intra-, and in others extra-tympanal.

Likewise in cases of granulations of the middle ear, and of otorrhœa, it has from time to time served me in good stead, and, in some instances, after the failure of other means of treatment. Besides the internal administration of the drug, I may here suggest that it might probably be used with advantage as an insufflation in the form of sugar of milk saturated with the tincture and dried. This modification of its use, however, I have not yet employed. As an illustration of the action of thuja in some cases of otorrhœa, the following may be adduced.

CASE III.—Mr. M., a hale old man of 83, applied for

advice on Oct. 19th, 1892, an account of deafness of the right ear. He stated that, after being exposed to a draught, he had suffered much pain, which was relieved by the discharge of matter. Examination revealed extensive rupture of the membrana tympani, evidently resulting from an attack of otitis media acuta. Hepar sulph. was given internally, with an insufflation of boracic acid.

On Nov. 16th, patient was again seen, but no material improvement had resulted from the treatment. Thuja 30 was therefore substituted for hepar, and the insufflation continued. This treatment was persisted in at intervals till March 22nd, 1893, but without any appreciable effect. Patient complained that he could not take the medicine, because after each attempt he experienced a disagreeable sensation in the ear and throat, as though all moisture in those regions were completely dried up. There was no cessation, however, of the otorrhœa. It seemed probable, from these symptoms, that a medicinal aggravation had been produced, and in order to test the effect of a higher dilution, a few pellets of the thousandth were placed on the tongue, the patient being requested to take no more medicine of any kind before again reporting himself. On April 5th, he returned, stating that the discharge had ceased entirely, and that his ear and throat felt quite comfortable, though the hearing had not returned.

Here, then, was an example of the apparent success of a higher attenuation, after the failure of a lower one of the same drug—a circumstance which may not be uninteresting to those members of our Society who are still sceptical as to the curative properties of any dilution higher than hand-made two hundredths.

CASE IV.—I shall now give a brief epitome of the striking case already alluded to as reported by Dr. Hughes in the *Monthly Homœopathic Review* for Sept., 1869.

Mr. A., aged 63, was seen by Dr. Hughes on the 23rd March, 1869, and found to be suffering from a polypus, of the raspberry-cellular variety, in the left meatus. Thuja 12 n. and m., was prescribed. This medicine was continued till April 12th, when the polypus had assumed a blackish

colour; and on the 20th, it had disappeared, though otorrhœa and deafness persisted. Merc. sol. 4 was then given, and continued till May 12th, on which date the polypus was discovered to have reappeared. Thuja 12 was accordingly resumed for a month, and then replaced by the 30th dilution of the same drug. Under this treatment the polypus increased in size, at the same time fading in colour, till, on June 22nd, it had become dead-white in appearance. On July 8th, the polypus came away *en masse*, the otorrhœa ceased, and hearing thereafter improved.

For the two next cases, I am indebted to my friend Dr. Black, of Torquay.

CASE V.—Mr. —, aged about 45, above medium height, corpulent, but fond of out-door sports, came to me complaining of deafness in one ear, and of a discharge, partly watery, partly bloody, that kept oozing from it. On waking up in the morning, he found the pillow stained sometimes with blood, sometimes with watery-looking discharge. On examining the ear with a Brunton's otoscope, I observed a polypus of the mucous sort attached to the posterior wall of the meatus, and projecting forward so as to obscure about three-fourths of the tympanum. The surface was smooth and glistening, and streaked with blood. I told him what he was suffering from, and that I should give him some medicine which had been the means of removing such growths in the hands of others, although I myself had had no practical experience of it. Although sceptical of the result, he took along with him some thuja 30, of which he was told to take five drops in a little water twice a week, and he left behind the memory of a face lit up with a kind but incredulous smile.

A week afterwards I met him in the street, and he said in passing: "I have had no discharge from that ear since I took the first dose of the medicine." "All right," I replied, "I'm glad to hear it. Go on, and come to see me when the month is up." He presented himself at the end of the month, and told me there had been no return of the discharge, and his hearing was better. I examined the ear in which I thought the polypus had been, but could not see a vestige of it. Thinking I had made a mistake, before

saying anything I asked to look at the other ear. This I found as clear as a bell, so I told him his polypus was gone. He said, "I thought it must, for I feel all right."

CASE VI.—Mrs. — asked me to look at baby's navel, as she thought it was not quite right. The infant was five weeks old. On looking at it I found a fleshy-looking mass, about the size of a small bean, projecting from the umbilicus. It was somewhat conical at the apex, and had a broad base. The child was given thuja 30, two drops in eight teaspoonfuls of water, a teaspoonful three times a day. I saw it again three weeks after, when it had become reduced in size to the head of a match. I do not recollect seeing it again, and my impression is that the mother told me the child was all right.

It has been pointed out that thuja has not yet been shown to have produced aural or other polypus in any of its provers. In reviewing the foregoing cases, the critical Hahnemannian may, therefore, well ask why the drug effected the cure of such a growth, and if such a cure can indeed be regarded as homœopathic.

In order to solve these questions, the action of thuja on cutaneous, muco-cutaneous and mucous surfaces generally, and more particularly on that of the conducting apparatus of the ear, may now be briefly considered.

Such action may be illustrated by the well-known effect of the drug on the mucous lining of the urethra, several provers while taking it having experienced genuine attacks of urethritis, with its attendant symptoms of inflammatory swelling, dysuria and purulent discharge. In others, condylomatous patches about the anus, warty excrescences on the corona glandis and on the lips, have been developed, and some have reported the appearance of true papillomata on the hands, &c. The latter, however, seem to have had warts at some previous period of their lives, and may therefore have had a predisposition to those growths which thuja evoked anew.

Less well known, perhaps, are the catarrhal effects produced by this drug on the Schneiderian membrane, and what may be regarded as its processes lining the Eustachian tubes and tympanum.

In the *Cyclopædia of Drug Pathogenesy*, the nasal symptoms recorded by various provers are as follows:—Obstruction of nose, from which a quantity of blood was blown at evening; frequent sneezing; increased secretion of mucus from the nose; stoppage of right nostril, alternating with running; in right nostril a feeling of soreness or ulceration,—with other similar effects.

Likewise in the ear we find the following subjective symptoms induced:—Shrill ringing in the ear, which, after a few hours, as suddenly changed to dull buzzing and groaning, latter sensations gradually changing to a noise as of a bubbling liquid; feeling of stoppage in left ear, with diminished power of hearing; sticking from right velum palati into internal ear; painful stitches from depth of right ear through external ear; feeling as if the external organ were filled with water, similar to the sensation felt when one dips his head under water; sensation as though something were squeezed out at both ears.

It will be noticed that no objective symptoms are mentioned in connection with the ear, but the effects recorded both in that organ and in the nares suffice to indicate the direction in which the drug acts. They may be fairly interpreted as the outward expression of hyperæmia of the membrane lining those parts, and of increased secretion of mucus from its glands. There is thus an analogy between the effect produced by thuja on the urethra, and that on the nasal and aural mucous membrane, in both inflammation and abnormal discharge resulting from its exhibition. On the genital organs, and also on the skin, warty growths have likewise been set up, and also cured, by its means. From thence to polypus, there is but a step, both growths being closely allied histologically; and though thuja is not known to have caused aural polypus, yet it is as easy to conceive that it is as capable of curing it, as it is of curing warts. Nor is it difficult to trace out the *modus operandi* of such a cure. Given an aural polypus, it rests on and springs from an inflamed base, drawing its nutriment from that abnormally vascular region. Now, let the pedicle of that polypus be ligatured, and what happens? It presently

withers, dies, and drops off. And we may assume that this is just what takes place in a case to which thuja is homœopathic. It acts on the inflamed base, dries up the hyperæmic vessels, cuts off the blood supply at its source, and the polypus, no longer finding that nourishment which is necessary to its existence, has no alternative but to succumb.

Thuja *cures*, however, while the ligature or the *écraseur* only *remove*. In the former case the *cause* is got rid of, and hence recurrence will be impossible; but in the latter, the general morbid condition and local hyperæmia being unaffected, the polypus may be expected to re-appear at no distant date.

Another explanation of the action of thuja in aural polypus may be sought for in its reputed relation to the syctic diathesis. Hahnemann did, it is well known, recognise a morbid condition, set up originally by the suppression of a special form of gonorrhœa which he termed *sycosis*. This affection, he says, "has been heretofore treated with mercury internally, and externally by cauterisation, burning, cutting, or ligatures. This violent external treatment has been employed against the excrescences on the genital organs. The excrescences first appear upon those parts of the body several days, and often weeks, after the infection by the act of coition has taken place. They are accompanied with a sort of gonorrhœa from the urethra, are sometimes dry and in the form of warts, but more frequently soft, spongy, emitting a fœtid fluid, *sui generis*, of a sweetish taste (almost resembling that of herring-pickle), bleeding readily, and having the form of coxcomb or a cauliflower (*brassica botrytes*). . . . The natural and immediate consequence of such violent treatment was that the excrescences generally came out again, and were again subjected to painful and cruel treatment. In case, however, they did not re-appear in their original form, they broke forth in the shape of more disagreeable and more dangerous secondary ailments."¹

He then goes on to speak of the combined effects of suppressed sycosis and the mercurial treatment. These are

¹ "Chronic Diseases," vol. i., p. 111.

“ excrescences formed in other parts of the body, either in the shape of whitish, spongy, painful and flat elevations in the cavity of the mouth, upon the tongue, the palate, the lips ; or in the shape of large, elevated, brown, dry tubercles in the axillæ, upon the neck, upon the hairy scalp, &c.”¹ This morbid condition is to be met by thuja, which, he states, is homœopathic to it.

Now, whether polypi, in their various orificial situations, are to be considered analogous in ætiology to sycotic manifestations, as they are to some extent analogous histologically, is a question which has not yet been determined. If they are, then the curative action of thuja in the examples referred to is easily explained, and is to be found in its specific relation to the sycotic dyscrasia underlying those cases. It is to be observed, however, that there was no history of sycosis, whether inherited or acquired, so far as could be ascertained, in the cases of aural polypus narrated at the outset of this paper.

CASE VII.—Before closing this subject, I should like to refer to one more case of a somewhat different kind, but analogous in some respects to polypus, in which thuja also proved effectual. The case to which I refer is one of papilloma of the eye-lid.

The patient, Miss C., in whom this occurred, applied for treatment on December 29th, 1892. All that could be seen externally was a slight bulging of the lower eye-lid, suggesting the possible presence of a Meibomian cyst. Eversion of the lid revealed a papillomatous growth, springing from the palpebral conjunctiva in the situation indicated in the accompanying sketch. When the eyelid was in its usual position, the apex of the growth turned inwards and downwards, and lay between the lid and the eyeball. When the lid was everted, and the base thus drawn down, the apex rose into an erect position.

The patient very much objected to any surgical proceeding, and it was therefore determined to give thuja a trial. This medicine was accordingly given in the 30th dilu-

¹ Ibid., p. 112.

tion, a dose thrice daily, and a lotion of the mother tincture in water was also used to bathe the eye. By the close of the following month, a considerable diminution in size had taken place, and on March 23rd, the little tumour was found to have shrunk to about one-fourth its original size. This case is still under treatment, but as the growth is now so greatly reduced in size that its final disappearance is evidently but a question of time, I feel at liberty to bring it before your notice.

There is yet another form of papilloma which, judging by analogy, we may reasonably suppose to be amenable to treatment by thuja. I refer to that intractable and dangerous, though fortunately somewhat rare disease, villous tumour of the bladder. This growth, it is well known, is papillomatous, and if papillomata in other situations of the body can be cured by thuja, why not this also? When recognised early—and in these days of cystoscopic examination this ought to be no difficult matter—I suggest that this drug be tried both internally, and locally as an agent for washing out the bladder. By such means, it seems possible that the disease might be successfully dealt with in its inception, and surgical procedures thus obviated. Happily for the patient, the latter alternative does present a fair prospect of cure, as shown by a case reported by Dr. Hector Cameron in the *Glasgow Medical Journal* for February of this year. For the removal of the tumour, in this instance, supra-pubic cystotomy was performed, and the pedicle ligatured and cut through, the patient making a good recovery.

Do not let it be supposed that, in thus dwelling on the merits of thuja, I have any intention of advocating its invariable use in the class of disease we have been discussing, or of regarding it as a kind of patent panacea for polypus. To do so would be contrary to the first principles of homœopathy, which require that every case should be treated on its own merits, and in accordance with its own peculiar symptoms. I hope, however, that enough has been said to show that this drug is an active one in the cases to which it is suited, and if the experiences recorded encourage any of

my colleagues to test its virtues for themselves in corresponding circumstances, my object in reading this paper will have been attained.

Dr. JAGIELSKI had had some experience of treating polypoid growths and swellings of the mucous membrane of the nose, which he considered due to an unhealthy dyscrasia. Since he had used thuja he had never had the opportunity of seeing polypus in the ear. In nasal cases he had found it relieve a most unpleasant symptom, the pressure on the bridge of the nose. Thuja was used both internally and externally, and a brush was passed through the nostril. It was not necessary to use the dilutions—but the drug itself might be used. He had treated seven or eight cases in this way. He found that thuja alone did the work well enough. He had known *calcareo carbonica* act locally on the uterus in a patient suffering from polypus. He had also cured a polypus protruding from the os uteri. He used thuja several times at the root and the lip, and had the pleasure of finding the growth shrink up entirely, without bleeding, or any sign of the previous existence of the polypus. He had used the 30th, and locally applied the mother tincture.

Mr. DUDLEY WRIGHT had applied thuja several times, but had never been satisfied that it was not the action of the spirits of wine with which the preparation was made which caused the shrinking; he had given up thuja, and used spirits of wine instead. When thuja was given and boracic acid applied locally he was not certain that it was not the boracic acid which cured the case. If the drug was used, it should be used alone. It was impossible to decide, if two drugs were used together, which produced the effect. *Sanguinaria* had failed in aural polypus. In some cases where neither *sanguinaria* nor thuja had done good, there was diseased bone, and in those cases silica was the best remedy, although some lotion should also be used to procure asepsis. He had treated a case of papilloma of the larynx for seven months with thuja, in various strengths, 30 to 12, but the child was none the better. In another case there had been a certain amount of improvement. Thuja was not of much value in laryngeal cases. With regard to galvano-cautery, he thought the hot wire might be injurious. With respect to nasal polypus and necrosing ethmoiditis, he thought there seemed to be a general consensus that no such disease existed, but that it was a natural process.

Dr. MOIR said that polypus had to be treated in each case according to its history and progress. Multiple polypi in the

nose required one treatment—polypus in the uterine cavity another. He had never seen a case of nasal polypus cured by medicine, or read a report of such a case. Nasal polypi he was accustomed to tear away with a snare, but they recurred. He did not know whether electric cauteries produced better results, though in the ear cases they produced striking improvement. He had himself been treated by Dr. Cooper for polypus with sanguinaceous snuff, and the polypus disappeared in about three days.

Dr. DUDGEON said that the well-known action of thuja in the production and cure of condylomata suggested its use in the somewhat analogous pathological structure of polypi. In condylomata Hahnemann directed that the thuja should first be given in the 30th dilution, and if it was necessary to repeat it, then in progressively lower dilutions, viz., the 24th, 18th, 12th and 6th dilutions. He also advised the excrescences to be touched with the pure juice of the green leaves of thuja, using it with equal parts of spirits of wine. It would probably be better to apply the fresh juice without admixture with alcohol, as thereby we should avoid the astringent or irritant action of the spirit.

Dr. DYCE BROWN admitted that Mr. Dudley Wright's general argument was sound; but the treatment of aural polypus by external means had not been at all successful. If polypus can so easily be cured in this way we should not hear of so many operations, which are only resorted to because the disease was unamenable to local treatment. He was disposed to agree with Dr. Alexander.

Dr. COOK differed from Dr. Dyce Brown, and had not found internal remedies of much use—at any rate in nasal polypus. One popular treatment was a solution of boracic acid in alcohol, given sometimes dilute, but with the strength increased as the patient was able to bear it. The effect was to shrivel and disperse the polypus. One defect in Dr. Alexander's paper was that there was much said of the successful cases, but not a word of the failures. He had attacked nasal polypus by one medicine after another, but failed to touch it.

Dr. PINCOT said he was asked to see a little child with a polypus as big as a haricot bean protruding from the umbilicus. Boracic powder, after bathing with warm water, was applied, and in two days the thing had disappeared.

Mr. GERARD SMITH said there was often a growth of exuberant granulations on the umbilicus of infants; it was not a polypus, but in three cases out of four, children got perfectly well after the use of fuller's earth and cleanliness.

Mr. KNOX SHAW regarded polypus, not as a primary disease, but as a final development of a pre-existing malady. Surgical procedure was the really more scientific, as they treated the final development at once, and then were able to attack the pre-existing disease which caused the polypus. This was more especially the case with nasal polypus, as he had hardly ever done any good by treating nasal polypus, as polypus alone. Much good, however, could be done by treating subsequently the unhealthy condition of the mucous membrane. He was speaking in reference to grave surgical treatment of such cases. The principle was the same, whether you applied boracic acid or spirits of wine, and thus dried up the polypus, or used a cold or hot snare. The one was a slow killing, the other a rapid guillotine.

Dr. BURFORD agreed with Mr. Shaw. The Germans some time ago described this adenoma diffusum or adenomatous hypertrophy, of which the actual polypi are the last elements in the course of events. Mr. Shaw had done well to distinguish between the development of the lesion culminating in polypus, and the absorption of the polypus itself. These were two distinct processes. Dr. Alexander had alluded to the inflamed condition of the base surrounding the polypus. It remained to be proved whether remedies had any effect upon the polypus itself. The conditions of absorption and other conditions were better applied to the hyperæmic state of the adjacent parts than to the polypus itself. In uterine polypus the notion was that the polypus discharges and bleeds. This was not so. It was the parts surrounding the polypus which bled, and when the hæmorrhage was stopped the main cause of the disease had not been attacked. In this connection he was more inclined to agree with Dr. Alexander than with Mr. Shaw. There was much more to be gained by prophylaxis than by the removal of the polypi in the final development. In many cases polypi were multiple, and half-a-dozen repeated operations would be necessary for their successive appearances. If that tendency to recur was controlled by thuja, then homœopathy was valuable prophylactically with regard to the absorption of tumours. We have still to learn that there were considerable powers on the part of nature for the absorption of these neoplasms, and one was very glad to hear of these views of homœopathic treatment to prevent the recurrence of tumours.

The PRESIDENT (Dr. Galley Blackley) regretted that so few had anything to say about aural polypus. He had never had an opportunity of trying thuja in aural polypus, but he had seen it

tried in one or two cases of papilloma. He had used an ointment of the extract of thuja over and over again. He had heard of one case of papilloma of the bladder, under the care of Dr. Bayes, in which thuja only was given, with the result that the man got well after having been reduced to a very serious condition by persistent hæmaturia.

He said that Mr. Shaw and Dr. Burford had shown that something could be done in the way of prophylactic treatment before these growths become pronounced. Unfortunately facts were not brought early enough before them. If a doctor were told of a predisposition, the opportunity would arise of judging the respective merits of medicine or the snare or other surgical means. There was, he was convinced, a great deal of help to be derived from thuja.

Dr. ALEXANDER, in answer to Dr. Cook, who asked about his failures in treating nasal polypus with thuja, reminded his hearers that nasal polypus was not the subject of his paper. He had never cured a case of that disease with thuja, but had heard of cures by other medicines. Dr. Thomas Simpson had reported a case of nasal polypus which so shrivelled up under calcaria 200 that no trace remained. He had himself treated a large number of cases by means of the galvano-cautery snare, and in the majority the removal of the growths was successful. When their origin was recent, removal was often followed by recurrence. The most successful cases were generally those of old standing, where the growths had been long present, but the polypus-forming process appeared to have become exhausted. The removal of the polypi in such cases usually effected a radical cure. With regard to the question of necrosing ethmoiditis, when he first heard of the theory he was rather sceptical about it, but from personal observation he had come to the conclusion that there was a good deal of truth in it, and also in the doctrine of vertical cleavage. Of the latter phenomenon he had actually seen several examples, and frequently, when polypi were removed, spicules of dead bone came away with them, while bare bone could generally be detected with the probe. If a foreign body, such as a sequestrum, were present in any situation in the body, the result would be irritation, which led to suppurative changes and granulations. A like result was found in the nose, in the production of polypus from the presence of necrosis. The employment of chromic acid for the extirpation of nasal polypi had been referred to, but often produced extensive inflammatory swelling, and was, therefore, objectionable. Mr. Dudley Wright had

objected to the use of boracic acid, but in the cases where it had been used it was simply employed as a cleansing agent, and had nothing to do with the cure of the aural polypus. He did not see how prophylactic treatment could be adopted, as patients were not seen till polypus had actually appeared, and its occurrence could hardly be anticipated. He agreed with Dr. Burford that when thuja was applied locally, it acted by absorption into the blood, and that when it cured, it did so in virtue of its being homœopathic to the dyscrasia. He was glad to hear of the President's case of the cure of cystic papilloma, but asked if it had been ascertained that it was a true case of papilloma of the bladder. Had any fragments of the tumour been traced in the urine?

The PRESIDENT replied that the case was so long before the days of cystoscopy that he could hardly answer the question.

BRONCHOPNEUMONIA OF CHILDREN.¹

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THE introduction of so familiar a subject requires perhaps a word of explanation. The frequent, I may say almost epidemic, appearance during the winter and spring of bronchopneumonia at the north dispensary district, the difficulties sometimes attending its proper diagnosis and treatment, and its too often fatal termination, have led me to choose it as the subject of my paper.

True lobar pneumonia has a specific cause and well-defined characters—in the most literal sense of the term it is therefore a *specific* disease. This is far from being the case with bronchopneumonia. One observer (Osler) has described it as a pulmonary lesion which may affect any part of the lung. This gives an explanation to the meaning of the indefinite course, diverse symptoms, and the no less

¹ Read before the Liverpool Branch, May 11, 1893;

varied gross pathological features of the disease. It throws some light on the fact that various micro-organisms, not excluding the redoubtable bacillus tuberculosis, have been assigned as causes of lobular pneumonia. We may say, briefly, that bronchopneumonia is nothing more than an acute catarrh of the alveoli produced by the usual causes of inflammation.

I have previously said that the gross pathological appearances differ in many cases. Both lungs are usually affected, and the consolidated lobules may be scattered throughout the lung substance, aggregated together into patches, or confined almost to an entire lobe. Patches of collapsed lung often accompany these consolidations, as well as emphysema, which, however, is most often found along the anterior border of the lung. Lastly, an area of consolidation near the surface may give rise to pleurisy.

Although the naked eye changes are so various, a microscopic examination of a consolidated lobule always shows us the same thing. The alveoli are filled with catarrhal cells, proliferated from the epithelial lining. One might say it was a continuation of a similar process in the tubes, where the disease so often originates.

From recent observations it seems probable that micro-organisms play some part in the production of this disease. Its occurrence as a sequel or complication of whooping cough, measles, pyæmia or other germ disease seems to point in the same direction. The lungs, enfeebled by defective blood supply, fever, or the exhausting fits of whooping cough, form a ready nidus for the microbes, which soon gain ground in a tissue too weak to resist their action.

The most susceptible age for bronchopneumonia seems to be from one to five years, and less frequently in older children; old people are also liable, but not to the same degree as children. Among the poorer people who live in damp cellars or filthy courts, who are constantly breathing an unwholesome air, and whose children are frequently neglected, the disease is not only more prevalent but, as might be expected, more severe than among the better-favoured classes.

Rickets is undoubtedly a predisposing condition, the softened ribs and weakened muscles of the thorax preventing proper respiration, and the general state of malnutrition which is present aiding in the susceptibility to this, as well as other, diseases. A rachitic subject affected with bronchopneumonia has not the full advantage of the lung areas which remain healthy, and so the disease is likely to run an unfavourable course. Tuberculous constitutions, or those with a family history of phthisis or other tuberculous disease, are liable either to develop a rapidly fatal form of bronchopneumonia, or to recover and at a subsequent date to fall victims to consumption.

