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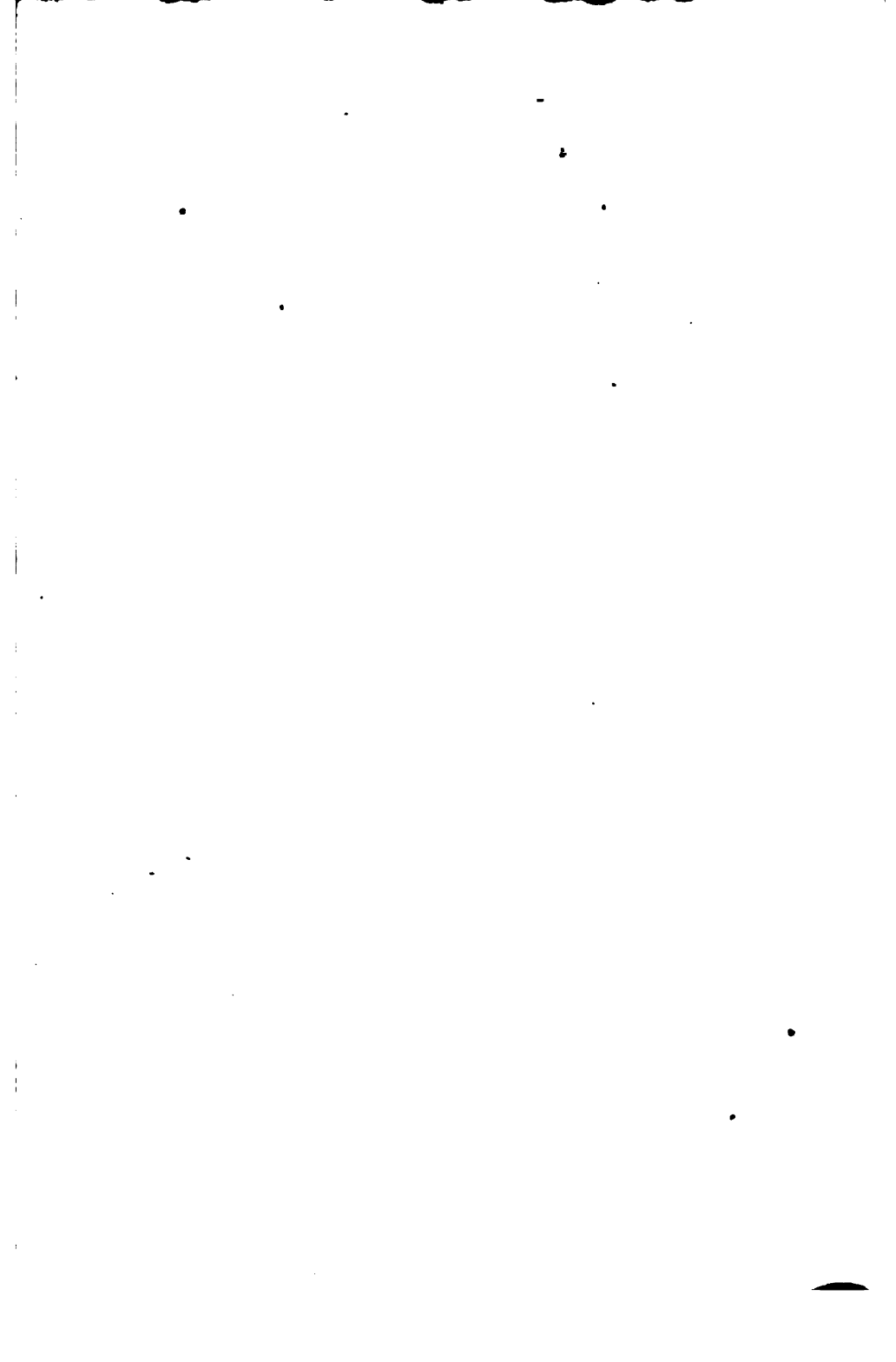
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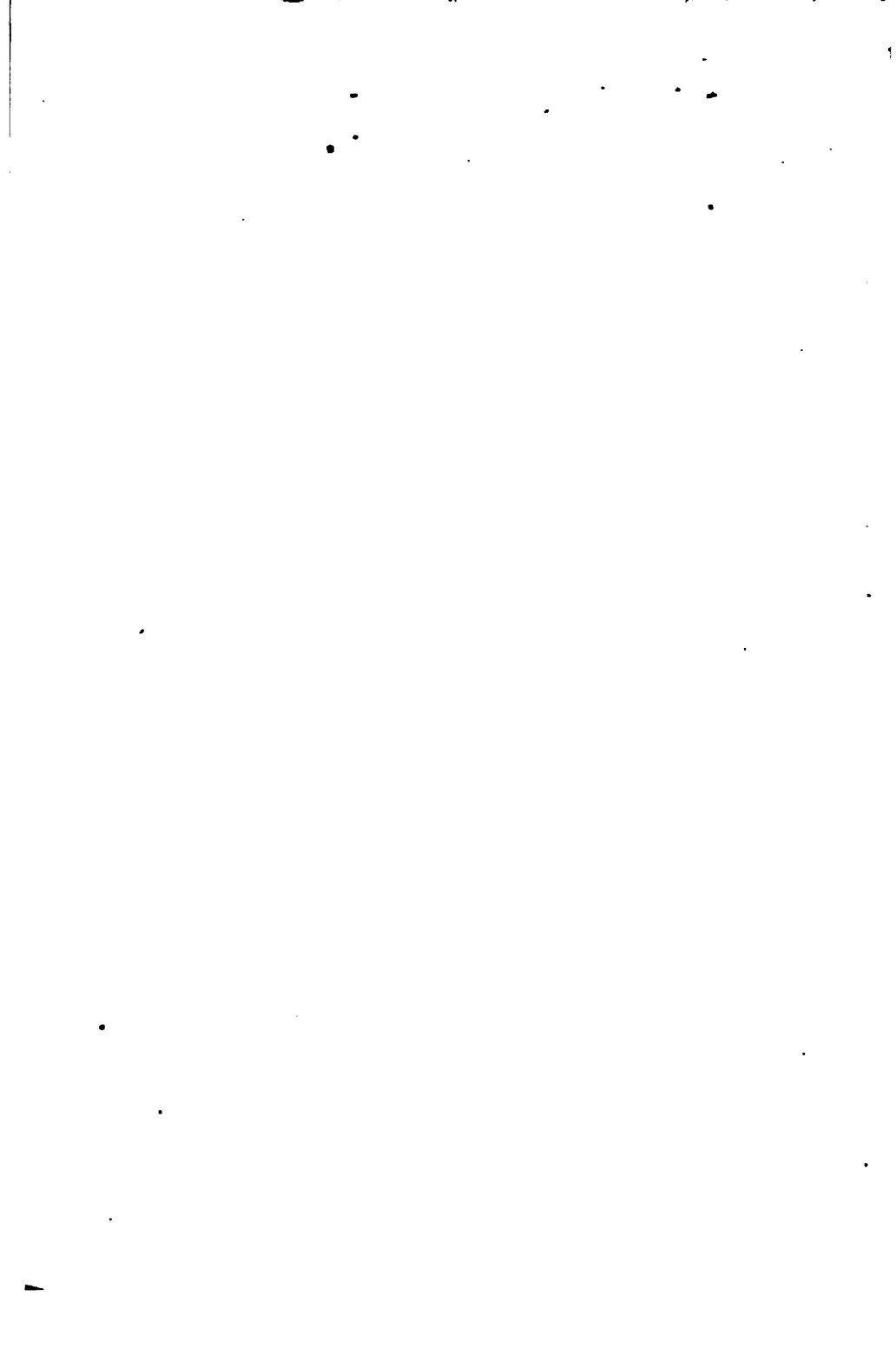
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# The Journal