Of the exciting causes, bronchitis affecting the larger or smaller tubes is the chief, and it is for this reason, more especially, that measles and whooping cough are the most frequent precursors of bronchopneumonia. My own experience leads me to think that pertussis is the more frequent cause of the two. But besides these, the other well-known conditions which are accompanied by, or give rise to bronchitis in young children, as dentition, chill, intestinal catarrh, may lay the foundation for this disease. Lastly, diphtheria, scarlatina, typhoid, septic fevers have sometimes bronchopneumonia as a complication.

Bronchial symptoms and physical signs, indicating more or less catarrh usually, but not invariably, precede the onset of the disease. When this is the case they are soon followed by an exaggeration of all the symptoms: more hurried breathing, higher fever, and a cough which, instead of being loose and rattling, becomes short, more hacking and often painful. The temperature varies from 102°-105° in the evening, with morning remissions of several degrees. The chart often shews an intermittent character, the morning temperature falling below normal. In some cases, however, the onset is sudden, or announced by convulsions, a large area of lung is attacked at once, but the subsequent course will usually indicate the true nature of the disease.

In a fully developed case the face is flushed or pale and livid, the expression anxious, the *alæ nasi* work vigorously. The child is inclined to lie quiet, and submits passively to

examination; all his efforts being concentrated on respiration, he is too occupied even to cry out. The respirations, varying from 50 to 80, or even more per minute, are shallow, often noisy and difficult, and if bronchitis of the larger tubes accompanies the condition, loud sonorous râles are heard even at some distance from the patient. In the movements of the thorax, in advanced cases, one notices that the accessory muscles are called into play, and the lower intercostal spaces and epigastrium fall in with each inspiration. Pleurisy, when present, is not an early feature; it may be recognised by the painful character of the cough and the physical signs of friction or marked dulness, with loss of breath sounds and ægophonic resonance. Children generally swallow their sputum, but when it is brought up, either by the forcible cough of pertussis or by the act of vomiting, it is at first frothy mucus, sometimes blood-streaked, and in the later stages mucus and pus. When bronchitis co-exists, however, the expectoration may continue yellow throughout. The above characteristic symptoms may not be so evident in slighter cases, or in those where there is little bronchitis. Moreover, meningitis or some other disease may mask the presence of any pulmonary condition, hence the importance of the physical signs which, unfortunately, are not so definite as in lobar pneumonia.

The percussion note may be resonant all over the chest, or there may be patches of impaired resonance. Anteriorly the note is often hyper-resonant from the presence of emphysema. The dull areas may be either due to collapse or consolidation; but if the former is the case the breath sounds, instead of being augmented, are impaired in intensity and sometimes inaudible. Auscultation gives us breathing either puerile, harsh, or, over consolidated areas, bronchial, either tubular or blowing. The breath sounds are often masked by accompaniments both moist and dry, which, when heard through consolidated lung, have a peculiar ringing or consonating character. When these consonating râles are discovered, although we may not be able to determine any definite impairment in the percussion note, we may be sure that there is some bronchopneumonia present. We must

remember that when we are examining a lung with bronchopneumonia we may expect to find the physical signs of consolidation, collapse, emphysema and bronchitis. One marked character of the physical signs is that they vary at different times in their position and character. First one set of lobules are attacked, then, while these are clearing up, another is affected—perhaps in some more distant portion of the lung—and so on.

The successive involvement of various portions of lung accounts for the insidious course of the disease and the no less gradual decline and protracted convalescence. As the pyrexia begins so it ends, falling by a very decided lysis, but one marked by remissions and intermissions. The disease itself may last from one to several weeks, its course depending on the amount of lung involved.

The complications of bronchopneumonia may be either pulmonary, affecting the lung and directly due to the condition present as bronchitis, emphysema, pleurisy, empyema, bronchiectasis; or due to the spread of the poison to a remote organ—auto-infection, *e.g.*, meningitis in a tuberculous case; or lastly, to debility produced by the disease, as diarrhœa, otorrhœa, &c.

With regard to tubercle, it is always an important question whether any given case be tuberculous or simple, so that pulmonary tuberculosis may exist either primarily (acute), or secondarily (chronic). It is said that if there is much lividity, high fever, and on auscultation universally scattered râles and harsh breathing, the case is one of tuberculosis. An unfavourable family history, the occurrence of meningitis as a complication, have also to be considered in this connection as pointing to the probability; but perhaps the only certain diagnostic point is the discovery of tubercle bacilli in the sputum. On the other hand where the disease runs a prolonged course, when the temperature will not subside after some weeks of illness, when there are no signs of the clearing up of the affected areas, when night sweats and hæmoptysis supervene after the more acute stage has passed, the case is one of phthisis engrafted on the simple form of bronchopneumonia.

Many authorities assert that capillary bronchitis and bronchopneumonia are one and the same disease. It seems, however, more probable that the latter is only a further stage of the former. A case of capillary bronchitis is seldom without some bronchopneumonia, and bronchopneumonia seldom without some capillary bronchitis. The difference is more one of degree than kind. When inflammation of the lobules follows an acute attack of capillary bronchitis we are made aware of the fact by a rise of temperature to 103° or 104°, by the change in the character of the cough, by the greater degree of dyspnoea and by the physical signs of consolidation.

It is often very difficult to distinguish true pneumonia from the lobular form of the disease. In the latter, in some cases, the onset is sudden; but usually the subsequent course of the disease and the temperature is different. There may be pleurisy in both conditions, but in the croupous variety it is an early symptom and the pain is usually of a severe character. The expectoration when attainable will aid us, and physical examination may elicit the fact that a portion and not the whole of a lobe is implicated.

Other pulmonary conditions such as pleurisy and empyema can be eliminated by a careful consideration of the symptoms and physical signs. Typhoid fever, meningitis and other acute illnesses, which may exist either independently or in conjunction with bronchopneumonia, have also to be considered, but the history of the case and the predominance of the chest symptoms, both subjective and objective, will help us to arrive at a correct diagnosis.

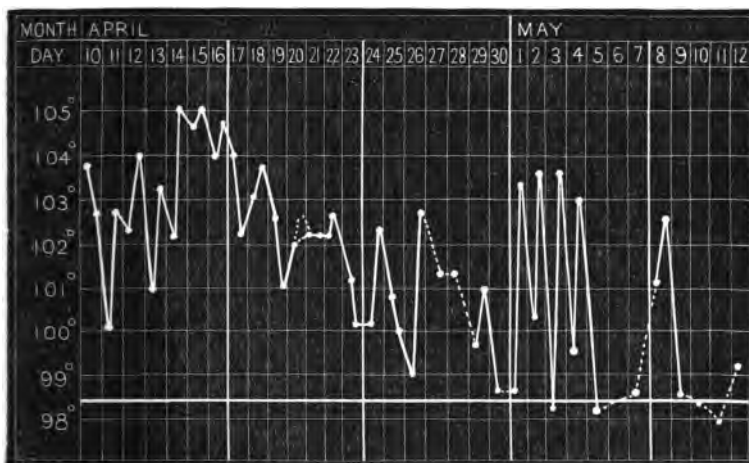
With regard to prognosis, it is never advisable to take a gloomy view of a case, as even the most severe and apparently hopeless cases recover. The younger the child the more serious is the outlook,—an infant under two, that is to say during the period of dentition, having a poor chance of recovery. The underlying diathesis, rickety or tuberculous, on which the disease is grafted, is another factor of great importance both as to life and as to the subsequent health of the patient.

The following case is a good example of a severe and prolonged attack of bronchopneumonia in a boy aged 3:—

William Clydesdale, aged 3, was first seen on April 8, 1893. One month ago had measles, followed by whooping cough, from which he is still suffering. Bronchitis developed about a week ago.

Family history.—A younger sister died of consumption of the bowels, an elder of phthisis at puberty.

General appearance.—The child was poorly developed; rickety, with small chest, protruding forehead, pale face and prominent abdomen. The skin was dry, temperature 99.2° ; tongue moist, white fur. Pulse quick and small, over 120. Respirations hurried, shallow, with loud wheezing; expiration followed by a short sigh. The lower intercostal spaces were drawn in with inspiration. *Percussion* hyper-resonant anteriorly, resonant posteriorly. *Auscultation.*—Numerous râles, especially at the bases.



On April 10, the temperature had risen to 103.8° , tongue had thick, white fur. There was frequent thirst. A greater degree of dyspnoea, and exaggerated movement of accessory muscles and *alæ nasi*. Posteriorly at left base dulness on percussion, and also some impairment at the right base. Râles distinctly louder and more consonating at bases. The following day diarrhœa was noticed.

Dulness, tubular breathing and consonating crepitations at left apex posteriorly, and left base anteriorly and posteriorly, were noted on April 12.

On April 17 both bases showed *marked* dulness posteriorly. The breathing was distinctly tubular at the right base.

By April 20 the dulness was less marked posteriorly, and breathing was not tubular. Crepitations were still abundant; the tongue was cleaner. Frothy expectoration noted for first time.

On April 27 the patient had an attack of otorrhea. The temperature was then 101.4°.

From May 1 to 5, the temperature was remittent. The left apex and right base still showed signs of consolidation.

The patient recovered from the acute attack about May 12, but was still very weak. The breathing was better and the fever had subsided. There still remained some dulness at the right base and over left apex. The breathing was harsh, and there were still some crepitations.

The treatment adopted was that recommended further on in this paper. The medicines used were ant. tart. 3x, trit. for the first few days, followed by phosphorus 3x and at a later stage arsenicum 4x; two drop doses of veratrum viride ϕ were given when the temperature was high. During the fourth week the medicines used were arsen. iod. and calc. carb., together with cod liver oil.

The general treatment of these cases consists in putting the patient to bed in a warm room, carefully avoiding any draught, for which purpose, if necessary, a curtain may be placed around the bed. A bronchitis kettle is useful in many cases, both in rendering the breathing easier and also in helping to loosen the expectoration. Poulticing is only admissible in the earlier stages, or in mild cases. A jacket poultice, as often recommended, only interferes with the respiration, especially when there is much dyspnoea; the muscles have usually enough to do without lifting a heavy poultice up and down, and for this same reason care should be taken that the child, although sufficiently covered, is not in any way bound or wrapped up tightly in blankets or shawls, as is so often the practice among the poorer people. Cotton wool may be placed over the chest loosely, and it should be changed every day.

Ice bags have been highly recommended, but they are only admissible when the patient can be carefully watched, and the applications frequently changed. In a dispensary

practice it is therefore impossible to apply them, even with the help which is received from the district nurses, of whom I am glad to take this opportunity of saying we owe a great deal for the care and attention which they give to our patients. Most cases of bronchopneumonia call for the administration of stimulants, for there is always the danger of cardiac failure, from the extra work which is thrown upon that organ.

Not the least important stage of a case is that of convalescence. It is well during this period to keep two aims in view. In the first place, to restore the strength of the patient by strengthening diet, change of air, &c., if possible, and in the second place, by the aid of well chosen medicines and cod liver oil, to lessen the chances of tuberculous deposit.

With regard to homœopathic medicines, I do not wish to take up the time by mentioning all the possible remedies, but will content myself by simply mentioning a few, which I have found the most useful.

Ant. tart. only in early stages, when there is not much pyrexia, but a great deal of bronchitis.

Arsenicum.—Although it does not correspond to the pathological condition, I have found it very useful in those severe cases where there is high fever, adynamia, dry tongue, sordes on the teeth, frequent thirst for small sips of water.

Phosphorus, I need hardly say, is a very useful medicine, and very efficient in most cases.

Veratrum viride I have used in two or more drop doses of the mother tincture, where the temperature is very high, the pulse very quick.

Hepar. sulph.—When the expectoration has become muco-purulent—towards the decline of the disease.

Arsen. iod. and *Calc. carb.* during convalescence; the former especially in cases suspected to be tuberculous.

I do not wish it to be thought that these medicines should be given empirically; as in other diseases so in bronchopneumonia, the remedy should be chosen which most effectively covers the symptoms and conditions present. For here as elsewhere the law of similars holds good.

Dr. HAYWARD agreed with the remarks of Dr. Thomas, with regard to poulticing, as the weight of a poultice often adds to the difficulty of breathing. The treatment of bronchopneumonia is a feather in the cap of homœopathy, its statistics are so good that we feel that no other treatment can be so successful. Dr. Thomas had not mentioned aconite—very useful when there is much restlessness and tossing about. He would feel more confidence in postponing the use of arsenic, in favour of the more marked pathological remedies, such as phosphorus, bryonia and antimonium tart., which all bring about pathological effects similar to the disease. The symptoms of veratrum-viride are much the same as those of aconite; but the skin is not quite so dry, and the restlessness not so marked. He thought that calcarea carb. was more likely to be called for than arsenic. iod. at the stage of commencing tuberculosis.

Dr. GORDON SMITH considered the use of kali. bich. in certain cases beneficial.

Dr. HERBERT WILDE asked Dr. Thomas what proportion of those cases that develop into phthisis he would consider bacillary. He had not discovered bacilli except in one case, out of many he had examined. He found phosphorus more reliable in these cases than any other drug.

Dr. CAPPER agreed with Dr. Thomas as to the hopeful prognosis, even in very severe cases. Bronchopneumonia was one of the most prevalent diseases in dispensary practice, and he had had experience in a large number of cases. They frequently get better after lingering for weeks. With regard to poultices, he was inclined to use them occasionally, and had certainly seen benefit from them. He found arsenicum and phosphorus by far the most useful medicines, arsenic so well meeting the adynamia so often manifested. He mentioned the value of ipecacuanha in certain cases, and also referred to spongia, iodine and calcarea phosp. He thought aconite only useful in the earliest stages, or when new patches of inflammation were commencing to be developed in the course of an attack.

Dr. JOHN HAYWARD agreed with Dr. Capper as to the sphere of aconite. He had found ipecacuanha very useful. He had lately been converted from the use of poultices, as they are frequently left on until much harm is done by cold air circulating between them and the skin. He usually ordered camphorated oil to be rubbed into the chest. It had probably some reflex effect, and undoubtedly did good. He considered bronchopneumonia one of the most fatal diseases in fat children. He.

referred to the value of quarter-grain doses of ammonia carb., administered every hour as a stimulant, alcohol often increasing the cyanosis. Ammonia carb. had also an elective action upon the lung, and he frequently administered it in alternation with the specific remedy.

Dr. GREEN agreed that hope should never be abandoned in these cases. Cases of this disease helped much to convince him in his early studies of homœopathy. Solanium acet. was of much value in asthmatic cases. He seldom employed poultices, but sometimes used a thin one without much weight, a mustard leaf or hot cloths. He had often found brandy of service. With regard to the pathology, theoretically there would be inflammation in the alveoli, but not in the bronchioles. The structure is almost identical, and this probably never really happens. He regarded the use of camphorated oil as something more than a placebo.

Dr. ELLIS said that he was glad to hear Dr. Wilde speak so well of phosphorus. Although antimonium tart. appears more homœopathic to catarrhal pneumonia, he had found its use disappointing. He agreed with Dr. Capper as to the occasional efficacy of poulticing, as he had seen cases much improved when they had been employed by patients without his instructions. Stimulation by turpentine stupes was very useful. He thanked Dr. John Hayward for his hint with regard to ammonia carb. He had used it in his early days of practice, but had lately neglected it. One lesson he had learnt from the late Dr. Drysdale, was the bad effect of too much stimulation, and consequently ultimate depression. He was not so much inclined to be sanguine as to the prognosis. Very many cases of phthisis began as bronchopneumonia.

Dr. GORDON said that his experience of the disease was not a particularly happy one. He would have been more interested if Dr. Thomas had given the medicines used day by day in the case he narrated. There was no question as to the value of phosphorus. Antimonium tart. did not prove of so much benefit as might be expected. Veratrum alb. came in well in some cases. With regard to poulticing, he thought that the friends of patients ought to be indulged in this respect if they wished it; otherwise the doctor would be blamed in the event of a fatal result. He had found one drachm of eucalyptus oil to two ounces of olive oil very useful as an inunction.

Dr. CHARLES HAYWARD considered two drops of veratrum viride a very strong dose for a child. He had used solanium

acet. for adults with very disappointing effects. He had found carbo veg. and ammonia carb. much more useful. Where antimonium tart. failed, calcarea carb. frequently succeeded.

Dr. HAYWARD thought that probably the evidence against antimonium tart. in such cases was on account of the exhibition of too low a potency. The best results were obtained from the sixth centesimal.

Dr. HAWKES said that iodine should be thought of in cases of emaciation, or where harsh breathing became a prominent symptom. He had found phosphorus the best remedy, but it should be used in pilules, and in the third centesimal. Antimonium tart. he had found disappointing in all strengths. Hughes recommended arsenicum, and he had found it valuable. He had almost discarded poultices. Sulphur was useful in chronic cases. He asked Dr. Thomas whether he had noticed that bubbling râles lead to a bad prognosis. He did not often use bryonia in catarrhal pneumonia. Lycopodium he had found disappointing. Broncho-pneumonia of pertussis was often helped by coccus cacti and cuprum. The physician should always be on the watch for pleuritic effusion, and be ready to aspirate if necessary.

Dr. THOMAS, in reply, said that he had seen benefit from poultices in early stages, and in mild cases. He had not used ammonia carb. as a stimulant, but had seen no bad effects from the use of brandy. In answer to Dr. Charles Hayward, he said that he had tried veratrum viride 1x, to reduce the temperature, but without good results.

ON ANTISEPTICS: WITH ESPECIAL REFERENCE TO THE USE OF OZONE.¹

BY EDMUND A. COOK.

I PROPOSE that we should exchange our opinions upon the subject of antiseptics generally, and should devote a little attention to ozone in particular. Of course a great deal that I have to say is already known to most of you, but if we exchange our opinions, if we discuss a matter such as this, which though old has many points which may be new to many of us, we may each derive some benefit, although

¹ Read before the Society, June 1, 1893.

we may disagree on many points. The antiquity of the subject is simply beyond historical knowledge; because there can be no doubt that the earliest literature, the earliest laws we have, contain many elements which show that the writers of these laws had an intimate knowledge of antiseptics. This was shown, for instance, in the ideas underlying the Levitical directions which were distinctly antiseptic, when it was ordered that the blood should be taken without the camp and the refuse be buried, and in the rite of circumcision. And we know quite well that without these ordinances disease would have super-vened quite rapidly. And we find that even in modern times there is a process for the disinfection of sewage matters which is called the A B C process. Years ago when that process came out I asked the patentee, Why on earth he called the process the A B C process, and he said "I will tell you. I got it entirely from the Bible, from the ideas given there in the Levitical directions as to the disposal of refuse and sewage."

Of course we cannot pretend to anything new. The germ theory of disease which has been sprung upon us as new and fashionable in medicine is really only the old fashion sprung up again, like the crinoline and other matters. A century and a half ago there were men insisting with great vehemence upon the truth of all or most of the ideas which are current in our midst to-day. The germ theory was in fact the same as the one of the present day, only it did not take rapid hold of the minds of those who heard it, and, therefore, by and by it dropped out of fashion. Then, again, in mediæval times we seemed to have gone back, and when Sydenham, the prince of English physicians, arrived upon the scene, people appeared to have gone back to utter ignorance of most antiseptics. Still there was a glimmering of reason and common sense in their proceedings, for they strove to imitate nature; when they noticed that the disease caused excess of heat in the patient they strove to encourage this high temperature; they had noticed disease growing better after a sweat, they strove to promote perspiration—truly in an ignorant and

crude manner and utterly oblivious to the fact that fresh air had anything whatever to do with the matter, and, therefore, they excluded that. Sydenham reformed the whole medical treatment, and produced an era in the medical profession, running counter to every prejudice and rousing every opposition which vested interests could provoke. In modern times we have improved and do not treat people by exclusion of fresh air.

Of course now we know everything, "we are the people and wisdom shall die with us." Everything is a microbe which is not the product of a microbe, and every disease under the sun is the product of a microbe in one or other shape or form. This of course was taking things to an extreme, and no doubt with the re-swinging of the pendulum in this matter they would by and by think that everything was amicrobic and that disease might be caused by disinfection. Each medical observer believed that by this theory there was something to kill in the pursuit of his vocation, and each scientific observer seemed to think that the perfection of killing in scientific matters was obtained when everything was killed—only the thing to be killed was not himself. I venture to demur to this. Let him put forward the not altogether original proposition that the struggle for existence was eternal—eternal in the sense of penetrating all claims of existence, and an imperative law of nature emphasised by the fact that nothing would nourish us but what had had life.

But, regarding with respect only our own life, we find even on that view forces—vital forces—arrayed against us and for us, and at the present stage of the conflict it was not exactly wisdom to act so crudely as to destroy all and sundry in our efforts for self preservation. The true interests of self preservation would teach us otherwise. Take, for example, the parasites found in plants. A plant is infested by one parasite, and if we look further we shall find there is yet another there whose function is to prey upon the first, absolutely aiding the higher organisations by so doing. But we in our ill-judged application of antiseptics slew one and all; we got the idea into our

minds that a substance was a good antiseptic because it destroyed all life with which it came in contact; our methods were carried on without regard to whether we were slaying our aids and friends or our enemies.

It was now fully recognised that the white amoeboid corpuscles of the blood were microbe destroyers and they can only act best when individually in the best state of health. Every medicament which debilitates them acts in favour of the microbe, and no matter how deadly it may itself be to the microbe, cannot be a proper antiseptic on account of its debilitating influence on the phagocytes. Take, for example, the action of corrosive sublimate; its dose (allopathic) is from 1-16 to 1-32 gr. It is of all popular antiseptics one of the most deadly. We are told to use it in puerperal cases in the proportion of 1 to 1,000, and to use as an injection *per vaginam* of about 1 pint. Now 1 to 1,000 will be 1 gr. to about 2½ oz., and after injecting a pint it will be almost impossible not leave behind at least 1 oz.; that is to say by the use of this antiseptic to prevent microbic life we administer to the woman ½ gr., equal to eight fair doses of this poison, and then we consider we are scientific! If the woman before the administration was not liable to microbic infection the absorbed poison will so debilitate the corpuscles that she will be a prey to any microbe which floats, and if you point to statistics proving great improvement in recoveries since the use of this treatment, I would rejoin, so much the worse; for they have been in spite of it. I would put forward the proposition that in any human being when the phagocytes were in vigorous health they were all-sufficient to deal with microbe life, when they are in feeble health the microbe gains ground—that, in fact, as they talk of a *vis medicatrix naturæ*, I might insist on a *vis antisepsis naturæ*. Therefore anything which debilitates the amoeboid corpuscles did absolute harm when they sought to do good.

We attack microbic or septic material (1) in the air, (2) in the body, (3) on the surface of the body, and speaking generally the average medical man believes, and certainly the average lay man believes, that if he set up a noxious odour sufficient to overpower a smell which he believed septic, we

might take it for granted we were safe. Instances will occur to all of you. I will instance the case of a street urinal where some antiseptic would be found, it might be chloride of lime or carbolic acid. It was absurd to think that chloride of lime when it came into contact with urine served any useful purpose as a disinfectant in the quantities used. When chloride of lime comes into contact with urine it begins immediately to decompose the urea, and as this latter is in excess there is no chance of any destruction of septic material—or if carbolic acid be used the result would be no better. Lauder Brunton writing of carbolic acid says: The results of experiments made in this way were very surprising. It was to be expected that carbolic acid would readily destroy the spores, but this was not the case. A 1 per cent. watery solution had almost no effect on them even after fifteen days' exposure. A 2 per cent. solution slightly retarded their growth, a 3 per cent. killed in seven days. Bear these proportions in your mind and then see what application is made of this substance. When a noxious odour was likely to occur, or when septic material existed, a man came round with a canister similar to a large pepper box, and dusted a small portion of powder over a grating or heap of matter. The powder contained about a quarter available carbolic acid, the rest being inert matter,—the percentage proportion to septic material being about 1-10,000; and this was thought sufficient to disinfect in spite of proportions proved necessary to do any good.