OF THE

## British Homeopathic Society

*NEW SERIES*

**VOL. VII.**

**SESSION 1898-1899**

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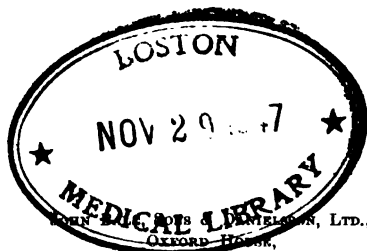
**London:**

**JOHN BALE, SONS & DANIELSSON, LTD.**

**OXFORD HOUSE**

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

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1899



83-89, GREAT TITCHFIELD STREET, OXFORD STREET, W.



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JOURNAL  
OF THE  
**British Homeopathic Society**

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No. 1.

JANUARY, 1899.

VOL. VII.

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

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THE BRITISH HOMŒOPATHIC SOCIETY: ITS  
*RAISON D'ÊTRE*—THE GROWING OF SOULS.

BEING THE PRESIDENTIAL ADDRESS DELIVERED AT THE  
FIRST MEETING OF THE SESSION 1898-1899.

BY ARTHUR C. CLIFTON M.D. (HON.) M.R.C.S.

GENTLEMEN, AND MY DEAR COLLEAGUES,—I have the honour of appearing before you this evening as President of this Society for the present session, a position which you have graciously conferred upon me, and at the same time provided me with two very able assistants—Dr. Burford and Dr. Epps—as Vice-Presidents; for which I now tender you my hearty thanks.

My duty, gentlemen, in this chair to-night will be to submit a few remarks for your consideration in relation to the various aspects of the work of this Society and our duties in relation to it. In that respect my remarks will be retrospective on the one hand and prospective on the other. I shall then conclude with a short sermon.

The title or text of my address is "The British Homœopathic Society: its *Raison d'Être*—the Growing of Souls."

In adopting this peculiar and somewhat presumptuous title, I assure you it is with no intention of merely shocking you, or making "your flesh creep," but from the fact that I verily believe in the growing of souls, and that unless our souls do grow in faith and knowledge they will wither and die. Moreover, it is because I think this Society exists for the distinct purpose of promoting the growth of soul in all its members in relation to their special calling as physicians and surgeons practising homœopathically—hence the general bearing of my remarks will be on that line of thought.

In the first place, gentlemen, you may fairly ask for my definition of "soul" in the connection in which I have used it, particularly as it is a term of deep and wide significance. Remembering, however, the advice of a very wise man and great philologist, to wit, "Never attempt the definition of any thought, word, or phrase which is practically undefinable," I will, with your permission, follow that advice, especially as none of the definitions in relation to the word "soul" in "Webster's Dictionary" meet my requirements here. Nevertheless, I am sure that it is quite due to you on the present occasion that I should give some clue to my meaning in that respect, and here, in brief, I say:—*That part in every man which constitutes his intellectual, mental, and moral being, whereby he thinks, reasons, feels, suffers, and wills; and which most men of thought and reflection recognise more or less as part, and even the greater part, of themselves.*

Now while I have avoided a strict definition of the term, I have, nevertheless, furnished you with all that you require on the present occasion in relation to it.

The British Homœopathic Society was founded, as you are aware, in 1844, mainly by the exertions and through the influence of Dr. Quin, who had studied under Hahnemann, and who, I believe, was the first homœopathic practitioner who settled in this country.

From the time when this Society was founded fifty-four years ago to the end of the last session, how many qualified

medical practitioners have openly espoused the principles and practice of homœopathy in this country, and have become members of this Society, together with others who have not been connected with it? The answer to this question cannot be quite accurately determined. Nevertheless, a careful examination which I have made of the various sources of knowledge places the total number at about four hundred and twenty.

This answer suggests a further question. Is this increase in the number of homœopathic practitioners in this country, and in the time named, satisfactory—considering the high claims of homœopathy as “the science of therapeutics,” together with the nature and amount of evidence which has been adduced in support of it?

At the first blush, it seems to me, and I think it will to you, that this increase falls far short of what might reasonably have been expected. But considering the nature of the therapeutic teachings of homœopathy, their deep and wide bearing in relation to disease, so contrary to the materialistic thought and practice of medicine for centuries; considering, too, that the number of converts named does not represent a tithe of what homœopathy has accomplished, that its teachings have revolutionised the whole field of medicine, and that there are hundreds of medical practitioners in this country who, to a great extent, adopt our methods of treatment without an open profession of the same; and remembering, moreover, the proverbial slowness of British men to accept new forms of faith and knowledge, together with the fact that we have had to fight for our very existence as homœopathic practitioners, we have no reason to take a pessimistic view of the progress of homœopathy in this country at the present time.