If we apply antiseptics to fever of an infectious character in the body, we think we have done enough if we lower the temperature; and on the surface of the body the treatment of wounds is considered correct, if we can freely smell the antiseptic. Now, in all septic life, as in all life, there are (1) the vitality, (2) its environments essential. If a wound were treated in a moist atmosphere, whether with or without antiseptics, it would require far more care than in a dry atmosphere, for an environment of moisture was the very best for growth of septic germs. There were places on the earth where wounds never did well, there were others where wounds never did badly, and the

difference was due to presence or absence of moist heat. For instance, there was a place south of Los Angeles in Southern California having on its east high snow-capped mountains, and during certain months the wind came down from the mountain summit losing in the cold region all its moisture by congelation ; descending gradually into warmer regions it licked up every particle of moisture in its way, and with its gradually increasing temperature being more and more greedy for all it could get ; the result being that when it came to the plains it was so dry that men living there and striving to write with a lead pencil had to keep another in a vial of water by their side so that when the one got too dry and hard to write it might be changed for the wet one ; that fresh eggs laid exposed to the atmosphere quickly lost so much moisture from the inside that a hard mass was left, and respectable hens had got the reputation of laying them hard boiled ; that men wishing to light the gas needed no matches, but simply turning on the tap ran the hand through the hair and then held the finger near the pipe, when an electric spark did the needed lighting. In such an atmosphere, wounds could not but heal ; but mark the combining causes, dryness, and the fact that every movement generated electricity, and electricity ozone—nature's own disinfectant ; and the ozonised air being breathed as well invigorated the phagocytes, and microbes had no chance. Note well the fact that the ozonised air not only affected for good the open wound ; but by its powerful oxydising properties, combined with its diffusion, its inhalation was of immense benefit.

If you would realise the full extent of the problem on a large scale, picture yourself on the top of St. Paul's with the crowded mass of living material for more than a hundred square miles beneath you ; men and women with their exhalations, with the exhalations from sewage material and myriads of animals, with the smoke impurities, all gathered together in one vast whole ; where for weeks together sometimes there was not wind sufficient to lift the overhanging pall of fog, and then think, if you can, that the man with the disinfecting pepper box can further any good purpose ;

and more, when you have in that seething mass hospitals for cure, surgical wards for operation ; is it any wonder you lose cases—is it not a marvel you cure any? I have said that in my belief nature's own antiseptic is this ozone. The difficulty has been hitherto where to get it and how to apply it, because you know that no sooner does ozone come into contact with organic matter than it is decomposed. Ozone is the product of the action of the electrical discharge on oxygen ; it renders the oxygen active, it condenses it in bulk ; the specific gravity of ozone is known to be greater than that of oxygen as three to two.

The question was how they were going to produce this matter in such quantity as to render it effectual. Hitherto, all ozonisers for the last decade or two had been such as to demonstrate the presence of ozone in a small way, so that if they applied the nose closely they could smell it. Up to within recent times those were the only ozonisers practicable at all. Now, when I tell you that ozonisers are produced capable of making ozone to such an extent that it was proposed to do away with all other means of bleaching, you will see at once that it could be applied to disinfection. Whether or not it would be a commercial success, it ought to be perfectly possible to apply it to ordinary hospitals. Sir B. Ward Richardson some years back stated that ozonising the air of wards was distinctly the best way of aiding recovery of the sick. With the ozoniser he used, he found there was apparently some irritation of the bronchial tubes in certain cases. I obtained the ozoniser Dr. Richardson used, and used it to the best of my ability ; I put it in a sick room and got quite as much ozone as it would yield, and in no case did I find irritation of bronchial membranes. The only way, in these days, of producing ozone was by means of the electrical current, wherever an electrical current could be got ; and the ordinary house supply was practically the best. Practically the simplicity of the whole business was such that there was no excuse, so far as trouble and expense went, against it being adopted in every hospital ward which was supposed to be scientifically conducted. I have with me various ozonisers which have been invented by Mr. Andrioli. The principle of

these ozonisers is one and the same in all; they consist of a glass plate on one side of which is a sheet of tin foil, on the other a plate studded with numerous points. The one side of the plate is connected with one pole from an induction coil or transformer, the other with the opposite pole; when the current passes, the discharge takes place by glow (not spark) from every point, and the air or oxygen passing over the points produces quantities of ozone. The ozonisers now shown have a secondary battery of about two ampères current, but they would be far more effective with a house supply. I believe that even with the secondary battery we can, with these ozonisers in our wards, derive a benefit far exceeding the cost and trouble which is needful to procure it.

Mr. HANBURY (Visitor) remarked that the easy production of ozone was a matter of great importance commercially, that his firm had taken an interest in the matter from a conception of the great use to which it could be put as a disinfectant and deodoriser, and from its general application to medical purposes. Mr. Andrioli had manufactured many forms of his apparatus, all involving, however, the same principle, viz., the discharge of electricity of great intensity silently, and as a flow discharge. He had applied this to inhalers of various patterns and some of these might be seen upon the table. Doubtless the application of ozone to disinfecting rooms and aerating wards of hospitals had a great future before it, and he would be most happy to show any gentleman interested the larger apparatus in full work, producing large quantities of ozone.

Dr. BYRES MOIR said Dr. Cook had brought forward an interesting subject, but he was disappointed that he did not go on to demonstrate the advantage to London of collecting ozone, and distributing it all over London from a central station. He thought he was quite right in what he said with regard to its properties. It was nearly twenty years ago when the subject was brought before the society and in the *British Journal of Homœopathy*, in 1874, by Dr. Scott, exactly on the same lines as Dr. Cook. Air impregnated with less than one in three millions of its bulk of ozone purified its own volume of air loaded with the effluvia of 4 oz. of highly putrid meat, demonstrating the strongly disinfectant power of ozone in all cases where infection depended

on decomposing organic matter. Air containing only $\frac{1}{1,000,000}$ th of its own bulk of ozone possessed a distinct ozonic smell. This was advanced at the time to show the power of decomposing organic matter. This question of ozone was brought forward with a view to its influence on outbreaks of cholera, influenza, and such epidemic diseases; but nothing definite has so far been determined as to whether ozone does influence these outbreaks or not. Country air, with a fair proportion of ozone, was said to be favourable to vegetation, but air strongly impregnated with ozone was said to destroy—or at all events retard—the growth of plants.

Dr. DUDGEON said one great advantage attending the use of ozone, if it possessed the antiseptic qualities described by the reader of the admirable paper, was that it did not seem to do any harm. All the other antiseptics that they were acquainted with were more or less dangerous in their application. No doubt perchloride of mercury was a dangerous antiseptic when applied in any but very minute quantities. The great Lister, who made his fortune and received his baronetcy in consequence of having invented the carbolic spray, declared at the Berlin Congress that he was ashamed that he had ever done such a thing. Carbolic acid was often injurious to the patient—which might be endured, as patients are made to suffer; but it occasionally injured the operating surgeon, and that could not be tolerated at all. The only question about ozone was whether it could be generated in such quantities as to be employed as a disinfectant by the ingenious little apparatus they had seen that evening. If they could ever get an ozoniser, as had been explained, on the top of St. Paul's, to disinfect the whole of London, that would be a great triumph of art; but it remained to be seen whether it could be produced on a sufficiently large scale to be effective in unwholesome localities.

Dr. CLIFTON said that with regard to earth as an antiseptic, for many years he had employed it as a dressing to varicose ulcers of the legs, and found that, with the earth changed two or three times, it was a great benefit. Were they to understand that in what they called ozonised fluid there was no good?

Mr. KNOX SHAW regretted that his knowledge of chemistry prevented his doing full justice to the reader of the paper, and entering into a learned controversy as to the chemical part of the subject he had brought before them. But as a practical surgeon, one who was always anxious to hear and learn anything that would advance one in one's method of treatment, he would offer a few remarks. The principles brought before them were those of

aerial disinfection; and from Sir Joseph Lister, who was one of the greatest exponents of surgical disinfection, they had gathered that after all it was not in the air that they must look for the source of the danger in their surgical operations, and that was why he gave up the use of the spray; that he had formerly looked to the carbolic acid to destroy the germs that were floating in the atmosphere, and so prevent them falling on the wound, whereas he had now discovered that it really did not so very much matter about using spray at all, as they could not with any success attempt to kill the germs in the air. So that though it might be an excellent plan to supply what was lacking in the atmosphere in the way of oxygen, the oxygen being consumed by the human beings around them, it was a different thing when they came to apply it practically to the treatment of surgical wards. He had hoped that Dr. Cook would have enlightened them a little more as to this. He believed that there were certain forms of disinfectants which rather based their claims to use upon their being ozonised. He thought Kingzett, in his "sanitas" produced by the oxidation of turpentine, claimed it to be an oxidising agent with a certain proportion of peroxide of hydrogen, and therefore an ozoniser. They would still be obliged to carefully sterilise their dressings and instruments if they relied entirely on ozone in their room for operating. Many persons had owed their death to the excessive use of perchloride of mercury. Could ozone be used locally in the lotions? He would ask Dr. Cook to give those who were surgeons a little inkling as to how they should manage their cases if ozone were to fulfil all the expectations he wished them to believe as likely to come from its general use.

Dr. HUGHES expressed his profound sympathy with the end Dr. Cook had proposed to himself in his excellent paper. It was to do away with the poisonous germicides hitherto in use, substances injurious to host as well as to guest, and to substitute nature's own antiseptic, in its most concentrated and active form of ozone. The only question in his own mind was whether ozone was truly germicide, *i.e.*, destructive of the vitality of the bacilli of specific diseases like charbon and relapsing fever, and not merely a checker of putrefaction and other septic changes. He would be glad if Dr. Cook could resolve this doubt.

Dr. GOLDSBROUGH doubted if they were all so fully impressed with the importance of the subject as they ought to be. There were several considerations which arose to his mind upon which he would like Dr. Cook's opinion. They had first the important question as to the quantity of ozone. What was its

effect? If produced in quantity and applied to certain surfaces of the body there would be some pathological changes seen, so that there might be danger in its use as an antiseptic. The question as to quantity then was a very practical one. He (Dr. Goldsbrough) took it from Dr. Cook that as he considered ozone to be nature's own antiseptic, it was so by virtue of the production of free oxygen or pure air. Dr. Goldsbrough remembered visiting Professor Hamilton's laboratory at Aberdeen, when the professor mentioned—in regard to the cultivation of bacteria—that if the cultivating media were taken down to the sea-shore, the bacteria could not be produced or propagated. Was this due to the increased amount of ozone wafted from the sea, or to what might be termed a normal standard of purity in the atmosphere, containing a certain amount of ozone in relation to its oxygen? Dr. Goldsbrough thought the safe ground to go upon was to ascertain the standard of the purity of the air which would prevent the cultivation of bacteria, and this would pave the way for the application of ozone in cases of surgical procedure. The surgeon did not want *any* putrefactive changes to take place in or near his patient, and his great object was to create an environment where these changes could be avoided. Another point of great importance in relation to the employment of antiseptics was the state of vitality of the patient, and here the question of homœopathic medication was closely allied, and the use of medicines in all cases where antiseptics were called for was a right use.

The whole subject was more or less surrounded with uncertainty, and yet we seemed on the verge of a great advance, which would be aided by the steps taken by Dr. Cook.

Dr. DAY said that that day he had learned a thing which he did not know before, and he thought it was appropriate to the subject under discussion; viz., the use of charcoal in the arrest of putrefaction. A patient of his told him that he had been in the habit, for many years past, of using charcoal in the larder to arrest the putrefaction of meat in hot weather. This charcoal lasted for an almost indefinite period, and it proved most efficacious in entirely preventing bad smells, and game that was quite high was rendered eatable after being cooked with a piece of charcoal enclosed in it. He had been thinking whether it would be desirable to surround *septic* ulcers, &c., with bags of charcoal in a dry form, or, on a larger scale, by surrounding the patient with troughs or other receptacles filled with charcoal, which would have the triple advantage of safety, simplicity and economy. For this purpose charcoal should be used dry, and not moistened as in the form of the charcoal poultice.

Dr. THOMAS thought the good they got from the use of ozone was in the readiness with which it parted with its oxygen, and nature's best antiseptic was plenty of fresh air, which contained plenty of oxygen. There was one method which had not been mentioned, by which they could apply oxygen locally, and in an easy form, and that was by the use of peroxide of hydrogen. He had tried it in one or two cases of unhealthy ulcers, and had found it of the greatest benefit in stimulating the parts, and bringing about healthy action; and until they could get oxygen more easily he should suggest that peroxide of hydrogen might be used locally in the case of wounds.

Dr. BURFORD, after expressing high approbation of the character of Dr. Cook's address, said Dr. Cook sometimes became the victim of a scientific imagination. They had had elaborately presented to them that night that ozone would do this, that it might do that, or that it ought to do the other. They had had presented to them the superstructure of theory, requiring as its correlative a more developed basis of experiment. He had missed that record of experiments and that series of interrogations of nature which would have carried much more permanent conviction to them than what they had had, valuable as it was, of Dr. Cook's own intense personal convictions. He took it that some points which had been supported, would not have been supported had they had a more scientific observation in the way he had indicated. He must not be supposed to be detracting from the unanimous appreciation accorded to the view of importance of antiseptics, and the whole value of ozone from the point of view that it was a safe antiseptic. But he would point out that they had arrived at a newer and better way; viz., that as prevention was better than cure, to prevent bacteria from increasing was far better than the use of any antiseptic ever discovered. The best scientific demonstrators of this were Tait and Bantock, who, with most satisfactory results, paid no attention to antiseptics at all. With regard to the illustration of ozonising London from the top of St. Paul's, people might be found in the future to object to compulsory ozonisation, as they now objected (and rightly) to compulsory vaccination. In conclusion, he trusted that next year they would have the pleasure of listening to Dr. Cook again on the same subject, but with the counterpart of this evening's address, i.e., a series of original experiments and observations on the antiseptic powers of ozone.

The PRESIDENT (Dr. Blackley) said he thought all of them were at one with regard to the necessity of doing away with a

great many of the powerful antiseptics that had been used for so long, and there was undoubtedly a great opening for something that would act beneficially, without in any way prejudicing the health of the patient. He had himself, for a good many years, been accustomed to use peroxide of hydrogen, and he had been extremely pleased with it. Several speakers had suggested that they wanted more precise information as to the application of ozone, and whether it was an applicable remedy for disinfection. That, he took it, was really the thing they would like very much to know. Of course, dry ozone was all very well for the purpose of counteracting the germs floating in the air of a sick ward, although even there they would like a little information as to whether the air of a perfectly dry ward was as easily disinfected as if there was moisture present. Peroxide of hydrogen was a substance easily made use of, and if ozone was—as it appeared to be—more powerful still in its effect, they would be glad if Dr. Cook would tell them if it could be used in a similar way to the peroxide solution. Of course, permanganate of potash had a great reputation as giving off nascent oxygen; but its cost, if it is to be effective, was enormous. He had heard of a small fever hospital, where the estimated cost of properly disinfecting the dejecta of the typhoid cases was estimated at something like £10,000 a-year. Many speakers seemed to have missed one point, viz., that ozone was more than pure air; ozone was something more than pure oxygen, or even nascent oxygen. It was oxygen in a very active form, and as such was very acceptable. Dr. Burford had been talking about his ideal antiseptic. They had air which was septic, and if Dr. Cook or Dr. Burford could tell them how to make it aseptic, they would be leading them a great way.

"ROARING" IN INFANTS.¹

BY DUDLEY WRIGHT.

Surgeon, Diseases of the Throat, and Assistant Surgeon, London Homœopathic Hospital.

I AM fully aware that in choosing the name "roaring" to describe the disease I am about to speak of, I have not hit upon a very happy word. I know well that it is bad, both on account of the fact that I am thereby naming a disease by one of its symptoms, and also that, inasmuch as it is the name used to designate a particular disease in horses—a disease somewhat different in nature from the one under consideration, confusion and misconception therefrom are liable to result. I have, however, been almost compelled to adopt this name, since, for reasons to be mentioned hereafter, the cause of the disease is not sufficiently clearly defined to justify one in adopting a nomenclature based on pathological grounds.

Dr. Robertson, of Newcastle-on-Tyne, it is true, in writing on the disease in the *Journal of Laryngology*—which treatise, by the way, is the only one on the subject I have been able to find in medical literature—calls it "posticus paralysis in infants;" but though it is probable that the peculiar symptom which is almost the only objective feature of the malady is due to bilateral paralysis, or more strictly speaking, paresis of the posterior crico-arytenoideus, still, since this point has not been determined, owing to the difficulty in making a laryngoscopic examination in infants, I do not think we are justified in using this term. Dr. Robertson recognises this and, therefore, uses it only provisionally, and I, likewise, am quite willing to accept a more fitting one whenever suggested.

Chronic roaring in horses I mention solely for the sake of showing that it is in most cases—for the term has rather a loose application—somewhat allied to, though differing in degree from, the one under consideration.

¹ Read before the Society, May 4, 1893.

By examining the figure shown in Fleming's work on "Chronic Roaring in Horses," it will be seen that the roaring is due to a more or less complete paralysis of the left vocal cord, the muscle most affected being the crico-arytenoideus posticus of that side, which in the figure is seen to be wasted and converted into a shrunken mass of fibrous tissue, whereas its fellow is clearly defined and manifests even some amount of hypertrophy.

This paralysis has been caused by pressure upon the left recurrent laryngeal nerve, and this pressure is usually exerted by enlarged bronchial glands, but can, of course, be caused by any tumour in any part of the course taken by that nerve. As a result of this paralysis the cord assumes the cadaveric position, and hence forms an obstruction to the entrance and exit of the air, dyspnoea and stridor being the result, the latter accompanying both the expiratory and inspiratory acts, and being more marked the greater the volume of air passing the obstructed point, and hence accentuated during violent exercise, &c.

In infants, however, the paralysis is probably bilateral instead of unilateral, and further, is limited to a single pair of muscles, the *posterior crico-arytenoidei*—the abductors of the vocal cords. A corresponding important difference in the objective symptoms exists in the fact that stridor only accompanies the act of inspiration.

The following three cases met with amongst the patients of this hospital—two having been under Dr. Moir, by whose kindness I had many opportunities of examining them, and the third one of my own patients—will give you a fairly good picture of the disease.

The first case, that of a little boy, aged 4 years, was brought to the hospital in December, 1890, for marked stridor, accompanied by some dyspnoea. There appeared to be a suspicion of a syphilitic history, the mother having had a rash and sore throat, and the child likewise had had an eruption which appeared on the buttocks as well as other parts of the body. The rash had disappeared at 6 months of age, at which time the child was vaccinated. The present difficulty in breathing came on at 9 months of age. It

commenced gradually, and reached its acme in about a month, and remained in a stationary condition for three years. The noise was always present, even when asleep, and it was so loud that people living two floors above could distinctly hear it.

The child had been treated at the Children's Hospital for some time but without apparent benefit. On admission there was a good deal of wasting. Dyspnoea was marked and breathing noisy; there was a depression at the ensiform cartilage and lower ribs with each inspiration. Examination of chest showed no abnormal area of dulness in front. The area of heart's dulness was diminished. There was tubular breathing over the upper end of the sternum with bronchial breathing on each side over the situation of the bronchi. Breathing at apices normal. Behind, beyond tubular breathing over the course of the bronchi, there was nothing of importance found. The trachea was slightly deviated to the right in the neck, and all the extraordinary muscles of respiration were brought into play, and the jugulars were much distended. The glands on either side of the angle of the jaw were slightly increased in size. Examination of larynx was not possible. The abdomen was slightly enlarged, the area of liver dulness being increased upwards, but no enlargement of the spleen was found. During his stay in the hospital, which was short, there was no great change. The temperature did not rise except at the end, when measles developed and the patient was discharged. It was noticed that the breathing was much more noisy during sleep. Treatment consisted in the administration of biniodide of mercury 3x, gr. 1 t. d. s., and belladonna 1x, mj. p. r. n.

Six months later, the child was re-admitted with symptoms of meningitis, which proved fatal within three days. It was noticed that the breathing had entirely lost its stertorous character, but that the cough was slightly "croupy."

At the *post-mortem* examination, inflammation of the meninges was present, but no tubercles. The pleurae were normal, and beyond some collapse of the middle lobe of the right lung, these organs appeared healthy. The thymus

was very large. The larynx and trachea were removed, but on examination they showed no gross lesion to account for the noisy respiration.

The second patient of Dr. Moir's was an infant aged 2 months. There was a distinct syphilitic history in the family, and the child itself suffered from snuffles, flattening of the bridge of the nose and mucous tubercles. The disease lasted until the child was 9 months old and then disappeared, the treatment being mainly the biniodide of mercury. The notes of this case are unfortunately scanty, and no remarks are made of the actual symptoms present.

The third patient was one of my own aged 14 months, who was brought for the noisy breathing which had been present almost since birth. No distinct history of syphilis could be obtained, the child had had bronchitis but no other illnesses. The noise, which was like a loud snore, was present only in the inspiration, the voice was normal in quality and quite powerful. Examination of the larynx was not possible. Auscultation showed that the noise was heard most distinctly over the thyroid cartilage. Examination of the chest gave a negative result. The patient was ordered biniodide of mercury, 3x, gr. 2 t. d. s. This was on January 20, 1890. On February 8, the child was brought back very much better, and on February 22, his third visit, thirty-three days from commencement of treatment, the noise had completely disappeared and the breathing was natural.

Dr. Robertson, in the paper referred to, gives details of three cases and mentions three others, six in all. His treatment consisted mainly in the administration of bromides, intubation of the larynx and removal of post-nasal adenoids when present. The three cases of which details are given recovered or greatly improved within a month or two, and none were immediately fatal. No mention of syphilis was made.

We have then here a distinct disease attacking young children varying in age from a few weeks to eighteen months and causing chronic inspiratory dyspnoea and marked stridor in breathing. The disease moreover attacks children in bad health, especially those who are the subjects of congenital syphilis.

The peculiar noise made is similar to that present in croup, it is only heard during inspiration, it is worse during sleep, and is never entirely absent at any time during the course of the disease; further, the voice remains unaffected. The disease is, as I have said, chronic in character and tends to persist many months or years if untreated. Had it been possible in any of these cases to have examined the larynx, our knowledge of the cause of these symptoms would be complete, and we could say with certainty whether the vocal cords were at fault or not; but hitherto the opportunity to do this has not presented itself.

In order to arrive at a knowledge of the nature of the disease we are compelled to adopt a process of exclusion, to put out of court those which we can prove it *not* to be, and then see what is left to choose from. Let us do this.

1. *Croup*. — Ordinary croup, understanding thereby a croupous inflammation of the mucous membrane of the larynx, it certainly is not. The length of time present is quite sufficient to preclude this; moreover, I do not think we should ever find a case of croup in which the obstruction to the breathing had become so great as to cause the amount of stridor noticed in our cases, and yet leave the voice intact. The same applies I think to chronic subglottic laryngitis, in which, moreover, the stridor is present both during inspiration and expiration.

2. *Spasm of the larynx or laryngismus stridulus* need not be confounded with the disease under consideration. The power to cough, the clear voice and the length of time over which the disease extends again afford a distinction.

3. *Growths of the larynx*, especially papillomata, are commonly met with in children, and might easily give rise to similar symptoms; but inasmuch as such growths occur on or around the vocal cords, the voice would in all probability be affected at some time or other during the course of the disease.

4. I think likewise we may exclude growths pressing on the trachea from without, such as enlarged thyroid or thymus or other glands. The thyroid has never been noticed larger than natural, and in the case in which the thymus was found

enlarged at the *post-mortem* it exerted no abnormal pressure on the trachea; besides this, pressure from without would not cause inspiratory dyspnoea and stridor only, but both inspiratory and expiratory.