*Obituary.*—Since the concluding meeting of the last session of this Society, it has lost one of its members, Dr. Stammers Morrisson, of Clapham, who passed away at Bexhill on July 23 last. Dr. Morrisson had been in bad health for a long time, and was attended by Dr. Cronin, and by Dr. Croucher at the last. He was one of our heroes in the proving of medicines. The pathogenesis of “lycopus

virginicus" we owe largely to him. He also contributed some important papers to this Society and to homœopathic journals. He was a very kind and affectionate man, devoted to his profession, and was a pronounced believer in homœopathy, the principles of which he always placed in the foreground and made them known.

I must also notice the death of Dr. Cornelia Stettler, of Chicago, which took place at sea, while on a voyage to Europe, on July 28 last, and was due to what was termed "cardiac paralysis." Dr. Cornelia Stettler had acted as clinical assistant to Dr. Ludlam, of Chicago, for several years, in addition to carrying on private practice of her own. She attended the last International Homœopathic Congress in this country, and brought with her a letter of introduction to me by Dr. Ludlam, speaking highly of her skill in gynecology and obstetrics. Dr. Ludlam desired me to take charge of and introduce her to my colleagues, by which reason, and from the interest which she took in the work of the Congress, she became known to you. I saw her on several occasions for about a week, and found her a most interesting and courteous lady, well versed in her profession and in the knowledge of homœopathic therapeutics. I am sure this Society will join with me in expressing our sympathy with her friends and Dr. Ludlam and his colleagues in her premature death.

This Society, under the regretful circumstance of losing Mr. Knox Shaw as its Secretary, nevertheless felt that it "need not sorrow as those without hope." As in ancient times, when the children of Israel lost Moses, their great leader, Joshua, the son of Nun, a man full of the spirit of wisdom, became his successor; I congratulate you that, although you have not secured a Joshua, you have secured a James in the person of Mr. James Johnstone as your Secretary and leader, whose energy and work here, and at the hospital, for some time past is of good augury for the future. It is true he is comparatively a young man as years go, but he is far from being inexperienced in life, and is, moreover, skilled in the scientific and practical aspects of his profession, and is eminently desirous for the advancement of homœopathic

therapeutics. At the same time, able and persevering as I feel sure Mr. Johnstone will prove, his task will be no light one, particularly as new work will shortly be undertaken. I trust, therefore, that every member will lighten his labour as far as possible, and I am sure you will all join with me in wishing him a long life and a prosperous career.

It was my privilege to be elected a member of this Society in 1861, in the same year with Drs. George M. Carfrae, Richard Hughes, and Henry Wheeler. Our seniors now in membership are Drs. Bradshaw, elected in 1860; Harper, in 1859; W. B. Scriven, of Dublin, in 1856; George Wylde, in 1854; and at the top of the tree of knowledge and advanced medicine, Drs. Robert Dudgeon and Edward Hamilton, both of whom joined the Society in 1847. The two latter gentlemen may, at the present time, be considered the Fathers of the British Homœopathic Society.

Under these circumstances, and as I am sure you all desire to give honour to whom honour and respect are due, you will allow me, in the name of the Society, to express your wish that they may have several years of health and happiness. At the same time, I think we might adopt a similar expression of good-will to their juniors in membership (four in number) up to and inclusive of the year 1860, and that our Secretary be instructed to convey that message to each and all of them.

I wish now to direct your minds to the consideration of the aims and purposes which the founders of this Society had in view, and this can be done in no better way than by presenting you with a speech by Dr. Quin, the President of the Society, at its first annual meeting in 1846. Dr. Quin then said :—

“There can be no doubt that a Society constituted as this is, is pre-eminently fitted for the development of talent, the acquirement of knowledge, the augmentation of your means of combating disease, and the extension of the principles you advocate; for, however valuable may be the knowledge you derive from practice, it is chiefly in the interchange and reflection of that knowledge and that experience in a Society like the present that you can

properly and efficiently cultivate your intellectual and exalt your moral powers. In your dissertations and your debates the inexperienced profit from the knowledge of the skilful and the learned; the young practitioner gains confidence from becoming acquainted with the method of practice of the elder and more experienced physician, and by having his own method of treatment approved of or corrected in the course of your discussions. Thus the knowledge, the skill, and the experience of each individual become the property of the Society, and diffuse their valuable results over all."

Those words of wisdom so eloquently propounded by Dr. Quin, and by which he also voiced the aims and purposes of those who were associated with him in the founding of this Society, I think you will agree are as pertinent to the present occasion as they were then; and while I will not drag them from their special application and force them into my service here, I nevertheless suggest that they largely illustrate and support what I have said is the *raison d'être* of this Society, to wit, "the growing of souls"—the soul of each member of it in knowledge and skill in his profession, and particularly in relation to homœopathic therapeutics.

There is one clause in particular in that speech, or rather a three-fold clause, which should always be borne in mind in relation to the objects of this Society: "The acquirement of knowledge, the augmentation of your means of combating disease, and the extension of the principles you advocate." What those principles were was not specifically set forth; they were rather taken as granted and beyond dispute, by reason of the very name applied to the Society. While the extension of those principles was a great and leading part of the objects of the Society, it was not intended to preclude the augmentation of other knowledge and means of combating disease. If the latter were not to be sought after, this Society would veritably have been a sectarian Society, which it never has been, and I hope never will be, but rather that it should be Catholic in thought and purpose. While this is to a great extent a "Medico-Chirurgical Society" for the study and culture of medicine generally, it stands for much more, viz., for the study and culture of



homœopathic therapeutics expressed in the formula "*Similia similibus curentur*," and that that study should be the prevailing and dominating force over the whole. Were it otherwise, there would be no reason for the existence of this Society, and it would be better carried into the maelstrom of general medicine, as it had failed to conform to its ideal.

The charge has often been brought against us by our opponents in medicine that this is a sectarian Society by reason of its name, coupled with the fact that only those medical practitioners who avow their belief in the principles and practice of homœopathy are eligible for membership. That charge does not weigh heavily on my mind, although I think it is not without some colour. I nevertheless contend that it is far from being a correct representation, inasmuch as, while the culture of homœopathic therapeutics is a large and most important part of our study, we neglect no other field; hence we cannot rightly be termed sectarians, but that our opponents really are so is proved by the fact that they not only refuse to admit us to their societies, but also decline to examine the principles and the practice we advocate, which are supported by evidence beyond dispute.

Moreover, so far as we are sectarians, the position of sectarianism has been forced upon us by reason of the ostracism to which we have all been exposed; and while some of our colleagues adopt the title of "homœopath" or "homœopathic physician," for the most part they adopt the title "physician" or "surgeon," or, when the principles of their practice is called for, they may add the words "practising homœopathically." Personally, I prefer the title "homœopathic physician" or "homœopathic medical practitioner." I therefore consider we are not sectarians, but nonconformists, and I have yet to learn that others are more catholic in thought and act than we are.

Again, I would remark that, while this is neither the proper time nor the most suitable opportunity for the consideration of the work of the Homœopathic Hospital and its *raison d'être*, yet, as that institution is the true offspring of

this Society, and is closely connected with it by many ties, so that its medical officers are chosen exclusively from those who are members here. I think it is within the limit of what is right and of advantage to make a few observations this evening in relation to it. And, first, I say that my remarks with regard to the principles and the work of this Society are also largely applicable to the work of the hospital. For there can be no manner of doubt, from the mere fact of its special name, that its founders and those who contributed largely of their wealth to its erection and its support, and have continued to do so, never meant that its work should be as much for surgery as for medicine, and while some cases in its wards might require and ought to have surgical skill and help, homœopathic therapeutics should nevertheless take the largest place there. I am unaware how the hospital stands in that respect, but I know, and you all know, that its surgeons are as skilful as any in the United Kingdom; and we are equally proud of its physicians, by reason of their ability and their devotion to homœopathic therapeutics.