It is to an unnatural position of the vocal cords that I think we must look for the explanation of the disease, and that abnormal position brought about not by spasm but by paralysis. The only muscles which in a state of paralysis could bring about this condition of affairs are the crico-arytenoidei postici. A bilateral inactivity of these muscles will produce all the symptoms enumerated, to wit, inspiratory dyspnoea and stridor and the maintenance of a clear voice, and I think that we may assume that this is the correct explanation. But into the question of how that paralysis was brought about in the various cases I cannot enter, and will only remind you that it may be caused by pressure either on both recurrent laryngeal nerves or on the trunk of one vagus nerve, or by changes in the spinal accessory root and nucleus. We must also remember that inflammation and adenoid growths of the naso-pharyngeal region may reflexly bring about a similar result.

Inasmuch as there are several ways in which this condition may be caused, I do not think that in every case the origin of the disease will be the same. We can always easily satisfy ourselves whether a morbid condition of the naso-pharynx is the exciting cause, but for the diagnosis of the others mentioned, extreme refinement is necessary, and I do not think this always attainable. That syphilis plays an important part I can quite believe, and the fact that the three cases mentioned improved so rapidly under merc. biniod. lends colour to this view.

I have nothing more to say with regard to the treatment of such cases than that attention should be paid to the local condition of the pharynx and naso-pharynx, and that if adenoid vegetations be found they should be removed. The administration of the biniodide has been so satisfactory that we may almost trust to it alone to work a cure.

Occasion might arise, owing to the intensity of the dyspnoea, for the performance of tracheotomy. Under the

circumstances I should think that intubation would be a far preferable procedure, and we have seen that it was followed by good results in Dr. Robertson's hands.

Mr. Cox had seen two of the cases, and thought that paralysis did not altogether explain the symptoms. It seemed to him that something more might be said for the tracheal pressure theory. They were certainly very interesting cases; in one of them it appeared that tracheotomy would be required immediately, yet the case went on for days without producing any marked exhaustion. He considered that the undoubted benefit obtained from the exhibition of merc. biniod. pointed rather to the presence of enlarged glands than to paralysis.

Dr. ALEXANDER referred to a case of chronic hoarseness of twelve months' duration in a child of 5 years of age, which had resisted medicines that appeared to be indicated, such as causticum, carbo. veg. and phos. He had examined the child repeatedly with the laryngoscope, but had failed to discover any neoplasm or noticeable departure from the normal condition in the vocal cords. He asked Mr. Wright if he thought it likely that the hoarseness in this case might be due to a latent condition such as he had described in his examples of "roaring."

Mr. WRIGHT in reply said that he should have mentioned that the biniodide treatment which had uniformly given such good results originated with Dr. Moir. With regard to the case mentioned by Dr. Alexander, he thought it was probably one of paralysis of one vocal cord due to pressure on the recurrent nerve. In all the cases of "roaring" there was never any impairment of the voice, *i.e.*, the power of adducting the cords was intact. In Dr. Alexander's case he thought the cause was probably enlargement of the bronchial glands, with resulting reflex hoarseness. In cases of pressure upon the recurrent nerve one vocal cord is, or in rare cases, by reason of a mechanism at present not fully understood, both are, completely paralysed, *i.e.*, both abduction and adduction are more or less completely prevented, hence the voice is affected, and there is rarely any marked stridor, the cords remaining in the cadaveric position, and thus a fair sized space is left. Thus there can scarcely arise any difficulty in distinguishing between cases of recurrent and abductor palsy. At the same time it must be remembered that both conditions may be brought about by exactly similar causes.

THE TREATMENT OF CHRONIC OÖPHORO-SALPINGITIS (CHRONIC INFLAMMATION OF THE UTERINE APPENDAGES).¹

BY D. DYCE BROWN, M.D.

Consulting Physician to the London Homœopathic Hospital,

AND GEORGE BURFORD, M.B.

Physician to the Gynæcological Department, London Homœopathic Hospital.

I. BY D. DYCE BROWN, M.D.

IN having the honour of, acting with my friend Dr. Burford, opening the discussion on the above subject, I would draw your attention to the request that we have received from the Honorary Secretary, that we should not write a *paper*, nor an *essay*, but simply and shortly introduce the subject, and give lead to the discussion. I make, therefore, no apology for my remarks being short, and for not entering into an account of the symptoms of the disease or diseases included in the specified text, nor of their pathology, further than is necessary for the discussion.

The essential questions are—(1) Shall we adopt therapeutic treatment thoroughly and throughout? (2) Shall we, if this fail to cure, give up the case as hopeless of cure? or (3) shall we recommend operation? (4) What are the cases where we should decline to recommend an operation, even though for long we make little progress towards cure by therapeutic means? (5) What are the cases where we should not hesitate to advise operative procedure?

In considering these points, we should remember on the one hand, that persistent and careful therapeutic treatment in structural diseases of other organs does result in cure by homœopathic medication, after having been given up by the old school, and that it is at the best a confession of weakness to resort to operation. On the other hand, in considering the advisability of surgical procedure, we must not resort to it with a light heart, but keep in view—(1) That the operation

¹ Read before the Society, June 28, 1893.

may be fatal; (2) That it is not, as in ovariectomy, kill or cure, but that it may kill, and when it does not, may not cure. (3) That the woman, after operation, is precluded from marriage and child-bearing, and is mutilated in these important organs for life; and (4) That the forcible and premature cessation of the catamenia may be followed by all the evil systemic effects of premature menopause which are so well known. These considerations I do not name to frighten one from advising the operation in cases markedly calling for it, but only to be kept in mind, to prevent our advising such a course without grave consideration. In the title of this discussion, cases of what are sometimes called "pure neurosis" are not named or included. But we can hardly exclude them, since certain operators advise oöphorectomy in cases where the neurotic disturbance both locally and generally is the only disease, and where no evidence of structural disease can be made out. But I maintain that we never, I may say, meet with a case of *pure* neurosis. There is always a certain amount of chronic congestion, engorgement, or inflammatory action existing in cases where no structural disease can be found, and where the prominent features are distinctly neurotic. And, moreover, even where structural alteration can be detected, it is in many cases of a comparatively slight nature, while the main features of the case are essentially neurotic. I therefore propose to include these neurotic cases in my remarks.

In reply then to my first query, shall we adopt therapeutic treatment thoroughly and throughout? I think there need be no hesitation in answering yes. In nine-tenths of the cases we meet, therapeutic means should be adopted fully, thoroughly, and for a prolonged time. My own experience is that by so doing, cases which by certain surgeons would have been relegated to the knife have got well, or so far well as, with care and watchfulness on the patient's part, to enable her to go about and enjoy life. A prolonged time of careful treatment should then be always adopted. In the tenth case, when we may feel rather hopeless of therapeutic cure, owing to the structural lesions we may have discovered, we should still give every chance to therapeutic means, in the hope of

preventing operation, and so doing credit to the advanced methods of homœopathy. I give at the end three cases illustrative of this contention. (2) Shall we, if we fail to cure by therapeutic means, give up the case as hopeless? or shall we (3) recommend operation? To this I would answer, If the case still shows no evidence of marked structural change, and the symptoms, though obstinate, are essentially neurotic, we should not advise operation, as it is in these very cases that the least satisfactory results are obtained. They are often left as bad as ever, or nearly so, and the game is not worth the candle. We should continue to persevere with every possible mode of adjuvant treatment, in the hopes of ultimately succeeding. But on the other hand, if structural disease is manifest, and has become more so, in spite of treatment, then operation should be resorted to. This distinctly answers my fourth query,—What are the cases where we should decline to recommend an operation, even though little progress is made towards cure by therapeutic means? They are those where no structural disease, or only a very slight amount of it, is detected, and where the case is as nearly as possible a pure neurosis. Such cases show bad results after operation, matters being left practically *in statu quo*. A case of this kind was sent up to this hospital to Dr. Burford. At a consultation, it was decided that, being a case such as I have described, operation was unadvisable. The doctor who sent the case was much annoyed, and wrote rather sharply on the matter. She was discharged, and he sent her, I heard, to Dr. Bantock. Perhaps Dr. Burford may allude to this case, and if the doctor who sent the case is present, perhaps he will tell us the result. Fifth and lastly, what are the cases when we should not hesitate to advise operation? These are when the amount of structural disease is so manifest and serious as to virtually preclude the hope of medicinal cure, when the neurotic and general symptoms are subordinate to the local ones, when the patient is precluded from the amount of pain from standing or walking, and when there is rise of temperature at night. In such a case we should advise, at least, exploratory incision, leaving it to be seen whether the parts are so matted with

adhesions as to render further proceedings unsafe, or whether the parts can be safely removed. This doubt, which can only be solved by exploratory incision, is one of the difficult points in such operative procedure. On the whole, I consider oöphorectomy to be an operation which should seldom be resorted to, and then only in cases where nothing else can be done, and where such structural disease exists as to render the woman a complete invalid.

As to the treatment, therapeutically, of such cases, it is impossible in the limit assigned to these remarks to go fully into it. The selection of the remedies depends entirely on the individual case. All I can do is to name those that I trust most in, viz., *actæa*, *ignatia*, *belladonna*, *aconite*, *lilium*, *sepia*, *sulphur*, *calcareæ*, *pulsatilla*, *bryonia*, *mercurius corr.* and *biniod.* Locally hot fomentations and pelvic compress, the latter either in front or all round, acetic acid to spine, and hot injections; also and very important, tepid hip baths for ten minutes at a time.

I shall now add a few cases illustrative of my remarks. I have, I may say, only come across (1) one case where operation was thoroughly satisfactory; (2) two cases where there was a partial improvement, for which the patient was thankful, but not such improvement as, in my mind, could be called satisfactory as a result of operation and its risks. (3) I have met with two cases where no benefit has followed oöphorectomy, and have known of others indirectly. The first was operated on by a well-known and skilful operator of the old school, and the second was operated on by Dr. Burford. He may allude to this case, which he kindly asked me to undertake some time after the operation. This patient still menstruates regularly but with much pain, although both her ovaries were removed. Her general neurotic state is slowly but steadily improving under therapeutic means, so that from not being able to sit up in bed, she has just returned from a trip to the seaside, and has gone off again to Norfolk. I have little doubt of curing this case entirely, but it is now over two years since the operation was performed. (4) Cases cured and much benefited by therapeutic means only:—

Case 1.—Mrs. A., the subject of peri- and parametritis with involvement of the right ovary and tube, firm pelvic adhesions, rendering the uterus immovable and tender; constant discharge of pus through the uterus, coming probably from the Fallopian tube, great tenderness on pressure on the ovary and in the vagina, pain in whole of right half of pelvis and down thigh and leg, preventing her lying with ease with the leg straight out, occasional rises of temperature at night, loss of health, inability to sleep, and inability to be in the erect position without much pain. She was nearly cured, when she got a chill when up out of bed on a cold day, and had a relapse of her former symptoms. This lady was under my care for two years, and then got completely well. She reported herself at Christmas last as quite well, and able to go about with ease. I had not then seen her for over a year.

Case 2.—Mrs. B. had, after a confinement, a parametric abscess, which burst into the rectum. She regained her health so far, but the discharge of pus *per rectum* continued. When I saw her, her health was much affected, she had constant pelvic pain, preventing her attending to her household duties. The uterus was very slightly movable, the roof of the vagina on the right side was hard and tender, and the right ovary was tender and enlarged. Under silica 6 and a daily hip bath this lady reported herself after three months as practically well, able to go about her duties, eating and sleeping well, and with an entire cessation of the rectal purulent discharge.

Case 3.—Mrs. C. had been under the care of a fairly well-known obstetrician in Scotland, who had, from what I heard of his treatment and advice, mistaken the case, supposing it to be only neurotic. I found her with a high temperature, great pelvic pain, sleeplessness, unable to stand or even sit up in bed without pain; her left ovary and tube much enlarged and tender, great tenderness on vaginal examination, and night perspirations. I diagnosed oöphoro-salpingitis, with probably pyo-salpinx, and told the husband that probably operation would be necessary. However, he was anxious to see what therapeutic measures would do. I prescribed aconite, bell., hot fomentations and hot injections, and advised her being placed under the care of another local doctor. Mr. C. reported a month after that his wife was so much improved as to be able to sit up out of bed, had not much pain, and was eating and sleeping well. I have heard since that she is fairly well, requiring care, but able to go about the house again.

Case 4.—Mrs. D. came to me with a history of pelvic inflam-

mation, which had been treated in a decidedly rough allopathic manner. She was unable to walk without pain, and could not even get ease in bed without the leg being drawn up. The pain, even in bed, kept her from sleep. Much pain in defæcation and at the period. On vaginal examination the uterus was immovable, and the roof of the vagina hard and tender. Her right ovary and tube were enlarged and tender. She had been advised to have operation for removal of the right ovary. This I advised against, as unless the uterus were removed as well no good could be done, in my opinion. She was anxious to see what homœopathic treatment would do. With rest in bed for a fortnight, then on the sofa, compresses and hot injections, bell., sepia, sulphur, merc. corr. and actæa, she got so free of pain that she slept well, and ate well, and was gradually able to walk a moderate amount without pain. The adhesions remained of course, but the tenderness in the right ovary and on vaginal examination was reduced to a minimum, while the ovario-tubal swelling diminished to a marked extent, the pelvic hardness as felt in the vagina became markedly softer, and the uterus slightly moveable. The patient then went home to the North of England. This case shows how much can be accomplished by homœopathic therapeutic means.

Many cases of minor degree could be given, where cure was accomplished, and in others such a degree of improvement, as to lead the patients to consider themselves practically well, so long as they were content to lead a quiet life, and avoid fatigue.

Lastly, as I said, cases of oöphorectomy *may* prove fatal, an element in the decision not to be forgotten. I add one fatal case: a young lady was sent to me with constant pelvic dragging pain, preventing her walking without much pain, or in fact, doing anything but lying up. Her general health was in consequence considerably affected. On vaginal examination, the left ovary could be easily felt much prolapsed, and very tender to touch. The pelvic pain was evidently due to this and this only. Therapeutic treatment was here hopeless, and a pessary would have been useless, even if it could have been borne. She was operated upon, but succumbed to peritonitis. One must thus not forget the possibility of a fatal issue.

II. BY GEORGE BURFORD, M.B.

There are three distinct clinical types of chronic lesions of the adnexa, differing also in pathological characters. They are:—

(1) The type resulting from a general tropho-neurosis where a toxæmia or anæmia induces chronic changes in the abdominal sympathetic. Ovarian phenomena, *inter alia*, ensue, and finally ovarian changes of the cirrhotic type.

(2) The type resulting from some reflex traumatism, usually a chill, or a wetting. Chronic pelvi-peritonitis ensues, probably secondary to tubal catarrh; tubes and ovaries are impacted in the midst of dense adhesions, which contort and constrict the adnexa, entirely crippling their physiological functions, and inducing constant and distressing pain.

(3) The type resulting from some septic poison, either gonorrhœal or from fermentative absorption, where changes of much the same character as in the former type exist, with also clear evidences of a pyretic stage. This variety has as its distinguishing clinical feature an oscillating condition of health, with a very marked tendency to easy and prolonged relapses.

Of the second type, the traumatic, and the third type, the septic, I may remark that they lend themselves fairly easily to remedial measures in most cases, but that a moiety exists, proof against the permanence of drug relief, where nothing but removal of the affected organs will bring permanent gain, and protect against that easy liability to relapse which is the chief, as it is the most disquieting, feature of these pelvic states.

For some years past I have been at intervals engaged in original work in the investigation of a hitherto undescribed morbid condition, examples of which have come under my notice with increasing frequency. My study has been to give cohesion and sequence to an amorphous group of symptoms, to trace a natural history and a clinical course, and to record the effects of various modes of treatment in breaking up the cycle of disease phenomena. If therefore I give you now a

miniature sketch of my views, it is with the hope that your own varied experience may supplement points on which my sources of information are somewhat defective; as well as supply the wholesome test of criticism to the results I have already elaborated.

No greater fallacy vitiates the judgment of the clinician than the assumption that the intensity of symptoms must have its counterpart in a corresponding pathological change in the affected tissues. And, turning our attention to the feminine reproductive apparatus, "nowhere in the body is it more true that the intensity of pain is in many instances in inverse ratio to the pathological condition sought for to account for it." In no part of the body are nerve reflexes more easily evolved, in no part of the body is nervous equilibrium more unstable, from no other source are nerve impulses radiated over the whole organism with greater frequency and force. The physiological interpretation of this is that the function of reproduction is one of the very oldest in the scale of nature; that every addition in the course of evolution has had to be co-ordinated with this pre-existing function, and therefore a definite nerve correlation has been established between it and every higher faculty of a later date.

Here, then, is a clear reason why the occurrence of puberty so profoundly influences all other elements in the organism; and the disarrangement of its mechanism, or its development in a debilitated organism, so readily affects and is shared by every other function of the body corporate.

My clinical studies of morbid conditions during reproductive life have occupied themselves with increasing frequency concerning an abnormal course, in which a general type of disease can be distinctly made out, while every quantitative variation is presented in individual cases. A young lady, mostly of the upper or middle class, enjoys fair health during her early years. Often she is plump and inclined to stoutness, is liable to adenoid hyperplasia, and her frequent slight ailments show a certain vulnerability of constitution. The incubus of puberty is now laid upon her, a heavy draft upon the resources of an organism never more

than a minor quantity. The new periodic function is halting and irregular, a sufficient proof of the difficulty of its co-ordination by a relatively feeble organism. The period from the first is of the dysmenial type; for a few years the patient struggles on, until some slight affection, a wetting, a strain on lifting, or a time of insufficient nourishment at school, causes a pain in the flank, or some similar local distress which is exacerbated at the period, and continues in a lessened degree during the whole interval. This, conjoined with the dysmenial pain, constitutes a *status doloris* which once established ebbs and flows, but is rarely entirely lacking for any length of time.

Local physical examination at this juncture may reveal absolutely no deviation from the normal, or merely some version or flexion or ovarian prolapse, the simple restitution of which affects the general condition but in the slightest degree.

This is but the initiation of the patient's woes. Constant and intractable lumbar backache gradually develops, and the whole spine becomes tender and painful, the points of maximum intensity being over the upper lumbar and last dorsal and lower cervical vertebræ, the latter area being a notable seat of pain in well-marked cases. Up the cervical spine the pain is traced, and becomes continuous with an occipital or occipito-vertical headache, of daily advent. Asthenopia so marked as to practically prohibit any prolonged effort at near vision, is present in every case. An apepsia with an appetite defective, faddist, and finally deplorable, is followed by dyspepsia of the flatulent or irritative type. Marked constipation invariably exists, further enhanced by the effort at evacuation being frequently painful. The capacity for sleep is so defective that hypnotics are freely taken to induce even an attempt at somnolence, and the experience of the night is a constant restlessness, followed by a troubled and dreamful slumber. A capacity for taking alcoholic stimulant is developed, so that I have known a young lady swallow as a nightcap a modicum of spirit such as a confirmed toper would denominate stiff, and this with but little apparent effect. The

hands are attenuated and chill, the feet stonily cold, the hair prematurely gray, the pupils frequently dilated, and the *tout ensemble* is a state of life which confines the sufferer almost entirely to her room, every effort being the precursor of aches and pains, languor and exhaustion.

I have cited here a well-marked case, taken from life; but any and every stage and degree of this morbid entity exists, according to the patient's degree of vitality and powers of resistance. Some cases are so slight that they can scarcely be affiliated to this category; others, more developed, forecast only too definitely the tendency of their debilitated vitality; while yet others seem to have suffered all the assaults which the slings and arrows of outrageous fortune can make upon them.

Taking a broad view of phenomena, we have here to deal with a trophic neurosis of a new type because conditioned by a latter-day set of influences. We have as the prime element in this clinical picture a type of constitution styled by Niemeyer "vulnerable." Upon this organism, whose resources hitherto have been fairly equal to the demands of juvenility, comes the stress and strain of puberty; and the halting, irregular, and painful performance of this new function sufficiently attests the difficulty of its co-ordination by the bodily powers. This is the first serious crisis in the course of development—a crisis which comes at a time when, forsooth, the moderate energies of the budding girl are absorbed by the intellectual cramming of the high school, or depressed by a defective regimen or an increasing limitation of out-door life, and the feeble remnant is entirely swamped by the imperious demands of the newly-developed functions.

The whole after-history is one long-continued protest on the part of the organism against the thrusting upon it of the vocation of the reproductive life, the demands of which it is utterly unable to fulfil.

The nerve centres primarily controlling the uterine, tubal and ovarian activities lie in a spinal tract between the planes of the last dorsal and second lumbar vertebræ.

The ganglia here situate are kept in a constant state of

irritation by the afferent vibrations engendered by imperfectly performed functions, and the effort to meet the disproportion between fully developed organs and defective vital power to work them. In the course of time the constant irritation of these nerve centres is not only felt as local pain, but is radiated to every part of the cerebro-spinal and sympathetic system by virtue of that intimate nerve interaction already spoken of. The withdrawal of a definite amount of available vigour from the other vital necessities soon tells unfavourably upon the assimilative agencies. The circulation of anæmic and toxæmic blood still further adds to the incumbrances of the body corporate. Lessened nerve supply brings about dyspepsia, and dyspepsia again eventuates in a still further deterioration of the nutrition of the nerve centres. And so the vicious circle is constructed, and ultimately there is slowly developed a typical example of the lesion described by neurologists as spinal neurasthenia.

Treatment.

I have failed in my pourtrayal if I have not made clear and vivid to you the various elements and the various stages of the disease process under consideration. The background on which the morbid picture is painted, is the type of organism which can fairly pass muster so long as but limited demands are made upon it. How much the urban mode of life, the restrictions upon girls' physical development, the assiduous deploying of their energies upon brain work of various types, and the hereditary tendency to reproduction of prominent nervous tensions in parents again in children, —these are elements which have to be worked out in each individual case. Briefly, when a young lady is brought to me in the early stages of defective health due to the demands of the early years of puberty, I always order complete cessation from intellectual work, life in the country under strictly natural conditions, and the limitation of energies to the establishment and consolidation of the physical growth and development of the body. The appropriate therapeutics find here their happiest sphere, as the fundamental defects are those of nutrition and assimilation. A senseless plan it

is to endeavour by drug action to induce a menstrual period in an organism, which has ceased its spontaneous performance; unless by strengthening and invigorating those bodily forces which have the process as their direct natural outcome.

In stages later still, where irritative reflexes are commencing, such as sickness, or other form of dyspepsia, and the characteristic spinal pain, and defective circulation, much good may ensue from applying Chapman's ice bag to the spine, rectal feeding, or massage. Each case requires its own line of treatment, together with the therapeutic aids so plentifully at your disposal. But I would earnestly caution you in these cases never to employ massage without also insisting on a forced feeding. Without this, the massage does much more harm than good, adding to, rather than lessening, the exhausting influences the patient has now to bear.

In chronic and inveterate cases, the last resort is the artificial induction of a premature climacteric. The scientific basis of this procedure is easy to demonstrate. The disease circle in advanced cases may be broken at various points. It may be broken by so notably quickening the powers of assimilation that the nutritive currents increase the vigour and lessen the atonic irritability of the nerve ganglia primarily affected. Or it may be broken by removing any detent such as an unhealthy environment, or improper or defective food, or an exhausting or too prolonged intellectual avocation. Or it may be broken by removing the prime cause of the depraved health, the charges made upon the system by the continuance of the periodic reproductive phenomena. Obviously there may come a time when even this is of no avail, when the spinal neurasthenia, the defective nutrition, the vital collapse, shall have so lowered the recuperative powers that there is no response to the removal of the prime cause in their occurrence.

I can only say that such cases I believe are very rare. I have never yet seen a case where considerable and lasting benefit did not follow the surgical induction of the climacteric. How are those cases to be accounted for when, after removal

of the ovaries, menstruation still persists? In one of two ways: either because every shred of ovarian tissue, the whole Fallopian tube, or a large area of the ovarian artery are not tied and removed; or because again, the constantly irritated utero-ovarian ganglia are now no longer controlled by the local condition, healthy or diseased.