While no one can accuse me, however, of favouring surgery at the expense of therapeutics, I must nevertheless put in a plea on behalf of surgeons against what is sometimes said, and perhaps not entirely without foundation, that there is too much surgery and too little medical treatment adopted. It stands to reason that where there is great skill in surgery there will be a great tendency of the practitioner to resort to it. That tendency is far from being confined to the surgeon, for patients themselves, when they can be assured that an operation will involve but comparatively little risk to life, and will quickly relieve them from a continuance of much suffering and will prolong their life, will often, and as I have personally known, press for an operation rather than undergo a long course of medical treatment which their cases would otherwise require. Further, every surgeon of our hospital will affirm, and it has often demonstrated, that no small measure of success in operations has been due to homœopathic therapeutic measures also employed. At the same time, with these

claims on behalf of surgery, there is great need for caution against excess in its employment.

I have been led to make these remarks not by way of criticism, but by reason of a question recently put by a gentleman who is a pronounced homœopath, a man of great influence and wealth, who has been a large donor to and is a liberal supporter of the hospital. He said: "How is your hospital getting on? I don't want to know anything of your surgery, which I suppose you must undertake in some measure, and which, I feel sure, will be quite up to date, but what of your therapeutic measures? Are they in accord with homœopathy, and are your results better than those of the old school? For unless they are distinctly and largely better there is no more need for the maintenance of your sectarian hospital than there is for the maintenance of the Temperance Hospital, if it should fail to show better results than other hospitals." That question, under different forms, you will often have heard from ardent lay homœopaths and patrons of the hospital, and is one which I think the great teaching power of the medical staff should lay to heart, and answer, not alone in the *Homœopathic Hospital Reports*, which are only seen by members of this Society, but in some measure (consistent with medical ethics) more than is at present done in the Annual Report of the hospital, which is furnished to the patrons and supporters of the hospital in general. I am well aware that this is a delicate subject, and one that requires judicious handling. At the same time, I contend that the lay public who are homœopaths, and are greatly concerned for the well-being of the hospital and the advancement of the principles and practice of homœopathy, should be well informed in relation to the nature of the work there and its specific results. I am sure if that were done it would not only satisfy their anxiety, but would lead them to contribute more liberally to the institution.

I pass now to another phase of my subject, viz., the nature and extent of the work of this Society during its several years of existence. In the early stage of preparing this address I made an attempt to gather up the several

aspects of it at the different periods of time, with the intention of comparing the one with the other, in order to show the progress made, particularly with regard to the character of the work. But from a review of *The Annals* and *The Transactions*, I found it too voluminous and the task too great, particularly for an occasion like the present. For that reason I abandoned it. Moreover, I subsequently found that Dr. Hughes went over the ground in an address in 1879, which you will find in the ninth volume of the *Annals*, although very much new work has been carried on successfully since that time of an eminently practical character; notably the publication of the *Journal of the Society*, the indexing of *British Homœopathic Literature*, and other works which most of you are acquainted with.

For the further promotion of the principles we advocate, as medicine and surgery have broadened out during the last few years, and the teachings from pathological research have also undergone great change, and perhaps become more clear and certain, and in which you have had a considerable share in the development, I think the time has arrived when fresh aspects of work should be taken up, and, in fact, must be taken up, if we are to maintain, exalt, and extend our cause.

While the particular methods and kind of work cannot well be pointed out, I contend that the present is a very favourable time for beginning new work. Our Society has largely increased in the number of its members, who are educated up to the most recent requirements of the medical schools, so that we possess much greater working power than aforesaid.

Before I offer any suggestions for other work in "fresh woods and pastures new" than what we have on hand at the present time, it may be well to enquire how we stand in the latter respect. First, there is that part which ye have always with you; that which is carried out through small committees for the arranging of dissertations and debates at the usual monthly meetings, and the editing of the *Journal of this Society*. Then there is the work of which Dr. Burford is Secretary, the indexing of *British Homœopathic Clinical*

Medicine, which, I believe, will be ready for publication in the course of a few months. Lastly, there is the greater work on which Dr. Hughes is engaged, the Index or Repertory of the Cyclopædia of Drug Pathogenesis, and which may be safely left to him to carry out efficiently and expeditiously.