CASES IN WHICH ABDOMINAL SECTION FOR REMOVAL OF THE UTERINE APPENDAGES HAS BEEN PERFORMED FOR LOCAL AND GENERAL MOBBID CONDITIONS.

- Case A.—Tropho-neurosis to maximum degree; removal of appendages on both sides. *Result*—*In statu quo*; no menopause ensuing.
- Case B.—Perioöphoritis on left side; removal of left appendages only. *Result*—Much improvement.
- Case C.—Prolapsed hypertrophied ovaries; removal of both sets of appendages. *Result*—Greatly improved.
- Case D.—Commencing atrophic cirrhosis; constitutional debility; removal of both appendage sets. *Result*—Much local improvement, menopause instituted; general health poor.
- Case E.—Gonorrhoeal affection of vagina, uterus and adnexa; marked nocturnal pyrexia; great iliac pain; removal of both sets of appendages. *Result*—Complete cure; menopause.
- Case F.—Copious watery uterine discharges; much local pain; greatly impaired locomotion; removal of left appendages only. *Result*—Marked improvement.
- Case G.—Tropho-neurosis, with acute local spasmodic pain; removal of both sets of appendages. *Result*—Very considerable improvement; menopause.
- Case H.—Chronic pelvi-peritonitis, from catarrh of tubes; gonorrhoeal? Appendages entirely buried in dense exudation; right ovary alone removed. *Result*—*In statu quo*.
- Case I.—Chronic pelvi-peritonitis, gonorrhoeal; pelvis completely blocked by dense masses of adhesions; appendages impossible to isolate. *Result*—Some general improvement.
- Case K.—Cirrhosis of ovaries (alcoholic); removal of both adnexa. *Result*—Moderate improvement.
- Case L.—Advanced tropho-neurosis, much local and general distress; removal of both sets of appendages. *Result*—*In statu quo*; no menopause ensuing.

CASES OF A SIMILAR CHARACTER UNDER GENERAL AND THERAPEUTIC TREATMENT MERELY.

- Case A'.—Very advanced tropho-neurosis; a chronic invalid; very slight benefit from protracted treatment.
- Case B'.—Commencing tropho-neurosis, with ovarian prolapse. Improvement tardy; general health below par.
- Case C'.—Advanced tropho-neurosis; some improvement under treatment, but easily relapses; chronic invalid.

- Case D¹.—Commencing tropho-neurosis, with gastric reflexes; considerable improvement under treatment; relapses.
- Case E¹.—Chronic pelvi-peritonitis, with marked tropho-neurosis; some degree of improvement by treatment.
- Case F¹.—Marked tropho-neurosis; chronic invalid; scarcely able to get about. Improvement—*nil*.
- Case G¹.—Chronic cirrhosis of ovaries; chronic invalid; no permanent improvement by treatment.
- Case H¹.—Commencing tropho-neurosis; no improvement under prolonged treatment.
- Case I¹.—Chronic pelvi-peritonitis, with probable impaction of appendages; former diagnosis "hysteria."
- Case K¹.—Tropho-neurosis, with marked dysmenia; some improvement under treatment.
- Case L¹.—Gonorrhœal disease of appendages; condition of health very variable; unable to follow avocation regularly; dependent on her own exertions. Present condition: health very defective.
- Case M¹.—Advanced tropho-neurosis, with great dysmenia; chronic invalid; some improvement under treatment.
- Case N¹.—Advanced tropho-neurosis, with much local distress; chronic invalid.
- Case O¹.—Marked tropho-neurosis, with gastric reflexes; improvement alternating with relapses; progressing.
- Case P¹.—Tropho-neurosis, with gastric symptoms and local distress. Improvement tardy.

Mr. KNOX SHAW felt diffident about taking part in the discussion, but during the past year he had been consulted by two patients who caused him to reflect somewhat on the subject under review, and had aroused in him an interest in a class of diseases he saw very little of. These two cases made him wonder whether after all we, as surgeons, were justified in making such a holocaust of the ovaries and tubes as had lately become prevalent, and whether we were on the right lines in attacking the ovaries themselves as the *fons et origo mali*. He asked attention to the following cure. Miss W., age 38, consulted him in November, 1892, owing to an inability to read or work without distressing pain, and complaining of a burning feeling and fulness of the eyes. The symptoms were so severe that continuous application of her eyes to work was an impossibility. She was a myope, and a lens of 6 D gave her normal acuity of vision. Her difficulty arose from a considerable degree of exophoria, or insufficiency of the internal recti, causing a tendency of the eyes to diverge. This state existed in distant vision, and was increased in accommodation. We must remember that the position of equilibrium in the ocular muscles is "the resultant of the varying amounts of innervation which are supplied to the muscles, and which are distributed among them in

proper proportions." In other words, it depends on a very complex nervous function. All well know how in certain individuals, known as the neurotic, or of a neuropathic predisposition, aberrations of nervous force play an important part in the development of the symptoms of which they complain. In his experience he should say that where one found suffering due to disturbance of the motility of the eye, one almost invariably found a definite neuropathic history, and that successful treatment was best obtained, not by treating the eye alone, but by taking into careful consideration the concomitant neurotic condition. Let us now see what was the past history of the patient. She had never been very strong. In 1889 she suffered from writer's cramp; one of Duchenne's "functional impotences," an inability to execute an act, needing, as in the use of the eyes, a carefully adjusted innervation of a number of muscles. Having recovered from this, she became a victim to that cataclysm of symptoms associated with chronic oöphoro-salpingitis, for which, in February, 1892, she had both her ovaries removed by Dr. Fenton. When Mr. Knox Shaw saw her ten months afterwards she was still suffering much from backache and pain in the side, and her "period" had not long ceased, so that an artificial menopause had not been induced. Now she had the ocular breakdown.

The next case, Miss M., age 44, was seen this April, complaining of pain at the back of the eyes, with smarting and a bad strained feeling. She could not use the eyes for long, and at night not at all. In the right eye she had a very trifling degree of hyperopic astigmatism (+ 0.5 D) and in the left eye a less degree (+ 0.25 D) of simple hyperopia. But she had, when testing the equilibrium of her ocular muscles, a marked excess of convergence or esophoria, due to insufficiency of the external recti. Enquiry revealed that for many years she had been a great invalid and quite unable to walk from the symptoms centering round a chronic oöphoro-salpingitis. Four years ago both ovaries and tubes were removed by Dr. Bantock, and she seems to have derived some benefit from the operation, but she still suffered much from backache, and was not able to do more than three hours' teaching a day.

These patients' lives are rendered miserable by a series of symptoms which are generally found to be out of all proportion to the discoverable pathological lesion, and which condition probably exists in many without exciting any such symptoms. Are we not justified in assuming that it is not so much the diseased ovary that is the most important factor in the development of the

symptoms, but the disposition to neuropathic manifestations that exist, in the patient in whom the ovarian disease is found? In what he was inclined to consider as somewhat analogous cases, it is not every case of abnormal equilibrium of the ocular muscles that causes distress to the patient. There must exist in the patient that preternatural affection of sense and motion, now commonly known as the neurotic temperament.

It would appear to him, therefore, to be as illogical to frequently remove the ovaries in these patients as it is to follow the advice of some of our American *confrères* and tenotomise in a wholesale manner the ocular muscles of the class of patient to whom he had just referred.

Dr. Cook said that the remarks of the first speaker were mainly valuable as indicating the difficulty of applying therapeutic methods to the treatment of ovarian disease and the need of great patience on the part of those treated. Dr. Dyce Brown's patients seemed content to go on with a tedious treatment of two or more years, and to be satisfied then with an amelioration, not a cure; in general, patients would not so long cling to one mode of treatment. Dr. Burford's suggestion, that at puberty the organism of many girls, taking on new and most onerous duties, was found of deficient strength for its increased load and thus failed in its weakest part, was interesting and suggestive. He agreed that the failure of operation to relieve symptoms might in many cases be attributed to delay—delay which permitted nerve disorganisation to progress so much that no operative procedure could remedy the matter. Still, he was met by the difficulty that in such weak constitutions as Dr. Burford had depicted, the mischief began at puberty; yet we could not suggest that that, or soon after, was an appropriate time for surgical remedies. We had to give some time to medicinal action, and that delay might render nugatory all surgical interference undertaken later. Certainly there was great scope for fresh energy in finding the appropriate treatment and medicine in young cases, and at the same time it appeared clear that there came a time at which nothing but surgery would avail. To suggest that a woman who never could lead a proper marital life, or become a mother, was rendered a worse case by being deprived of diseased ovaries under appropriate precautions, was absurd. Various causes contributed to the prevalence of such cases; clearly a female animal in natural conditions, soon after sexual functions became possible, was prompted to indulge them. This could never be permitted in civilised life among women, and the re-

straint—the unnatural restraint—induced, often during life-long years, could not but have a mischievous physical influence, and the weaker the organism the greater the harm. Medical men must recognise fully this condition of things and its influence, and point their remedies to allaying this special excitement, and thus giving greater mental control.

Dr. JAGIELSKI had observed very often the reflex phenomena brought on by anomalies in the sexual organs, and had demonstrated the fact of these parts being the cause of the reflex phenomena in the brain, throat, head, and other parts by seeing these reflex phenomena produced in the patient by a digital pressure, vaginally in and around the uterus. Referring to massage, he regretted disrepute was brought upon it by cases requiring it being relegated to non-medical hands, instead of being treated by medical men who gave special attention to the subject. The great point in the value of proper massage was to prevent subinvolution, inflammatory thickening, and flexion and version, by a proper combination of massage, electricity and internal treatment. This will check much misery and prevent the so-called chronic mischief in gynæcology for which now operation alone appears to be the radical remedy.

POLYPUS FROM CYSTIC DEGENERATION OF THE CERVIX UTERI.¹

Dr. HAWKES showed to the Society a small uterine polypus which he had removed from a patient aged 62, who was admitted into the Hahnemann Hospital, Liverpool, on May 2nd, 1893. Examination revealed a small polypus growing from the anterior lip of the os uteri.

The small polypus was removed on May 4th, the patient having complained of more “dragging” than one would have associated with such a small growth. The narrow pedicle was merely snipped through with scissors.

On examination it proved to be the outcome of cystic

¹ Pathological specimen, Liverpool Branch. May 11, 1892.

degeneration of the cervix uteri. Relief followed this simple expedient, and the patient returned home a few days afterwards. It has been pointed out that under certain circumstances congestion and hyper-distension of the glands of the cervix occur, leading to a cystic condition. These cysts, through hypertrophy of the subjacent tissue, are forced forwards in the form of polypi.

HOMŒOPATHY IN RUSSIA.

At the Annual Assembly of the Society on June 28th, Dr. von Dittmann, of St. Petersburg, was present, and on the invitation of the President (Dr. Galley Blackley) made some remarks on the position of homœopathy in Russia. He said that homœopathy was making slow but steady progress in the Russian Capital. Although homœopathy had a hard battle to fight, a more friendly state of feeling was beginning to arise between them and the Allopathic School. The official medical authorities in Russia had great power; but homœopathy was supported by some patients of high rank, and the Emperor himself sympathised to a certain extent with their system. He had given no official recognition to homœopathy, but was rather friendly than the reverse. He (Dr. von Dittmann) had himself had the honour of being presented to the Czar, to whom he had appealed on behalf of a sanatorium which he had opened near St. Petersburg, to which opposition was excited. The Emperor had given a large sum for a homœopathic hospital. They had also secured the adhesion of some eminent practitioners, among whom was Dr. Brasol, who was doing very well. Public lectures have been given, which were attended by hundreds of people. No doubt there was some noise and disturbance at these meetings, and the big newspapers were opposed to homœopathy, but they were making progress, and he hoped before long to have a homœopathic hospital in St. Petersburg. There were homœopathic chemists who

sold a considerable quantity of homœopathic medicine. Funds were being collected, and in about ten months they hoped to raise about £2,000 a year for the hospital. In a couple of years they hoped to give gratuitous support to the patients in the hospital. A large number of Greek priests understood homœopathy, and dispensed homœopathic medicines, especially in the large number of districts where there were no physicians. They had also published translations of homœopathic treatises, and people would travel hundreds of miles to receive homœopathic treatment.

Dr. VON DITTMANN further added that since 1881, when he had the honour of taking part in the London Congress, three new homœopathic societies had started, at Kiel and Odessa. They consisted mostly of laymen. Dr. Brasol travelled a great deal and delivered lectures in halls hired by the different societies.

HOMŒOPATHY IN INDIA.

IN addition to Dr. von Dittmann, Dr. Majumdar, of Calcutta, was also a visitor at the Annual Assembly. In speaking of the state of homœopathy in Calcutta and India generally, he said that homœopathy was introduced into India by missionaries. One of his countrymen afterwards took it up, and converted Dr. Sircar, who had brought it forward at the Calcutta University. Since then little progress had been made, and there were few practitioners. He was converted to the system when he was a graduate, and since then about a dozen members of his college had followed his example. But there was at first no means of spreading the system in India. Five or six years ago a school was started and more progress was being made. A hospital was opened last year, and there were greater facilities for learning the system practically. There were thirty or thirty-five beds, and ten or twelve separate rooms for cholera patients. In the last year or two there had been no

cholera cases—they had exported the disease to Europe. In many places there were no homœopathic physicians, and scarcely any at Bombay. There were some countrymen of his practising at Calcutta, where also there were many homœopathic pharmacies. There were no practitioners at Madras; but the missionaries were spreading the system throughout the country, and lay practitioners were also extending homœopathy.

APHONIA FROM PARALYSIS OF THE LEFT VOCAL CORD SIMULATING PHTHISIS.¹

DR. A. E. HAWKES demonstrated the chromogen reaction in the urine of an anæmic girl who had been under his care in the hospital, and recorded the case.

Rose F., aged 20, was admitted into the Hahnemann Hospital, Liverpool, on April 22nd, 1893.

She was quite well nine weeks prior to admission, when she caught cold. Her family history was said to be satisfactory. Her catamenia were usually too free. She had aphonia on admission, but no cough.

Auscultation and percussion showed no serious pulmonary signs. There were, however, loud hæmic murmurs heard under the clavicles, on each side of the sternum, and all over the cardiac area round as far as the left scapula, and even to the spine, as well as in the vessels of the neck. The temperature was normal. The urine was free from albumen, but as the test was being applied a rose-red coloration was observed indicating the presence of a chromogen.

It may here be remarked that this rose-red coloration is obtained by adding impure nitric acid, that is, nitric acid containing some nitrous acid, to a suitable sample of urine. Dr. Herschell in the *Practitioner*, May, 1893, page 361, expressed the view that "the red pigment is dependent in some way or other upon the fæcal accumulation in the

¹ Liverpool Branch, May 11, 1893.

ascending colon, and secondly that the finding of such a pigment in the urine may be a valuable indication that such a retention of fæcal matter exists." His paper should be read, and his references followed up, by those interested in the subject. But to continue: On May 3rd a laryngoscopic examination made by Dr. Charles Hayward showed that the aphonia was due to the left vocal cord being fixed in a semi-inspiratory position. This paralysis was thought to be due to the recurrent laryngeal nerve having been involved in some pleural thickening.

There was much œdema of the right leg, and considerable pain in the right side of the abdomen, where some swelling (? cellulitic) was discovered. Examination of the blood shewed the red corpuscles to be about $3\frac{1}{2}$ millions per cubic millimetre. The corpuscles were of various shapes and sizes; the white corpuscles were relatively increased.

By May 8th the swelling and abdominal pain were better, and the chromogen reaction was much less marked.

On the 13th it was noted that she was much better, and that there was no suspicion of cellulitis. Her voice remained the same, but the chromogen reaction was still less.

By May 23rd she could walk about the ward, the œdema having gone.

She was much better on June 2nd, but the right leg swelled a little after she had been long up.

The chromogen reaction no longer appeared when nitric acid was added to the urine. The hæmic murmurs had become much less marked.

On June 26th the patient left the hospital, all the troublesome symptoms, except of course the aphonia, having disappeared.

On her admission the slight cough, the aphonia, the œdema, and the general appearance of the patient, somewhat closely simulated advanced phthisis, but further examination soon dissipated the notion. The medicine mainly used was arsen. iod. 5 x.

NOTES ON A CASE OF ACUTE TUBERCULOSIS.¹

BY A. F. HAWKES, M.D.

Physician to the Hahnemann Hospital, Liverpool.

PREPARATIONS showing tuberculosis of the lungs, spleen, mesenteric glands and intestines were shown to the Society, taken from the following case:—

E. G., a little girl aged 4 years, was admitted into the Hahnemann Hospital, Liverpool, on April 19th, 1893, with many of the symptoms of enteric fever. She had begun to be ill, it was said, eight days before admission, when vomiting and purging occurred. On admission her temperature was 103.4° F.; pulse 144, somewhat dicrotic; and respirations 36 per minute. Her tongue was dry, brown, and thickly coated; there was marked tympanites with tenderness, and some spots were visible on the abdomen; both bases of the lungs were found to be congested on examining the chest; the diarrhoea continued. It was, however, noticed that the child shrieked a good deal, and belladonna was suggested instead of baptisia, which she was taking. On April 21st flapping of *alæ nasi* was noted with hectic flush on the cheek and some tendency to herpes on the nose. Her temperature, respiration and pulse remained much the same. There were pneumonic signs at both bases. The next day the pulse was 168, temperature 102.2°. There was an aphthous condition of mouth; the child moaned a great deal. On April 23rd loud moist râles were heard at the bases; the pulse was 180, temperature 104°. The child was pallid and restless, but there was less tympanites. A few spots were still visible on the abdomen. She passed frequent greenish stools. Apparently the milk was undigested, although peptonized. The child died after being in hospital four days; during this time she had given to her baptisia, belladonna, phosphorus and mercurius cor., but without effect. The *post-mortem* showed a tuberculous condition of the left base, tubercles in the spleen, tubercle

¹ Specimen presented to the Liverpool Branch, May 11th, 1893.

of the mesenteric glands, and tuberculous ulcers in the ileum; a well marked intussusception was also discovered.

Dr. Hawkes pointed out the difficulty in the early diagnosis of these cases from typhoid fever, and emphasised the misleading features in the case: the temperature, condition of the tongue, the diarrhoea and the abdominal spots. He quoted Fagge to the effect that such errors—if such an unjust term is made use of—are excusable, especially if the patient comes from a dark and dirty cellar as this one did.

SOCIETY NEWS.

THE Annual Assembly, which brought session 1892-1893 to a close, was held on June 28th and 29th in the Lecture Room of the College of Organists, Bloomsbury, under the presidency of Dr. Galley Blackley.

Before proceeding to the election of officers, the President announced that the coming session would be the jubilee of the foundation of the Society, and in seeking to celebrate the occasion in a befitting manner the Council had decided to suggest to the Assembly the election of Mr. Hugh Cameron as president for the ensuing year. Of that band of sturdy homœopaths who gathered round Dr. Quin, in 1844, to found the British Homœopathic Society, and who became its original members, Mr. Cameron alone remains; and it was thought it would be a gracious act to ask him to become our President for the jubilee year.

On a ballot being taken, Mr. Hugh Cameron was unanimously chosen to fill the post of President, the choice of Vice-Presidents falling upon Drs. Madden and Goldsbrough.

After ten years' service to the Society as Treasurer, Dr. Dudgeon begged to be relieved of his office. The meeting expressed its gratitude to Dr. Dudgeon for the able assistance he had given to the Society, and being assured that Dr. Dudgeon was firm in his wish to retire, proceeded to elect the retiring President—Dr. Galley Blackley—to the office of Treasurer.

The Council was completed by the election of the following Fellows of the Society, Drs. Dudgeon, Hughes, Byres Moir and Neatby; and the following Members, Mr. Henry Harris and Dr. Washington Epps.

The Liverpool Branch of the Society at the last meeting of its session elected Dr. John William Ellis as President and Dr. A. E. Hawkes as Vice-President, Dr. Edmund Capper being re-elected Secretary.

At the Annual Assembly the Honorary Secretary moved on behalf of the Council, seconded by Dr. Byres Moir, an alteration in Law XVIII. (b) with a view to simplifying the election of officers to the Council at the Annual Assembly. This having been carried *nem. con.*, the section of the law referred to will now read thus:—“(b) At the last meeting of the assembly the officers of the Society shall be elected for the ensuing year. The President, Vice-Presidents and Treasurer, who shall be Fellows of the Society, shall be the first officers elected. Four Fellows and two Members shall next be elected, to form with the above, the Branch Representatives, and the Secretary, the Council of the Society.”

At the same meeting Mr. Dudley Wright proposed an alteration to Law XII. by leaving out the words “with the addition of having been in practice for seven years, five of which must have been devoted to homœopathy,” and to omit “they also.” The new Law to read thus:—

XII. “Fellows must possess the usual qualification of Members; must have been Members of the Society for at least two years, and have also contributed at least three original communications. The new Fellow shall, on election, pay an enrolment fee of one guinea.”

To this Drs. Hughes and Dudgeon moved an amendment to leave out “two” and insert “five.” This having been carried, the main question as amended was put to the meeting and carried.

Law XII. will now stand thus:—“Fellows must possess the usual qualifications of Members, must have been Members of the Society for at least five years, and must have contributed at least three original communications. The new Fellow shall, on election, pay an enrolment fee of one guinea.”

Acting under the provisions of Law XII. (c), which states that “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,” the Society, at its Annual

Assembly, elected Drs. John William Hayward and Herbert Nankivell Fellows of the Society.

At the same time, the Society added to its roll of Corresponding Members the names of that distinguished surgeon, Dr. Tod Helmuth; the able collaborator with Dr. Hughes in the "Cyclopædia of Drug Pathogenesis," Dr. J. P. Dake; and the Editor of the "Revue Homœopathique Belge," Dr. Martiny.

In acknowledging the announcement of his election, Dr. Martiny writes to the Secretary of the Society:—

"Bruxelles, 8 Juillet, 1893.

"Monsieur et honoré Confrère,—Je suis réellement flatté de l'honneur qui m'a fait la British Homœopathic Society en me nominant membre correspondant de la Société.

"Veuillez être l'interprète de mes sentiments de gratitude auprès de M. le Président et des membres de votre Société.

"Recevez, Monsieur et honoré Confrère, l'assurance de mes meilleurs sentiments.

"J. MARTINY."

Dr. Tod Helmuth says: "I thank the Society for the honour of its membership, and venture to express the hope that, at some not far distant date, I may be able to assist in its usefulness."

The Secretary has also received the following letter from Dr. Dake:—

"Nashville, Tenn.,

"August 2nd, 1893.

"Dear Sir,—I am in receipt of your letter informing me of my election as a corresponding member of the British Homœopathic Society. I desire to say that I appreciate the honour, as well as the privileges, of such membership, esteeming your Society as one of the foremost agencies for the propagation of medical reform. With many of your members I have the pleasure of a personal acquaintance, which I value most highly. Convey my thanks to your Society, and accept the same personally.—I am, very sincerely yours,

"J. P. DAKE."

Since the last issue of the JOURNAL, the Society has lost, by death, three of its members.

Dr. Carl F. Fischer, who died after a few days' illness in Chicago last June, was only elected a member of the Society this year, having retired from an Australian practice, and settled in England.

In July, Dr. Edward Wynne Thomas, of Birmingham, passed

away. His membership dated from 1864, and only this last Session he took part in the discussions of the Society.

Dr. Harmar Smith, who became a member of the Society in 1861, died on the 7th of August at an advanced age, at Bournemouth. Though at one time an active member of the Society, he had, since his retirement from practice, taken but little part in its deliberations.

Allusion is made in the Presidential Address to an announcement that has appeared in the monthly circulars sent to members, saying that Messrs. Gould & Son are willing to re-issue Part 1 of the Cyclopædia of Drug Pathogenesis, at a cost of 3s. 6d., if a sufficient number of members will subscribe to the part. There must be a considerable number of members whose set is incomplete, and they should take this opportunity of obtaining the missing part. The Secretary of the Society will be pleased to receive the names of intending subscribers.

Frederick William Giles, M.B.Dur., M.R.C.S.Eng., of the Hotel Continental, Cannes, and John Burns Southam, M.R.C.S. Eng., L.S.A., of 29, Talbot Street, Southport, having been duly nominated, were elected members at the Annual Assembly.

At a meeting of the Council held July 13th, Dr. Hughes was re-appointed Editor of the Journal, and Mr. Knox Shaw, Honorary Secretary of the Society.

REPORT OF THE COUNCIL.

Read at the Annual Assembly, June 28th, 1893.

By an addition to Law XXVIII. made at the last Annual Assembly, the Council has to present a report of the work and progress of the Society.

The Council has had five important and well-attended meetings during the year, at which a considerable amount of business has been transacted. At the close of the session it has to congratulate the Society on a year of unexampled activity and prosperity, sixty-six new members having joined since the opening of the session. The Society has to deplore the loss by death of one of its Fellows, Dr. Drysdale, of Liverpool, a veteran worker in the

FINANCIAL STATEMENT PRESENTED BY THE TREASURER AT THE ANNUAL ASSEMBLY.

June 28th, 1893.

RECEIPTS.		PAYMENTS.	
£	s. d.	£	s. d.
Balance in Bank	.. .. 39 0 0	Liabilities (1891-92):	
Cash in Hand..	.. .. 7 0 0	Rent .. ..	.. .. 20 0 0
Subscriptions (1891-92) paid in after		Printing .. ..	.. .. 10 0 0
Annual Assembly ..	.. .. 46 9 0	Reporting and Postage..	.. .. 11 15 9
	—	Library .. ..	.. .. 3 17 4
Subscriptions (1892-93)	.. .. 153 15 0	Refreshments .. ..	.. .. 5 3 0
Subscriptions paid twice	.. .. 4 4 0	Printing (less advertisements)	.. .. 74 0 6
Sale of Publications..	.. .. 7 16 4	Reporting, Postage, &c.	.. .. 27 10 2
Dividends .. ..	.. .. 9 6 8	Rent .. ..	.. .. 18 10 0
		Library .. ..	.. .. 16 1 4
		Refreshments..	.. .. 4 5 6
		Subscriptions returned	.. .. 4 4 0
			—
		Balance at Bank	.. .. 195 8 6
		Cash in Hand	.. .. 101 12 6
			.. .. 0 10 0
			—
	£297 11 0		£297 11 0

R. E. DUDGON, Treasurer.

Audited and found correct,
HENRY HARRIS, Auditor.

cause of homœopathy, who had been a member since 1857 ; Dr. Mackintosh, of Torquay, whose membership dated from 1868 ; and now within the last few weeks Dr. Blumberg, a member since 1875, whose work in Southport is so well known. One member has resigned. The membership of the Society is now one hundred and ninety-six.

An important branch, numbering fifteen members, has been formed in Liverpool by the affiliation of the Liverpool Homœopathic Medico-Chirurgical Society. The coming session being the Jubilee of the foundation of the Society, the Council is desirous of celebrating this event by still further increasing the roll of members, and relies upon every member aiding it in its efforts to include within its membership the few who have not yet realised the value to homœopathy of a large and united Society.

A new departure has been made by the issue of the Transactions, under the editorship of Dr. Hughes, in the form of a quarterly Journal ; the reception of this both among the members and the homœopathic body in America is encouraging.

The meetings have been better attended than usual, and the papers, as the Journal will show, have been valuable, varied, and instructive.

The Treasurer's balance shows the finances of the Society to be in a satisfactory condition. There have naturally been expenses connected with the increased activity of the Society which are not likely to be repeated.

SUMMARY OF PHARMACODYNAMICS AND
THERAPEUTICS.

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

JUNE—AUGUST, 1893.

PHARMACODYNAMICS.

Argentum Nitricum in Chorea.—Dr. Gross, of Regensburg, finds argentum nitricum—2nd to 4th trit., probably decimal—more effective in chorea than any of our ordinary remedies, and relates four cases illustrative of its power.—*Allg. Hom. Zeit.*, vol. lxiv., No. 24.

Argentum Nitricum in Pseudo-Membranous Enteritis.—Dr. F. Pritchard relates a case of this kind, recurring paroxysmally, in which, after several remedies had been given in vain, argentum nitricum, in the 6x trit., effected a rapid cure.—*Hahn. Monthly*, July.

Arsenicum Iodatum in Aphonia.—Dr. W. S. Pearsall reports two cases of aphonia, with flabby relaxed condition of laryngeal mucous membrane and imperfect approximation of vocal cords during phonation. Ars. iod., given in one case in the 30th, in the other in the 2x, proved curative.—*N. Am. Journ. of Hom.*, June, p. 394.

Atropine Poisoning.—Dr. Gunderlach records a case of this kind, in which gr. $\frac{5}{8}$ of atropine with gr. $\frac{1}{4}$ of cocaine, in solution, were swallowed by mistake. Morphine and physostigmine did something for the pulse, but the breathing continued slow (5-6) and shallow, and the patient seemed sinking, when about two drops of the 1st dil. of glonoin were injected subcutaneously. Respiration almost immediately became deeper, fuller, and more rapid, gradually rising to 12-16. Pulse, which had been 150-165, coincidentally became slower, and much stronger and fuller. The effect gradually passed off after one to two hours, when the injection was repeated; after each "new life seemed inspired, and the effect of each was better than the preceding."—*Amer. Hom.*, Aug 1.

Aurum in Keratitis and Iritis.—Cases of acute parenchymatous keratitis and of syphilitic iritis are reported by Drs. Boyle and Deady, in which aurum did everything that could be desired. In the first, the metal was given in the 4x trit; in the second, the chloride in the 3rd dil. There was here great mental depression.—*N. Am. Journ. of Hom.*, June, p. 395.

Borax in Epilepsy.—Dr. Clara E. Gary relates two cases which seem to show that the good effects of borax in epilepsy, lately vouched for by old-school physicians, can be obtained from the 1x trit. There were no distinctive symptoms in these cases.—*N. Eng. Med. Gaz.*, June.

Calcareo iodata in Fibroids.—Dr. Sarah J. Millsop relates two cases of fibroid tumour, one interstitial, one extra-uterine, in which very great reduction in size occurred from the use of the iodide of lime. The 2x potency was used.—*Hom. Journ. of Obstetrics, &c.*, Nov., 1892.

Calendula.—Dr. R. K. Ghosh sends from India some interesting experiences with calendula. It does not, he finds, prevent suppuration, but it checks this process when already set up and heals the wound. He dresses ulcers with the tincture-trituration, and seals them up. It is especially valuable when they are sloughing. The same preparation is used with the best result as a snuff for ozæna, even of syphilitic origin.—*Hom. Recorder*, July.

Dr. Bishop, a convert from the old school, relates cases which satisfy him that calendula is quite as efficient as the bichloride in septic and suppurating wounds, without its disadvantages.—*Amer. Homœopathist*, Aug. 15th.

Causticum.—The Société Française d'Homœopathie having desired M. Pistruszinski, pharmacien, to make an analysis of "causticum," prepared according to Hahnemann's instructions, he has done so, and reports that the resultant liquid is alkaline, giving no precipitate under tartaric acid and platinum bichloride, but under oxalate of ammonia shewing plainly the presence of lime. [This, Hahnemann says, his preparation should not do; and the examinations which Dr. Black, nearly thirty years ago,¹ caused to be made of the causticum prepared by British chemists, revealed potash only and no lime.—Ed.]—*Revue Hom. Française*, July.

Cedron in Neuralgia.—Mr. S., age 31, had suffered neuralgic pains since an attack of intermittent fever two years previously.

¹ See *Brit. Journ. of Hom.*, xxiv., 471.

They were "of periodic recurrence," and from time to time appeared in all parts of the body. Cedron 1x removed them in three weeks, and they had not recurred for seven months when the report was made.—*N. Am. Journ. of Hom.*, June, p. 393.

Cicuta.—This drug proved rapidly curative in a case of idiopathic tetanus, of rheumatic origin. The 3x dil. was given.—*Allg. Hom. Zeit.*, Nos. 13-14, 1893.

Cimicifuga.—Dr. Talbot communicates his experience with this remedy. Its great action, he thinks, is on muscular tissues, and hence on the uterus. It relieves the effects of over-fatigue, strain, and first use of the muscles after long inaction—as when fractures have occurred. The muscular pains of pregnancy are relieved by it, and parturition rendered materially easier.—*N. Engl. Med. Gazette*, June.

Duboisine in Restlessness of the Insane.—Prof. Spendel has been trying duboisine in insanity. He finds that it has no action in melancholia, paranoia, or simple insomnia, but excited insane persons whose rest is disturbed by motor unrest become quiet in five minutes after a dose of the drug; the muscles relax; and after twenty minutes sleep comes on that lasts two to six hours. He recommends beginning with half-milligramme doses (*i.e.*, gr. $\frac{1}{130}$), and gradually increasing to one milligramme.—*N. Am. Journal of Hom.*, Aug., page 542.

Ergot in Hæmorrhage.—In a clinical lecture on Hæmoptysis, reported in the *Clinical Review* of June 28th, Dr. Henry Green states that he has lost all faith in ergot; and that at the Brompton Hospital the drug is rarely used, one only of the physicians occasionally prescribing it in cases believed to be capillary.

Gratiola in Dyspepsia.—This rarely-used but well-proved medicine has rendered Dr. Tessier "incomparable service" in some forms of dyspepsia. His indications for it are: afflux of blood to head, with heat and somnolence; great distension of stomach; lassitude and somnolence after meals, constriction of throat, dysphagia for liquids, constipation, constriction of rectum.—*Revue Hom. Française*, Aug., p. 296.

Hepar in Pyo-salpinx.—"I have in mind a case I was called upon to see with Dr. Deffendorf, of Williamston, some years ago, in which we had a well-defined example of pyo-salpinx, the pus making its escape into the uterus—a typical case for laparotomy. The consent of the patient could not be obtained, and her condi-

tion also prevented a demand for an operation, but under the persistent use of *hepar sulphuris*, which seemed, not only from the pathological conditions, but from the totality of the symptoms as well, to be indicated, the patient was soon relieved of all her troubles, and she is now enjoying good health."—Dr. Phil. Porter, in *Hom. Journ. of Obstetrics, &c.*, Nov., 1892.

Hydrastis in Epithelioma.—Dr. Daudet reports a case in which digital examination, together with the constitutional state and appearance of the patient, and the fœtid character of the discharges, led him to the diagnosis of epithelioma of the cervix uteri. He prescribed *hydrastis* 12, a dose three times a day. Two days later, a copious, fœtid, blackish hæmorrhage set in, and in three or four days more the tumour came away in blackish matters having a sickening odour. All local symptoms disappeared, and the patient became quite well.—*Revue Hom. Française*, July, p. 291.

Iodine in Pneumonia.—Dr. McMichael relates two cases in which right-sided pneumonia, which was hanging fire under ordinary remedies, rapidly subsided when iodine was given. He believes the remedy to be as nearly specific as may be. In left-sided pneumonia it is comparatively ineffective.—*N. Am. Journ. of Hom.*, Aug., p. 530.

Dr. Calderwood relates three cases illustrating the efficacy of the same medication, and in all the inflammation was on the right side.—*N. Engl. Med. Gaz.*, July.

Lachesis in Wens.—Miss H., age 32, dark and plump, had two wens on right vertex; one vascular, and about half the size of an ordinary nutmeg, the other white, and a little smaller. The former often had pains in it, as from thrust of a sharp instrument; the pains sometimes ran towards the left eye. She had besides left ovarian troubles and many nervous symptoms that led to lachesis, under which the vascular wen disappeared; but it had no effect on the other.—*N. Am. Journ. of Hom.*, Aug., p. 529.

Lachesis in Cellulitis.—In a case of cellulitis of leg and thigh, following compound fracture of tibia, skin of affected parts reddish purple, general condition that of impending septicæmia, and temp. 105.5°,—*lachesis* 12 was given. The temp. fell to 99° in four hours, and uninterrupted recovery ensued.—*N. Am. Journ. of Hom.*, June, p. 393.

Lachnanthes.—Dr. Ghosh, of Calcutta, relates a case which seemed to be phthisical, in which, after the failure of iodide of

arsenic, he was led by the accompanying stiffness of the neck to give *Iachnanthes*. The 3x dil. did nothing, but under three-drop doses of the mother tincture improvement ensued in a week and went on to complete recovery. He has since used it in three similar cases "with good results."

He gave the remedy also in eight cases of stiff-neck. In three only did it prove curative, and in these there was concomitant cough—without chest symptoms. All three patients, moreover, perspired freely in hands and feet; and their stiff-neck and throat cough (with burning of palms and soles) came on or increased whenever such perspiration was checked.—*Hom. Recorder*, June.

Enanthe Crocata.—This obviously homœopathic remedy for epilepsy is being taken up, of course without acknowledgment, in the old school. The *Am. Homœopathist*, of August 15th, cites two testimonies to its efficacy from the *Chicago Medical Times*.

Phosphorus in Epithelioma of Tongue.—Dr. T. F. Allen reports a case of disease of tongue in a young man of 30, with no syphilitic history, for which other authorities had advised immediate extirpation, and which he could not but pronounce epithelioma. The patient's constitutional symptoms led him to give phosphorus. Improvement began immediately, and after two months, when the report was made, the tongue was almost well.—*N. Am. Journ. of Hom.*, July, p. 467.

Sanguinaria in Migraine.—Dr. S. G. A. Brown relates a case of the sanguinaria headache, which is interesting in that the remedy proved effective in the mother tincture. The malady had lasted for three years; and, after a two days' use of sanguinaria θ had not recurred for eight months.—*N. Amer. Journ. of Hom.*, June, p. 392.

Silicea.—Dr. Windelband reports a yet more successful experience with this drug than we have on record, including tuberculous joints, exostosis and caries, besides abscesses. It is noteworthy that he seems always to employ it in the 3rd trit.—*Zeitschr. des Berliner Vereines Hom. Aerzt.*, xii., 1.

Sticta in Cough.—Dr. Youngman reports some further cases in proof of the great efficacy of this medicine, given in the mother tincture and 1x dilution, against coughs. He sums up thus: 1st, *Sticta* is indicated in harsh, racking, incessant, "unprofitable" cough, of spasmodic type; 2nd, It is particularly adapted to neurotic, rheumatic and gouty individuals; 3rd, It is more valuable in subacute and chronic cases; 4th, It is more suitable to old age;

5th, It allays irritation, soothes irritable tissue, removes hyper-sensitive conditions of the respiratory mucous membrane, and promotes sleep.—*Hahn. Monthly*, June.

Thlaspi bursa pastoris.—Dr. Julia Button communicates some experience with this drug. She gave it in a case of climacteric metrorrhagia,—15 drops of the tincture to half-a-glass of water, a teaspoonful every hour. It controlled the hæmorrhage, but caused a severe constrictive headache; patient said it seemed as though her skull would crack if she did not move her head with great care. Glonoin relieved this, but the hæmorrhage recurred. Finally the 1x dil. was substituted, and this controlled bleeding without producing headache; and the trouble had not returned for six months when the report was made.—*Hom. Journ. of Obstetrics, &c.*, May.

Tuberculinum.—Dr. Chas. N. Roberts reports a case of what seemed meningitis, in a child of 2; the urine was also found solid with albumen. Helleborus, apis, calc. carb., were doing little for the patient; but tuberculinum 200 (Boericke and Tafel) initiated rapid improvement, which proved permanent.—*Hom. Recorder*, July.

Verbascum.—An article on the preparation known as “mullein oil” is contained in the *Hom. Recorder* for August, giving the history of its use—internally for enuresis and other urinary troubles, locally for deafness and earache.

THERAPEUTICS.

Acne.—A discussion on the treatment of this complaint took place at the meeting of the Hom. Medical Society of the County of New York. Dr. Arcularius has most confidence in cicuta in the pustular form, and calcarea carbonica for the papular variety, especially in women with catamenial derangement. Dr. Deschere finds kali bromatum, a grain three times a day, very effective in simple acne in nervous subjects.—*N. Am. Jour. of Hom.*, Aug., p. 140 of appendix.

Cholera.—Another candidate for homœopathicity to this malady, beside the colchicum of Dr. Sutherland mentioned in our January No., is the agaricus phalloides, brought forward by Dr. A. K. Crawford in the *Medical Century* for August.

Group.—Dr. Deschere thinks that in this disease our remedies are usually given too strong, and the trouble aggravated. He now

never uses anything below the 30th, and finds aconite in this dilution act marvellously.—*N. Am. Journ. of Hom.*, Aug., p. 140 of appendix.

Glaucoma.—Taking the hint given by the way atropine will sometimes stir up a latent glaucoma, Dr. Parenteau has administered the attenuated drug internally as a homœopathic remedy for increased tension of the eye, and with very satisfactory results.—*Revue Hom. Française*, June.

Puerperal Fever.—In a valuable paper on puerperal fever in the *Hom. Journal of Obstetrics* for July, Dr. Custis says, speaking of its medicinal treatment: "First of all comes rhus. I never saw a case where it was not called for sooner or later. So constant has been this experience, that I anticipate the condition by giving it in the absence of other directly indicated remedies, or when the temperature remains stationary, not improving under the medicines previously prescribed."

Snakebites.—Dr. U. W. Reed brings to our notice a plant called "Sisyrinchium"—of the "iris family," he says, which is in repute among the American Indians as a local application for snake-bites. He relates two cases in which rattlesnakes were the offenders, and where speedy and unlooked-for recovery ensued on applying a tincture of the roots, and giving it in fractional doses internally.—*Hom. Recorder*, June.

Dr. Alt, of Munich, has performed experiments on dogs, which seem to shew that the snake-poisons are eliminated by the stomach, and only after re-absorption therefrom produce their toxic effects, so that early washing out of this viscus renders them innocuous, or at least mild in their operation.—*L'Art Médical*, June.

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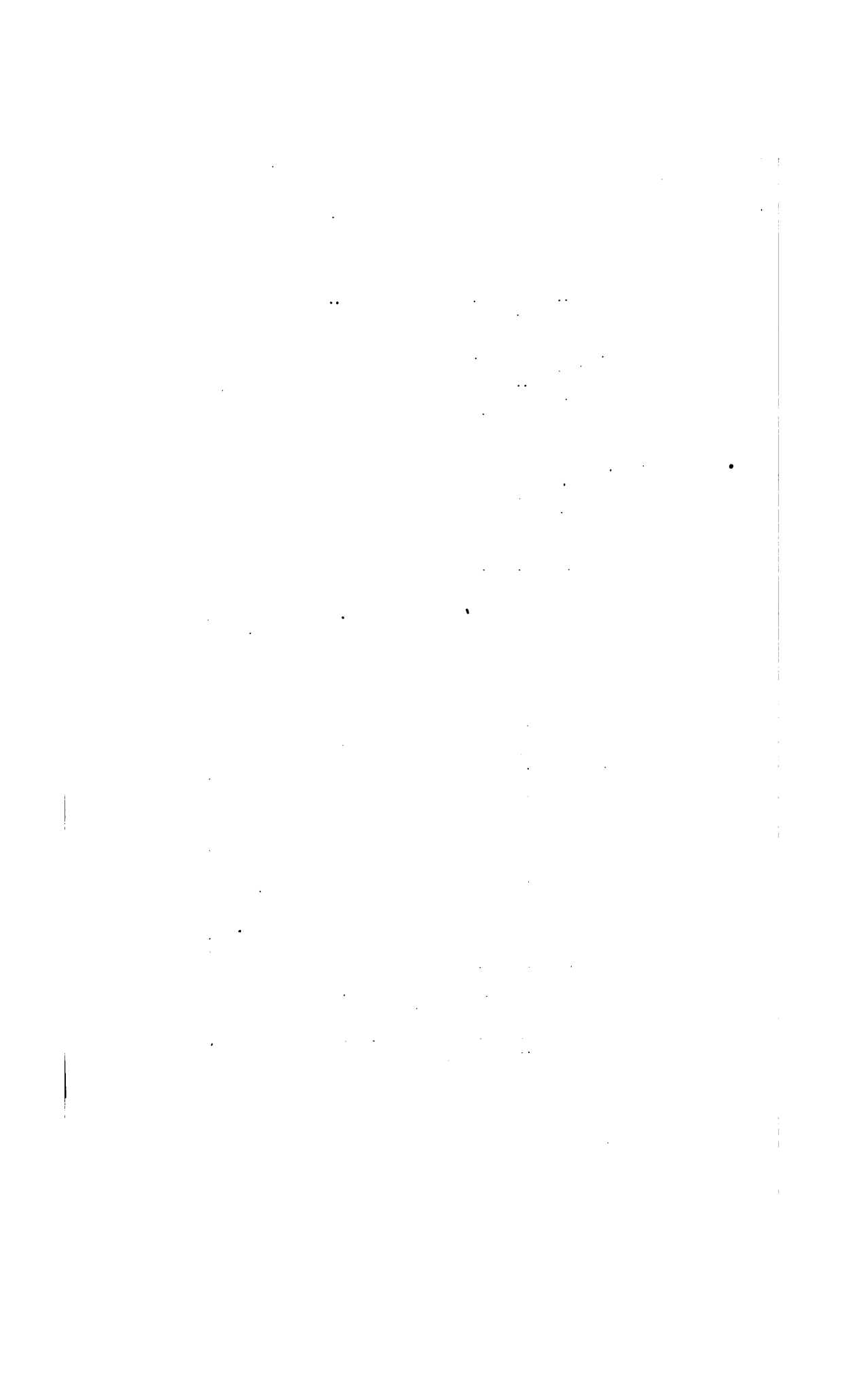
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L A W S
OF THE
BRITISH HOMŒOPATHIC SOCIETY

(INSTITUTED IN 1844)

Printed for the Society

London
JOHN BALE & SONS
87-89, GREAT TITCHFIELD STREET, OXFORD STREET, W.
1893

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LAWS AND REGULATIONS
OF THE
BRITISH HOMŒOPATHIC SOCIETY.

INSTITUTED IN 1844.

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, an Editor of the Transactions and an Honorary Secretary, all of whom—except the Editor of the Transactions and the Honorary Secretary, who shall be elected by the Council—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,¹ 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.

¹ See Law X.

VI. Every person desirous of becoming a Member of the British Homœopathic Society must be proposed by two Members. The 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 ballotted 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 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.

BRANCHES.

XI. For the further advancement and extension of the Society, Members may form themselves into separate bodies, to be styled Branches. Each Branch shall be free to govern itself as its Members think fit, but no Branch Law shall be valid which has not previously received the sanction of the Council. Each Branch shall pay its own expenses, and no Branch shall be deemed for any purpose the agent of the Society, or have the power to incur any obligation on its behalf.

FELLOWS.

XII. Fellows must possess the usual qualifications of Members, must have been Members of the Society for at least five 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.

HONORARY AND CORRESPONDING MEMBERS.

XIII. 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.

XIV. 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.

TRANSACTIONS.

XV. The Transactions of the Society shall be published quarterly in London, and shall be under the direction of an Editor, who shall be responsible for their proper issue.

Once in every year a list of the Officers, Fellows, Members and Corresponding Members with their addresses shall be published separately as a supplement to the Transactions.

ORDINARY MEETINGS.

XVI. 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.

EXTRAORDINARY MEETINGS.

XVII. An Extraordinary Meeting may be called by the President; or on the requisition of five Members.

ANNUAL ASSEMBLY.

XVIII. 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 President, Vice-Presidents, and Treasurer, who shall be Fellows of the Society, shall be the first Officers elected at the Annual Assembly. Four Fellows and two Members shall next be elected, to form with the above, the Branch representatives, and the Secretary, the Council of the Society.

(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.

OFFENCES AND PENALTIES.