Under those aspects of the case our slate is comparatively clean, and our course sufficiently clear to immediately consider and quickly undertake some other work, which, when accomplished, will redound to the honour of the Society and to the credit of those who share in its labours. I am happy to say that many of you are very desirous there should be a forward movement, believing, as you do, that it is high time work of a higher character than what we have on hand (with the exception of that under Dr. Hughes) should be taken up and carried out with vigour and assiduity. Otherwise, our Society will not only lose caste but become practically moribund and of no account, which, I am sure, you would all deplore.

You will have noticed that in my allusion to new work to be undertaken I said of "a higher character" instead of saying of a more "scientific character." This was done of set purpose; for while by no means depreciating scientific work, I contend there is much good and practical work in connection with homœopathic therapeutics oftentimes erroneously called scientific, that ought not to be brought to that test. Under the pressure of materialism and science at the present day, we are in great danger of exposing ourselves to the bitter taunt of Hazlitt, "In the days of Jacob there was a ladder from earth to heaven, but now the heavens have gone further off and become astronomical," and in that same sense in striving after the scientific we may lose the really practical.

In pursuance of the object we have in view, I now direct your attention to another Society that was founded about the year 1847, and named "The Hahnemann Publishing Society." That Society was formed by a few men of nobility and purity of soul, deeply in earnest and strong of purpose — men, too, of great academic attainments, culture, and know-

ledge, who had embraced the principles of homœopathy, and whose minds were fired with a desire to produce a literature alike scientific and up-to-date in medicine generally, but particularly representing the truest and best aspects of homœopathic knowledge. Its leading men and those who most largely shared its work were Dr. Drysdale, Dr. Dudgeon, Dr. J. W. Hayward, and Dr. Richard Hughes, but Drysdale and Dudgeon were the moving and inspiring spirits or soul of the Society. Those of you who attended our Congresses years ago will remember how Dr. Hayward, as Secretary of that Society, brought to the front its existence, the work that was being carried on, and the need there was for workers, and how he pushed it forward on every occasion. For several years, whenever I met Drysdale, nearly his first remark was: "Well, Clifton, what work are you doing for our Society? You know you are expected to do some work for it every day!"

Of the special and entire work of that Society I cannot here give an account. In fact, I feel it would be offering you an insult to suggest that you are unacquainted with it. I may, however, by way of aiding your memory, notice some portions of the work, such, for instance, as the "Pathogenetic Cyclopædia," the Cypher Repertory, the "Hahnemann Materia Medica"—several parts: aconitum, arsenicum, belladonna, uranium nitricum, and others; together with "Materia Medica, Physiological and Applied," Dudgeon's translation of "The Organon," and "Materia Medica Pura," &c. To those of you who are younger in years than many of us, and have not had opportunities of becoming acquainted with it, I suggest that it would make good reading on a railway journey, and be nearly as entertaining as "The Idle Thoughts of an Idle Fellow."

That Society, after continuing its labours for several years, finally transferred what work it had in hand to this Society. I will not on the present occasion go into the whole question of why that change took place, more than to suggest that it was mainly due to the fact that its founders and leaders attempted far more work than they could do themselves or could get done by others. Their means were

not, by a long way, commensurate with their ideals, consequently the work fell into the hands of a few, who felt there was no enthusiasm on its behalf by the many. Some lessons, however, of wisdom may be learned from its failure for future undertakings. "Take care where you build, that what serves you as a foundation may also serve you as a quarry."