XIX. 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.

XX. 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.

XXI. 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.

XXII. 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.

XXIII. 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.

XXIV. Expulsion deprives a Member of all the privileges of the Society, and his name shall be struck off the list of Members. The vote of expulsion shall be entered upon the Minutes, and a copy of such Minute shall be forwarded to the Member expelled, and to the Members generally.

XXV. A Member omitting to discharge his debts to the Society before the close of the Annual Assembly, shall be liable to have his name erased from the list of Members.

THE PRESIDENT AND VICE-PRESIDENTS.

XXVI. 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

XXVII. The Council shall consist of the President, two Vice-Presidents, the Treasurer, together with four Fellows and two Members, to be elected annually, and to be eligible for re-election; and a Fellow or Member to be nominated annually by each Branch. Three Members of the Council shall form a quorum. The Honorary Secretary shall *ex-officio* attend all Meetings of the Council.

The business of the Society shall be managed by the Council, who shall meet not less than four times a year; shall elect the Honorary Secretary and the Editor of the Transactions; shall direct the publications of the Society, and shall annually prepare a report of the work and progress of the Society, to be presented at each Annual Assembly.

TREASURER.

XXVIII. 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.

XXIX. 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 re-imbusement 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 Membership, a letter containing extracts from Laws IX., XX., XXI., XXII., and XXIII., 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.

P A P E R S.

XXX. 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.

XXXI. 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 the Council.

(a.) No Member shall publish, or furnish any materials for publishing, any transactions of the Society, without the authority of the President and the Council.



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.
2. Minutes of preceding Meeting read.
3. Subject of the Paper or Communication to be read at next Meeting announced from the Chair.
4. Communications from correspondents and translations read and discussed.
5. Paper read and discussed.
6. Meeting closed.

LIBRARY.

VI. That a Librarian be appointed, to take charge of the books, periodicals, and papers belonging to the Society, and that such books and periodicals (not being current numbers) and papers as may be taken from the Library by Fellows and Members shall be entered by the Librarian in a book kept for that purpose. All such books to be returned within a month, and periodicals within a week, of the time of their being taken away.

VII. Any work soiled or injured must be replaced at the expense of the Member so injuring it.

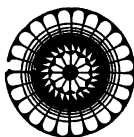
VIII. A book shall lie upon the Library table, in which each Member may propose the purchase of such works as he may

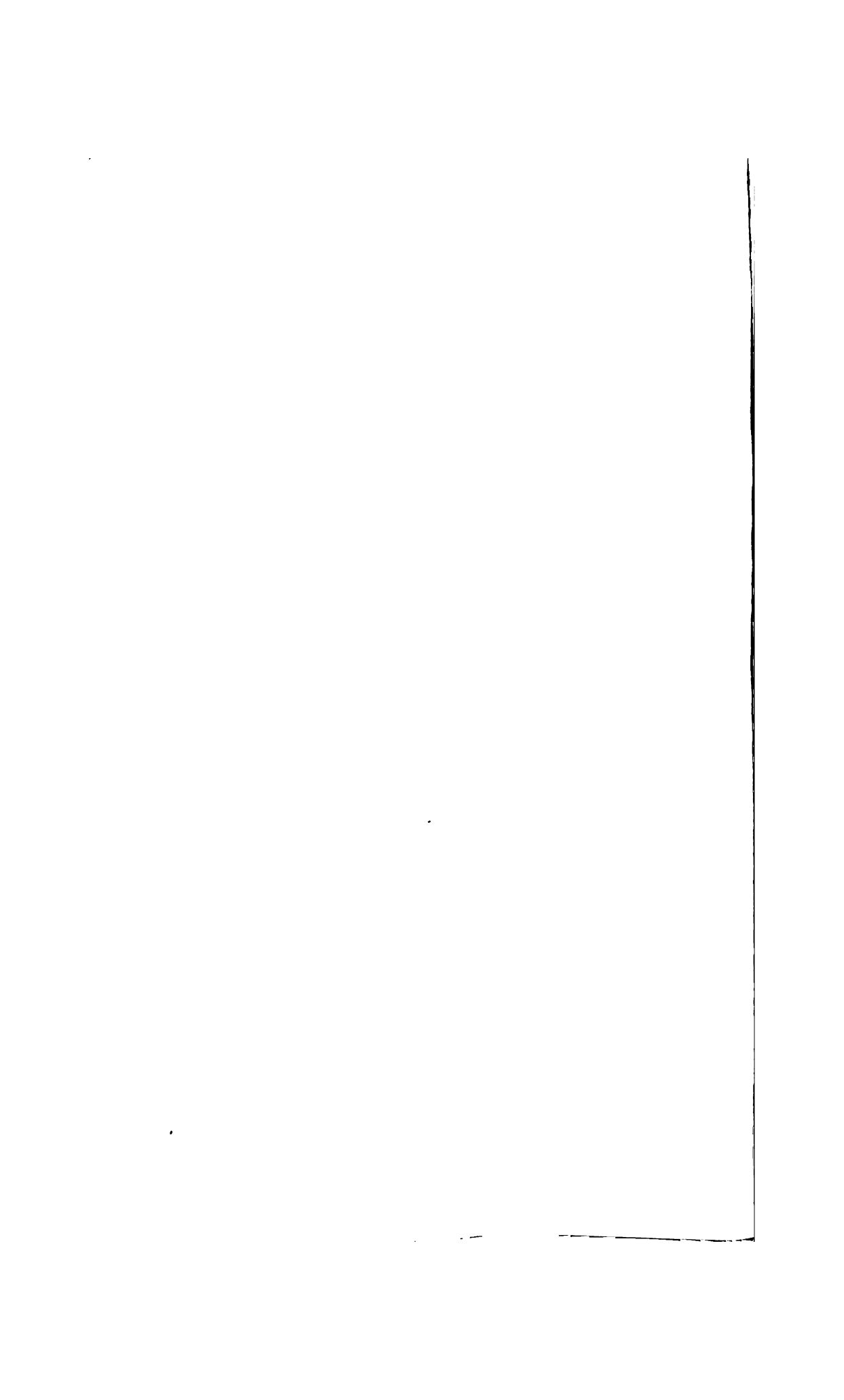
think suitable for the Library; which book shall be laid before the Library Committee at their next meeting, and without their order no book shall be purchased.

COMMITTEES.

IX. Committees shall be appointed by the Society, and shall consist of not less than five Members, of whom three shall form a quorum.

(a.) The President shall be Chairman *ex-officio* of all Committees, *Vide* Law XXVI.





BYE-LAWS.

SECTIONS.

I. The work of the Society shall be divided into the following sections :—

- (a) *Materia Medica* and Therapeutics.
- (b) General Medicine and Pathology.
- (c) Surgery and its special branches of Gynæcology.

II. Each section shall be controlled by a Committee of five Members elected at the Annual Assembly, who shall choose two of their number as Chairman and Secretary respectively. The Honorary Secretary of the Society shall be *ex-officio* a member of each committee.

III. Each section shall, as far as possible, have allotted to it three evenings in rotation during the session. The Chairman of the section shall be responsible to the Honorary Secretary for the production of papers on the evenings allotted to it.

ORDINARY MEETINGS.

IV. Ordinary Meetings shall commence at a quarter to eight, and shall not be prolonged beyond half-past ten, except

by a vote of the majority of the members present. The order of business shall be as follows :—

- (a) The minutes of the preceding meeting read.
- (b) New petitions for admission read.
- (c) Candidates for admission balloted for.
- (d) Miscellaneous business.
- (e) Visitors announced and introduced.
- (f) Specimens, cases, &c., shown.
- (g) Papers read and discussed.
- (h) Meeting closed.

V. Each Member is entitled to introduce a Visitor 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.

VI. A book shall be kept by the Secretary, in which Members introducing Visitors shall see that they sign their names previous to admission.

COUNCIL MEETINGS.

VII. The Council shall meet at least four times a year at seven o'clock on the evenings of the ordinary meetings of the Society.

LIBRARY.

VIII. That a Librarian be appointed, to take charge of the books, periodicals, and papers belonging to the Society, and

that such books and periodicals (not being current numbers) and papers as may be taken from the Library by Fellows and Members shall be entered by the Librarian in a book kept for that purpose. All such books to be returned within a month, and periodicals within a week, of the time of their being taken away.

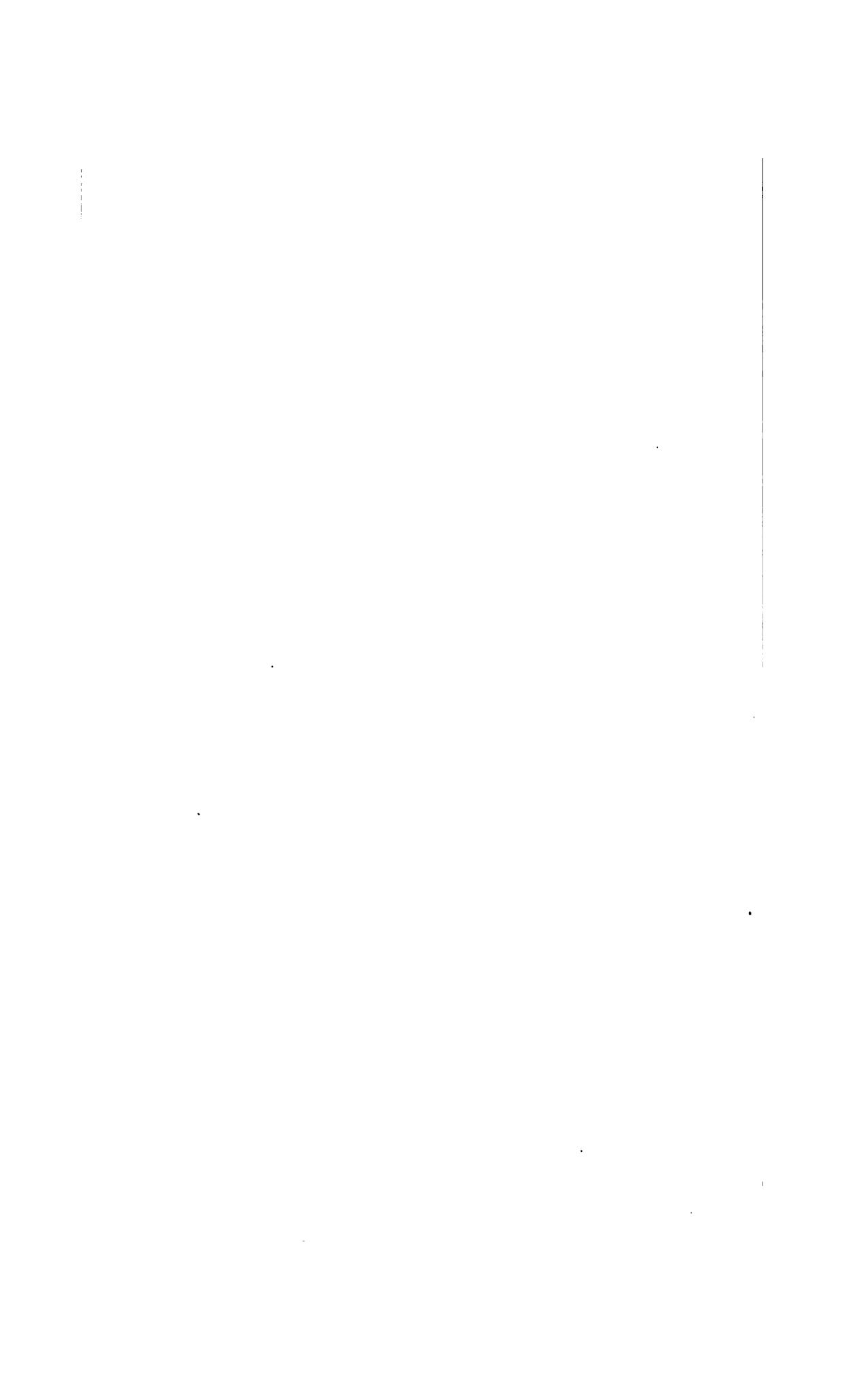
IX. Any work soiled or injured must be replaced at the expense of the Member so injuring it.

X. A book shall lie upon the Library table, in which each Member may propose the purchase of such works as he may think suitable for the Library; which book shall be laid before the Library Committee at their next meeting, and without their order no book shall be purchased.

COMMITTEES.

XI. Committees shall be appointed by the Society, and shall consist of not less than five Members, of whom three shall form a quorum.

(a) The President shall be Chairman *ex-officio* of all Committees. *Vide* Law XXVI.



OFFICERS AND COUNCIL
OF THE
British Homœopathic Society.

ELECTED AT
THE ANNUAL ASSEMBLY, JUNE, 1898.

President.

HUGH CAMERON.

Vice-Presidents.

EDWARD MADDEN, M.B.
GILES F. GOLDSBROUGH, M.D.

Treasurer.

J. GALLEY BLACKLEY, M.B.

Librarian.

E. A. NEATBY, M.D.

Council.

J. GALLEY BLACKLEY, M.B.	JOHN W. HAYWARD, M.D. (Liverpool).
HUGH CAMERON.	RICHARD HUGHES, M.D. (Brighton).
R. E. DUDGEON, M.D.	E. MADDEN, M.B. (Bromley).
WASHINGTON EPPS.	BYRES MOIR, M.D.
G. F. GOLDSBROUGH, M.D.	E. A. NEATBY, M.D.
HENRY HARRIS.	C. KNOX SHAW.

Library Committee.

J. GALLEY BLACKLEY.	R. HUGHES.
G. BURFORD.	E. A. NEATBY.
C. KNOX SHAW.	

Secretary.

C. KNOX SHAW,

PRESIDENTS OF THE SOCIETY

(FROM ITS FOUNDATION).

- 1844-78 FREDERICK HERVEY FOSTER QUIN, M.D.
1879 ROBERT ELLIS DUDGEON, M.D.
1880 STEPHEN YELDHAM.
1881 ALFRED CROSBY POPE, M.D.
1882-83 WILLIAM VALLANCEY DRURY, M.D.
1884 DAVID DYCE BROWN, M.D.
1885 JOHN HAMILTON MACKECHNIE, M.D.
1886 MATHIAS ROTH, M.D.
1887 RICHARD HUGHES, M.D.
1888-89 GEORGE MANN CARFRAE, M.D.
1890 ROBERT ELLIS DUDGEON, M.D.
1891 CHARLES THOMAS KNOX SHAW.
1892 JOHN GALLEY BLACKLEY, M.B.
1893 HUGH CAMERON.
-

TRUSTEES OF THE SOCIETY.

ROBERT ELLIS DUDGEON, M.D.
JOHN GALLEY BLACKLEY, M.B.

CORRESPONDING MEMBERS.

ELECTED

- 1861 DR. LÉON SIMON, 5 Rue de la Tour des Dames, Paris.
1863 DR. QUAGLIO, Munich.
1863 DR. NOACK, 4 Rue des deux Maisons, Lyons.
1863 DR. LADELICI, Rome.
1870 DR. IMBERT - GOURBEYRE, Clermont - Ferrand,
France.
1875 DR. LUDLAM, 1823 Michigan Avenue, Chicago.
1875 DR. TALBOT, 66 Marlborough Street, Boston.
-

- 1875 DR. ALLEN, New York.
1875 DR. S. A. JONES, Ann Arbor, Michigan.
1876 DR. LÉON SIMON, fils, 5 Rue de la Tour des Dames,
Paris.
1877 DR. JOUSSET, 241 Boulevard St. Germain, Paris.
1878 DR. CLAUDE, Rue Caumartin, Paris.
1878 DR. SIRCAR, Calcutta.
1892 DR. LAMBREGHTS, fils, Rue Stook, Antwerp.
1892 DR. BONIFACE SCHMITZ, Rue des Capucines,
Antwerp.
1893 DR. TOD HELMUTH, 299 Madison Avenue, New York.
1893 DR. J. P. DAKE, Nashville, Tennessee.
1893 DR. MARTINY, Rue D'Arlon 45, Brussels.
1893 DR. WINDELBAND, Königgrätzerstr. 88, Berlin.
1893 DR. SULZER, Lützowstr. 88, Berlin.

FELLOWS OF THE SOCIETY.

CHARLES HARRISON BLACKLEY.
JOHN GALLEY BLACKLEY.
EDWARD THOMAS BLAKE.
DAVID DYCE BROWN.
WILLIAM DEANE BUTCHER.
HUGH CAMERON.
GEORGE MANN CARFRAE.
JOHN HENRY CLARKE.
ARTHUR CROWEN CLIFTON.
ROBERT THOMAS COOPER.
ROBERT ELLIS DUDGEON.
GILES FORWARD GOLDSBROUGH.
EDWARD HAMILTON.
JOHN WILLIAMS HAYWARD.
RICHARD HUGHES.
JOHN HAMILTON MACKECHNIE.
EDWARD MONSON MADDEN.
BYRES MOIR.
HERBERT NANKIVELL.
EDWIN AWDAS NEATBY.
ALFRED CROSBY POPE.
CHARLES THOMAS KNOX SHAW.
GEORGE WYLD.
STEPHEN YELDHAM.

MEMBERS OF THE BRITISH HOMŒOPATHIC SOCIETY.

Founded 1844.

EXPLANATION OF THE ABBREVIATIONS.

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

Those marked thus (*) are Fellows of the Society, and those marked (†) are non-resident or retired from practice.

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

GENERAL LIST OF MEMBERS.

ELECTED

- 1892 ABBOTT, GEORGE, M.A., M.D. (Hon. causâ) Mass., L.R.C.P., L.M.I., L.A.H.Dub., L.R.C.P., L.R.C.S., L.M.Edin.; 11A, Standishgate, Wigan.
- 1888 ALEXANDER, ARCHIBALD SPIERS, M.D., C.M.Glasg.; Physician to the Devon and Cornwall Homœopathic Dispensary and Cottage 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, Manchester.
- 1891 BARROW, ROGER WILLIAM, M.D.Brux., L.R.C.P., L.M. Edin., M.R.C.S.Eng.; 3, White Ladies Road, Clifton.
- 1868 BELCHER, HENRY, M.D.Erlang., L.R.C.P.Edin., M.R.C.S. Eng.; Physician to the Sussex County Homœopathic Dispensary; 28, Cromwell Road, West Brighton.
- 1854 †BELL, VERNON, M.D.Edin., L.R.C.S. and L.M.Edin.; Highland Gardens, St. Leonards-on-Sea.
- 1892 BELLIS, EDWARD, L.R.C.P., L.R.C.S., L.M.I., L.A.H.Dub.; 4, Addison Terrace, Notting Hill, W.

ELECTED

- 1890 BENNETT, HENRY, L.R.C.P., L.R.C.S., L.M.Edin., L.A.H.,
L.M.Dub.; 323, Holloway Road, N.
- 1892 BIRD, ASHLEY, M.R.C.S.Eng., L.S.A.; Culverlands, Stan-
well Road, Penarth, Glamorganshire.
- 1871 *BLACKLEY, CHARLES HARRISON, M.D.Brux., M.R.C.S.Eng.;
Arnside House, Old Trafford, Manchester. (V.-P.
1881-2, 1886-7.)
- 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, Consult-
ing Physician to the Mason Orphanage; 23, Waterloo
Street, Birmingham.
- 1892 BLUMBERG, HENRY D'ARNIM, L.R.C.P., L.R.C.S.Edin.;
L.F.P.S.Glasg.; Warley House, Southport.
- 1892 BLYTH, WILLIAM FRANCIS, L.R.C.P., L.R.C.S., L.M.
Edin.; 97, Approach Road, Victoria Park, E.
- 1892 BODMAN, FRANCIS HENRY, M.D.Aberd., M.R.C.S.Eng.,
L.M.; Physician to the Bristol Homœopathic Dis-
pensary; Linden House, Oakland Road, Clifton.
- 1860 BRADSHAW, WILLIAM, M.D.Aberd., M.R.C.S.Eng., L.S.A.;
122, Holland Road, W.
- 1893 BROOKS, SAMUEL BREWER, M.R.C.S.Eng., L.R.C.P.Edin.,
L.F.P.S.Glasg., L.S.A.; 25, Peachey Terrace, Mel-
bourne Street, Nottingham.
- 1892 BROTCHE, THEODORE RAINY, M.D., C.M.Aberd.; 102,
Great Victoria Street, Belfast.
- 1871 *BROWN, DAVID DYCE, M.A., M.D., C.M.Aberd.; Consulting
Physician to the London Homœopathic Hospital; 29,
Seymour Street, Portman Square, W. (P. 1884.
V.-P. 1883. C. 1892.)
- 1872 BRYCE, WILLIAM, M.D.Edin.; 31, Charlotte Square,
Edinburgh.

ELECTED

- 1889 BURFORD, GEORGE, M.B., C.M.Aberd.; Physician to the Gynæcological Department, London Homœopathic Hospital; 20, Queen Anne Street, Cavendish Square, W. (C. 1892.)
- 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.; Ham-slade, Sweyn Road, Margate.
- 1873 BURWOOD, THOMAS WESLEY, L.R.C.P., L.M.I., L.R.C.P., L.M.Edin.; Strathmore, Florence Road, Ealing, W.
- 1876 *BUTCHER, WILLIAM DEANE, M.R.C.S.Eng.; Clydesdale Villa, Osborne Road, Windsor.
- 1844 *CAMERON, HUGH (*President*), M.R.C.S.Eng.; 62, Redcliffe Square, S.W. (V.-P. 1865-6, 1871.)
- 1864 †CAMPBELL, Hon. ALAN, M.D.Edin.; North Terrace, Adelaide, S. Australia.
- 1890 CAPPER, EDMUND (*Secretary, Liverpool Branch*), M.D., C.M.Edin.; Senior Stipendiary Medical Officer to the North Homœopathic Dispensary; 2, Newsham Drive, Liverpool.
- 1892 CAPPER, PERCY, M.B., C.M.Edin.; 9, Monson Road, Tun-bridge Wells.
- 1861 *CARFRAE, GEORGE MANN, M.D.Edin.; Consulting Physi-
cian to the Gynæcological Department, London
Homœopathic Hospital; 4, Hertford Street, Mayfair,
W. (P. 1888-9. V.P.-1882-3.)
- 1879 CASH, ALFRED MIDGLEY, M.D., C.M.Edin., M.R.C.S.Eng.;
Physician to the Torquay Homœopathic Dispensary;
Surgeon to the Incurable Hospital for Children,
Babbicombe; Limefield, Falkland Road, Torquay.
- 1892 CAVENAGH, JOHN PAUL, L.R.C.P., L.R.C.S., L.M.I.; 57,
Tything, Worcester.
- 1873 CHALMERS, ANDREW CRICHTON, M.D., L.R.C.S.Edin.;
305, Glossop Road, Sheffield.
- 1877 CHURCHILL, SAMUEL, M.D.Aberd., M.R.C.S.Eng.; 1,
Cheriton Terrace, Folkestone.

ELECTED

- 1880 *CLARKE, JOHN HENRY, M.D., C.M.Edin.; Physician to the London Homœopathic Hospital; 30, Clarges Street, W. (V.-P. 1888).
- 1861 *CLIFTON, ARTHUR CROWEN, M.D. (Hon.) New York, M.R.C.S.Eng.; Physician to the Northampton Homœopathic Dispensary; 65, Abington Street, Northampton.
- 1892 CLIFTON, FREDERICK WILLIAM, M.R.C.S.Eng., L.R.C.P., L.M.Edin.; 356, Glossop Road, Sheffield.
- 1873 CLIFTON, GEORGE, L.R.C.P.Edin., L.M., L.F.P.S.Glasg.; 48, London Road, Leicester.
- 1892 COLLINS, CHARLES PHILLIPS, M.D.Clev., M.R.C.S.Eng., L.R.C.P.Lond.; Norham Lodge, Leamington.
- 1892 †COOK, EDMUND ALLEYNE, Ph.D.Warburg, L.R.C.P., L.R.C.S.Edin. L.F.P.S.Glasg.; 88, Collins Street East, Melbourne, Australia.
- 1891 †COOK, HENRY WILLIAM JAMES, M.B., B.S.Durh.; 88, Collins Street East, Melbourne, Australia.
- 1869 *COOPER, ROBERT THOMAS, M.A., M.D., M.Ch. T.C.D.; Physician for Diseases of the Ear, London Homœopathic Hospital; 30A, George Street, Hanover Square, W. (V.-P. 1889-90.)
- 1893 CORBETT, HERBERT HENRY, M.R.C.S.Eng.; 19, Hall Gate, Doncaster.
- 1892 COX, RICHARD PERCY, M.D., C.M.Edin.; 2, Lime Grove, Oxford Road, Manchester.
- 1890 COX, WILLIAM SPENCER, M.R.C.S.Eng., L.S.A.; Ophthalmic Clinical Assistant to the London Homœopathic Hospital; Physician to the Kensington, Notting Hill and Bayswater Homœopathic Dispensary; 12, Sheffield Gardens, Kensington, W.
- 1892 CRAIG, GEORGE ALEXANDER, M.B., C.M.Aberd.; Physician to the Birmingham Homœopathic Hospital; 63, Soho Road, Birmingham.
- 1892 CRAIG, JOHN, L.R.C.P.Edin., L.F.P.S.Glasg.; Shelton House, Stoke-upon-Trent.
- 1892 CRAIG, JOHN SMITH, M.B., C.M.Aberd.; 137, Steelhouse Lane, Birmingham.

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- FRANCIS BAKER, M.D. St. And., M.B.C.S.Eng.;
1, White House, Lambeth Common, S.W.
- ALFRED BAKER, M.D. Edin.; Surgeon
to the London Hospital; to the
London Dispensary; and to the
London Homeopathic Hospital; 3,
St. George's Lane, Lambeth.
- ALFRED BAKER, M.D. St. And., M.B.C.S.
Physician to the Hastings and
London Homeopathic Dispensary; 26, Grand
Street, London.
- ALFRED BAKER, M.B.C.S.Eng., L.R.C.P.
1, Upper Parliament Street, Liverpool.
- ALFRED BAKER, M.D. Lond., M.B.C.S.Eng.,
L.S.A.; Assistant Physician and
Surgeon to the London Homeopathic Hospital;
1, Great Marlborough Street, London, N.W.
- ALFRED BAKER, M.B.C.S.Eng., L.S.A.; Sur-
geon to the Hospital for Soldiers' Wives and Children,
Aldershot; Army Medical Staff, Alder-
shot.
- ALFRED BAKER, M.D. St. And., M.B.C.S.Eng., L.R.C.P.
1, Ashfield, Sydney, New South Wales.
- ALFRED BAKER, M.B.C.S.Eng., L.R.C.P. Edin.; Shen-
ton, Malvern.
- ALFRED BAKER (Council), M.D. Edin., L.R.C.S.
Consulting Physician to the London Homoeo-
pathic Hospital; 53, Montagu Square, W. (P. 1879,
V.P. 1874-5, 1881. T. 1883-93. S. 1846-48.)
- ALFRED BAKER, M.B., C.M. Edin.; 2, Eldon
Newcastle-on-Tyne.
- ALFRED BAKER (President, Liverpool Branch), M.B.,
L.R.C.P., L.R.C.S. Edin.; Honorary Medi-
cal Officer to the Hahnemann Hospital, Liverpool;
1, Rodney Street, Liverpool.
- ALFRED BAKER (Council), L.R.C.P., L.M. Edin.;
Surgeon; Assistant Physician to the London
Homeopathic Hospital; 89, Great Russell Street,
London, W.C.

ELECTED

- 1889 **FERNIE, WILLIAM THOMAS**, M.D.Durh., L.R.C.P.Lond., M.R.C.S.Eng., L.S.A.; The Nook, Great Malvern.
- 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.; Assistant Physician to the Hahnemann Convalescent Home; Surgeon to the Bournemouth Homœopathic Dispensary; Clovelly, Suffolk Road, Bournemouth.
- 1888 **GILBERT, SYDNEY**, L.R.C.P., L.R.C.S.Edin., L.A.H., L.M.Dub.; Roseneath, Reigate, Surrey.
- 1893 †**GILES, FREDERICK WILLIAM**, M.B.Durh., M.R.C.S.Eng.; Hotel Continental, Cannes, France.
- 1881 ***GOLDSBROUGH, GILES FORWARD** (*Vice-President, C.*), M.D., C.M.Aberd.; Cedar Lodge, 133, Coldharbour Lane, S.E.
- 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.; Woodlawn, Leigham Court Road, Streatham, 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.
- 1892 **GREEN, VINCENT**, M.B., C.M.Edin.; 10, The Common, Ealing, W.
- 1876 **GUINNESS, ARTHUR**, M.D.Glasg., F.R.C.S.I., L.M.Dub.; Physician to the Oxford Homœopathic Dispensary; Acacia Lodge, Oxford.
- 1877 **HAHNEMANN, FREDERICK LEOPOLD ROBERT**, M.D.Leipzig; 14, Highbury Crescent, N.
- 1876 **HALL, EDGAR ATHELING**, M.B., C.M.Edin.; Physician to the Surbiton, Kingston and Norbiton Homœopathic Dispensary; Laurel Villa, Victoria Road, Surbiton.

X.

ELECTED

- 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. 1878-9. T. 1848-1881.)
- 1892 HAMILTON, JOHN, L.R.C.P.Edin., L.F.P.S.Glasg.; 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.
- 1871 HARRIS, HENRY (*Council*), M.R.C.S.Eng.; 111, Denmark Hill, S.E.
- 1878 HAWKES, ALFRED EDWARD (*Vice-Pres., Liverpool Branch*), M.D.Brux., L.R.C.P., L.M., L.R.C.S.Edin.; Physician to the Hahnemann Hospital, Liverpool; 22, Abercromby Square, Liverpool. (P. Liverp. Br. 1892.)
- 1888 HAWKES, EDWARD JOHN, L.R.C.P., L.R.C.S., L.M.Edin.; 4, West Cliff Road, Ramsgate.
- 1886 HAYLES, THOMAS HAHNEMANN, M.B.Lond.; 154, Drake Street, Rochdale.
- 1892 HAYWARD, CHARLES WILLIAMS, M.D., C.M.Edin., 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.
- 1868 *HAYWARD, JOHN WILLIAMS (*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.
- 1885 HILBERS, HERMANN GERHARD, B.A.Camb., L.R.C.P.; L.R.C.S.Edin., L.F.P.S.Glasg.; 49, Montpelier Road, Brighton.
- 1887 HILL, WILLIAM REED, M.B., C.M.Edin.; 29, Crouch Street, Colchester.

ELECTED

- 1861 *HUGHES, RICHARD (*Editor, C.*) M.D. (Hon.), L.R.C.P. Edin.,
M.R.C.S. Eng.; Physician to the Brighton Homœo-
pathic Dispensary; 36, Sillwood Road, Brighton.
(P. 1887. V.-P. 1885-6. S. 1879-84.)
- 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; 54, York Terrace, Regent's Park,
N.W.
- 1894 JOHNSTONE, JAMES, F.R.C.S. Eng., M.B., C.M., D.P.H.
Aberd.; 47, Sheen Road, Richmond.
- 1887 †JONES, DAVID OGDEN ROEBUCK, M.D. Toronto, L.R.C.P.
Lond.; 126, Carlton Street, Toronto, Canada.
- 1893 JONES, GEORGE REGINALD, L.R.C.P. Lond., M.R.C.S. Eng.;
3, Iden Villas, South Terrace, Eastbourne.
- 1866 JONES, JAMES, M.D. Edin., M.R.C.S. Eng., L.R.C.P. Lond.;
Physician to the Reading and Berkshire Homœo-
pathic Dispensary, Holybrook House, Castle Street,
Reading.
- 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, Birkenhead.
- 1886 KENNEDY, WILLIAM ADAM, M.B. Durh., L.R.C.P. Lond.,
M.R.C.S. Eng.; (*address not communicated*).
- 1879 KER, CLAUDIUS BUCHANAN, M.D. Edin.; Consulting Physi-
cian to the Cheltenham Homœopathic Dispensary;
Hadley House, Cheltenham.
- 1875 †KITCHING, CHARLES WATSON, M.B. Lond., M.R.C.S. Eng.,
L.S.A.; 6, Church Street, Cape Town, S. Africa.
- 1872 †KYNGDON, BOUGHTON, L.S.A.; Sydney, New South Wales.
- 1893 LAMBERT, JAMES RUDOLF PAUL, M.B., C.M. Edin.; Resi-
dent Medical Officer to the London Homœopathic
Hospital; London Homœopathic Hospital, Great
Ormond Street, W.C.

ELECTED

- 1891 LOUGH, GEORGE JOHN, L.R.C.P.I., L.M.; Assistant Surgeon to the Buchanan Cottage Hospital, and Assistant Ophthalmic Surgeon to the Hastings and St. Leonards Homœopathic Dispensary; 35, Wellington Square, Hastings.
- 1850 MACKECHNIE, JOHN HAMILTON, M.D. St. And.; Physician to the Hahnemann Dispensary, Bath; 15, Catherine Place, Bath. (P. 1885. V.-P. 1872. S. 1867-69.)
- 1893 MACNISH, DAVID, M.A., M.B., C.M.Edin.; Strathmore, Florence Road, Ealing, W.
- 1886 MCKILLIAM, ROBERT, M.D., C.M.Aberd.; 1, Bennett Park, Blackheath, S.E.
- 1892 MCLACHLAN, JOHN, M.D., C.M., B.Sc.Edin., F.R.C.S.Eng. 38, Beaumont Street, Oxford.
- 1876 *MADDEN, EDWARD MONSON (V.-P., *Council*), M.B.Edin., M.R.C.S.Eng.; Physician to the Phillips Memorial Hospital; Burlington House, Bromley, Kent.
- 1892 MAHONY, EDWARD, M.R.C.S.Eng., L.S.A.; Honorary Medical Officer to the Hahnemann Hospital, Liverpool; 30, Huskisson Street, Liverpool.
- 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; 56, Fitzroy Street, Fitzroy Square, W.
- 1885 MASON, HENRY, M.D., C.M.Glas., M.R.C.S.Eng.; 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.; 256, Oxford Road, 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. and C.M.Edin.; Physician to the London Homœopathic Hospital; 16 Upper Wimpole Street, W. (V.-P., 1891, 1892.)

ELECTED

- 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; 13, Lingfield Road, Wimbledon.
- 1877 MOORE, JOHN MURRAY, M.D., C.M., L.M.Edin., M.R.C.S.Eng., M.D.New Zealand; 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.; Grafton House, Clapham Common, S.W.
- 1882 MURRAY, JOHN, L.R.C.P., L.R.C.S., L.M.Edin.; 15, Trinity Gardens, Folkestone.
- 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, 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; Mulgrave Road, Sutton, Surrey.
- 1885 *NEATBY, EDWIN AWDAS (*Librarian, Council*), M.D.Brux., L.R.C.P.Lond., M.R.C.S.Eng.; Assistant Physician to the London Homœopathic Hospital; 178, Haverstock Hill, Hampstead, N.W.
- 1885 NEILD, FREDERICK, 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. Toronto, L.S.A.Lond.; 109, Cazenove Road, Stoke Newington, N.
- 1892 NICHOLSON, THOMAS DICKENSON, M.D., C.M.Edin., M.R.C.S.Eng.; Physician to the Clifton Homœopathic Dispensary; 2, White Ladies Road, Clifton.

ELECTED

- 1880 NOBLE, JAMES BLACK, M.R.C.S.Eng., L.R.C.P., L.M.Edin.;
167, Kennington Park Road, S.E.
- 1876 NORMAN, GEORGE, M.R.C.S.Eng., L.S.A.; Physician to
the Hahnemann Free Dispensary, Bath; 12, Brock
Street, Bath.
- 1892 OOKENDEN, 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.;
Greenstead, Madeira Road, Bournemouth East.
- 1886 PINCOTT, JAMES COLE, M.R.C.S.Eng., L.R.C.P., L.M.Edin.;
Surgeon to the Tunbridge Wells Homœopathic Hos-
pital and Dispensary; Calverley Parade, Tunbridge
Wells.
- 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.; 78, Beulah Hill,
Upper Norwood, S.E.
- 1884 PURDOM, THOMAS EADIE, M.D., C.M.Edin., L.R.C.P.,
L.R.C.S.Edin.; 25, Park Hill Road, Croydon.
- 1893 RAMSBOTHAM, SAMUEL HENRY, M.D.Edin., M.R.C.S.Eng.;
16, Park Place, Leeds.
- 1892 REAN, WILLIAM HENRY, M.R.C.S.Eng., L.S.A.; 36,
Vernon Terrace, Brighton.
- 1862 REED, ROBERT RHODES, M.D.Clev., M.R.C.S.Eng.; Mar-
ket Square, Lynn Regis, Norfolk.
- 1892 REED, WILLIAM CASH, M.D., C.M.Edin.; Physician to the
Devon and Cornwall Homœopathic Dispensary and
Cottage Hospital; 8, Queen Anne Terrace, Plymouth.

ELECTED

- 1872 †REID, LESTOCK HOLLAND, M.R.C.S.Eng., L.R.C.P.Lond.;
Bowmanville, Ontario, Canada.
- 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.
- 1892 ROBERTS, ARTHUR, M.D. St. And., M.R.C.S.Eng., L.S.A.,
D.P.H.; Hon. Physician to the Children's Sanatorium,
Harrogate; 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 Dis-
pensary; 63, Lower Mount Street, Dublin.
- 1878 ROCHE, ELEAZER BIRCH, L.R.C.P.Lond., M.R.C.S.Eng.,
L.M.; Physician to the Norwich Homœopathic Dis-
pensary and Hon. Medical Officer to the Orphans'
Home, Norwich; 27, Surrey Street, Norwich.
- 1892 ROCHE, WILLIAM; L.R.C.P.I., L.M., M.R.C.S.Eng.; 38,
Berners Street, Ipswich.
- 1892 ROSS, ALFRED, L.R.C.P., L.R.C.S.I., L.M.; The Elms,
Vernon Place, Scarborough.
- 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, L.R.C.P.Lond., M.R.C.S.Eng.;
114, Upper Richmond Road, Putney, S.W.
- 1880 SANDBERG, ARTHUR GREGORY, M.D., Verm. (Hon.),
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.
- 1892 SCRIVEN, GEORGE, M.D., B.Ch. Dub., L.M.; 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,
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ELECTED

- 1885 SHACKLETON, HENRY, A.B., M.D.Dub., M.R.C.S.Eng.,
L.M.R.C.P.I., L.M. ; 12, West Hill, Sydenham, S.E.
- 1888 *SHAW, CHARLES THOMAS KNOX (*Secretary, C.*), L.R.C.P.
Lond., M.R.C.S.Eng. ; Surgeon and Ophthalmic Sur-
geon to the London Homœopathic Hospital ; Surgeon
to the Buchanan Cottage Hospital, St. Leonards ;
Ophthalmic Surgeon to the Hastings and St. Leonards
Homœopathic Dispensary ; Consulting Surgeon to the
Tunbridge Wells Homœopathic Hospital ; 19, Upper
Wimpole Street, W. (P. 1891. V.-P. 1890.)
- 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.
- 1888 SIMPSON, THOMAS, M.D. St. And., M.R.C.S.Eng. ;
Physician to the Hahnemann Hospital, Liverpool,
and to the Bootle Homœopathic Dispensary ; 10,
Crosby Road, Waterloo, Liverpool.
- 1859 †SMART, JOHN CASS, M.D.Heid., Ext. L.R.C.P.Lond.,
M.R.C.S.Eng., L.S.A. ; Combe Hay, near Bath.
- 1885 SMITH, GERARD, M.R.C.S.Eng. ; Craigholm, Upper
Clapton, N.E.
- 1892 SMITH, ROBERT GORDON, M.B., C.M.Aberd. ; Physician to
the Hahnemann Hospital, Liverpool ; 164, Upper
Parliament Street, Liverpool.
- 1893 SOUTHAM, JOHN BINNS, M.R.C.S.Eng., L.S.A. ; Benar
View, Dolwyddelan, N. Wales.
- 1893 STACEY, HERBERT GLEESON, M.D.Brux., L.R.C.P., L.M.
Edin., M.R.C.S.Eng. ; 28, Park Square, Leeds.
- 1893 STALEY, JOHN CHRISTOPHER GEORGE, L.R.C.P.I., The
Mount, St. Anne's-on-Sea.
- 1890 STANCOMB, ERNEST HENRY MURLY, M.B., C.M.Edin. ; 2,
Lower Moira Place, Southampton.
- 1892 STEWINTHAL, 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.

ELECTED

- 1889 STONHAM, THOMAS GEORGE, M.D.Lond., M.R.C.S.Eng.;
Claremont, Belgrave Road, Ventnor.
- 1892 STOPFORD, ROBERT, L.R.C.P.I., L.M.; Physician to the
North of England Children's Sanatorium; 75, Hoghton
Street, Southport.
- 1887 STORRAR, WILLIAM MORRISON, L.R.C.P., L.R.C.S.Edin.
L.M.; Surgeon to the North of England Children's
Sanatorium; 37, 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.
- 1892 THOMAS, BERNARD, M.B., C.M.Edin.; Stipendiary Medical
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Liverpool; 40, Oxford Street, Liverpool.
- 1886 THOMAS, EDWARD JOHN HAYNES, L.R.C.P., L.R.C.S.Edin.;
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pensary; 18, Pepper Street, Chester.
- 1891 THOMAS, HAROLD WYNNE, M.R.C.S.Eng., L.R.C.P.Lond.;
Resident Medical Officer to the Phillips Memorial
Hospital, Bromley; 55, Park Road, Bromley, Kent.
- 1893 THOMPSON, CHARLES, M.R.C.S.Eng., L.S.A.; 226, Stam-
ford Street, Ashton-under-Lyne.
- 1855 †TUCKEY, CHARLES CAULFIELD, A.B., M.B.Dub., L.R.C.S.I.,
L.M.; Charleville, Kew.
- 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.
- 1893 WADDINGTON, CHARLES EDWIN, L.R.C.P.Lond., M.R.C.S.
Eng.; 2, Marlboro' Road, Manningham, Bradford.
- 1862 †WATSON, CHARLES GEORGE, L.R.C.S., L.R.C.P.I., L.M.;
Hobart, Tasmania.
- 1858 †WAUGH, Dr., Brisbane, Queensland.
- 1893 WEDDELL, JAMES CALL, M.D., C.M., L.M.Edin.; 9, Park
Terrace, Sunderland.

ELECTED

- 1861 †WHEELER, HENRY, L.R.C.P.Lond., M.R.C.S.Eng.;
Auburn Road, Hawthorne, Victoria, Australia.
- 1893 WILDE, FREDERICK GEORGE STANLEY, L.R.C.P., L.R.C.S.,
L.M.Edin.; Ingleside, Bayshill, Cheltenham.
- 1893 WILDE, HERBERT, M.B., C.M.Edin., L.R.C.P., L.R.C.S.,
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.;
Park House, Weston-super-Mare.
- 1891 WILDE, PERCY ROBERTS, M.D., C.M.Aberd.; Physician
to the Bath Homœopathic Hospital; 23, Circus, Bath.
- 1891 WILDE, ROWLAND STANLEY, M.B., C.M.Edin.; Park
House, Weston-super-Mare.
- 1892 WILKINSON, ALFRED GEORGE, M.R.C.S.Eng., L.S.A.; 28,
Newland, Northampton.
- 1892 WILKINSON, CLEMENT JOHN, M.R.C.S.Eng., L.S.A.; 112a,
Chorley New Road, Bolton-le-Moors.
- 1893 WILLIAMS, ARTHUR LLEWELLEN, L.R.C.P.Edin., L.M.;
127, Moss Lane, Manchester.
- 1892 WILLIAMS, EUBULUS, M.D. St. And., M.R.C.S.Eng., L.M.;
2, Beaufort Road, Clifton.
- 1892 WILLIAMS, LEMUEL EDWARD, M.R.C.S.Eng.; Surgeon to
the Skin Department, and Honorary Assistant Medi-
cal Officer to the Hahnemann Hospital, Honorary
Medical Officer to the Hahnemann Dispensary,
Liverpool; 62, Spellow Lane, Liverpool.
- 1892 WINGFIELD, JOHN, L.R.C.P., L.R.C.S.Edin., L.F.P.S.
Glasg., Chloroformist to the Dental Hospital, Bir-
mingham; Aubyn House, Alcester Road, Mosely,
Birmingham.
- 1889 WITHINSHAW, CHARLES WESLEY, L.R.C.P., L.R.C.S.Edin.,
L.M.; New Cross, S.E.
- 1893 WOLSTON, CHRISTOPHER, B.A.Lond., M.D. St. And.,
M.R.C.S.Eng.; Summershill, Chislehurst.
- 1877 WOLSTON, WALTER THOMAS PRIDEAUX, M.D.Edin.,
M.R.C.S.; 46, Charlotte Square, Edinburgh.
- 1876 WOOD, HENRY THOROLD, M.R.C.S.Eng.; 86, Seymour
Street, W.
- 1893 WOODGATES, HENRY, M.D.Glasg., M.R.C.S.Eng.; Physi-
cian to the Exeter Homœopathic Dispensary; Mona
Lodge, Lyndhurst Road, Exeter.

ELECTED

- 1889 WRIGHT, DUDLEY D'AUVERGNE, L.R.C.P.Lond., M.R.C.S. Eng.; Assistant Surgeon and Surgeon for Diseases of the Throat to the London Homœopathic Hospital; 32, Wimpole Street, W.
- 1854 *WYLD, GEORGE, M.D.Edin.; Fieldhead, Wimbledon Park, Wimbledon. (V.-P. 1876.)
- 1849 *YELDHAM, STEPHEN, M.R.C.S.Eng., L.R.C.P.Edin.; Consulting Surgeon to the London Homœopathic Hospital; Highfield House, St. Nicholas Road, Upper Tooting, S.W. (P. 1880. V.-P 1861-64; 1877).

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London (S.E.).

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Harris, H. (*Camberwell*).
McKilliam, R. (*Blackheath*).
Nankivell, F. (*Sydenham*).
Noble, J. B. (*Kennington*).
Powell, A. J. (*Anerley*).
Pullar, A. (*Norwood*).
Shackleton, H. (*Sydenham*).
Withinshaw, C. W. (*New Cross*).

London (S.W.).

Cameron, H. (*South Kensington*).
Cronin, E. F. (*Clapham Common*).

Gould, E. G. (*Streatham*).
Hamilton, E. (*South Kensington*).
Morrisson, S. (*Clapham Common*).
Sandberg, A. G. (*Brixton*).
Yeldham, S. (*Tooting*).

London (E.C.).

Burnett, J. C.

London (W.).

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Cox, W. S. (*Kensington*).
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Marsh, T. C.
Moir, B.
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Wood, H. T.
Wright, D. D'A.

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Epps, W. (*Bloomsbury*).
Lambert, J. R. P. (*Bloomsbury*).

Malvern.

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Arnold, F. S.
Blackley, C. H.

Cox, R. P.
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Moir, D.
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Margate.

Burns, A. H.

Nottingham.

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Eaton, H. A.

Hamilton, J.

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Rowse, E. L.

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Hawkes, E. J.

Rawtenstall, Lancs.

Finlay, J. T.

Reading.

Jones, J.

Reigate.

Gilbert, S.

Richmond (Surrey).

Johnstone, J.

Rochdale.

Hayle, T. H.

Steinthal, W. A.

St. Annes-on-Sea (Lancs).

Staley, J. C. G.

St. Leonards-on-Sea.

Bell, V.

Croucher, A. R.

Shaw, F. H.

Scarborough.

Flint, F.

Ross, A.

Sheffield

Chalmers, A. C.

Clifton, F. W.

Southampton.

Stancomb, E. H. M.

Southport.

Blumberg, H. d'A.

Stopford, R.

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