With regard to the "forward movement," and which several of you are eager for, I may say that at a meeting of the sections of this Society on the 22nd ultimo, which I had the privilege of attending, the subject was brought up, and warmly received, and it was unanimously resolved that at the first meeting of the *Materia Medica* section of the Society, the question should be considered in relation to the nature of fresh work to be undertaken. It was also suggested that this work should be largely on the lines of those of the "Hahnemann Publishing Society" (now deceased, or practically so), particularly those essays on *Materia Medica* in the form of monographs on drugs and "*Materia Medica, Physiological and Applied*;" or of quite a different kind of work, such, for instance, as the reproofing of some old drugs, or provings of new ones, which Mr. Wilkinson, of Windsor, has been undertaking.

The same meeting of sections, moreover, resolved and instructed the Secretary of this Society, in conjunction with the Secretary of the *Materia Medica* section, to ask three gentlemen each to give a ten-minute paper on the subject at the meeting, setting forth their views in order that we might obtain an instructive discussion upon it.

Two of the gentlemen selected for that purpose have already promised papers, and I feel certain that the other gentleman will do the same. I hope every member who can will be present on that occasion. I need not say that I look forward to that event with intense hope and expectation that it will lead to the further extension of the principles and practice of homœopathy and to the growth of soul of each member of this community in his special calling.

Under the very different circumstances and environment of the present time from those of the early and middle

periods of the Society, with the experience and medical lore we have gained here or from other sources of knowledge, which can never be obliterated from our minds till death, the records of which are on the shelves of this library for the guidance of future students, and will prove a great "path-finder" for them—in view of what is before us in the various aspects of work which have been carried on and are still maintained, and considering the additional work which I feel sure will soon be adopted, what should be our aim and determination? Here I am sure you will say: "While we can claim no loftier ideal than our predecessors, and many who are now with us, we will, nevertheless, do all in our power to promote and bring to perfection the objects before us."

Should that be your answer, gentlemen, and I am sure from what I know of you it will be in the main, I suggest that the most important element for your success will be the spirit, the animating and compelling force in each of you, whereby every man will consider that to whatsoever degree he has attained in the knowledge of his profession, he will not regard himself perfect, but will follow after and press towards the goal of his calling, laying aside every impediment, whether it be of a personal, educational, or intellectual character; inasmuch as that spirit will be the surest precursor of the growth and progress of each member of the Society and of the Society itself, and by the absence of it the new work will be feeble, vacillating, and of little effect. Although this world is largely calculated for the strangling of heroism, you may make it otherwise in this relation if you so determine.

Not having had the privilege of addressing you in the capacity of President of the Society before, while it has afforded me an opportunity of airing some of my views in relation both to the Society and the Hospital, and the special work of each (but which statement of such views does not commit you to accept them), it has led me also to suggest, yea, press upon your notice, in your *collective capacity*, some of the duties that I feel are of great importance for the future well-being of the Society.



Addressing now the younger members, particularly those of you who have yet to "win your spurs" in the profession, I urge you all to diligently attend the meetings of every kind of the Society. Take your full share of the work, of whatever nature it may be, great or small—if the latter, do not despise or reject it, inasmuch as if you prosecute it in a proper spirit you may make drudgery divine, and in the doing of it you will not alone promote the growth of your own souls, but it will lead to higher forms of work, according to your lot, and towards which you should ever aspire. I would also remind you of the wise observation of Carlyle, that genius is "the capacity for taking pains," which in no calling more than yours is so needful. Further, while you acquire greater skill and knowledge of your profession and confidence in the means you employ as healers of the sick and maimed, for your encouragement I may say that, having been a member here for over forty years, I have gained more knowledge and confidence in the practice of my profession than from any other source, and, at the same time, a warm and hearty friendship with nearly the whole of the members, to my great satisfaction and comfort now in the autumn of my life. I ardently hope you will be as fortunate as I in that respect, which you may be if you so determine.

Harping now on another string, but one which is in harmony with the former, I desire to submit a few words of exhortation, conceived in no dictatorial or papal spirit, which I hope will be received without offence, particularly as I do not offer them from the chair (except in form), but as an elder to you, my brethren, who are elders here, though most of you are younger elders than myself. To those of you, gentlemen, who, by years of devotion to the studies of your profession, have now climbed the "hill Difficulty," and have made a considerable and indelible mark on it for good, and gained a position of fame and high respect amongst us, I urge you will not forget the claims which this Society has upon you, not only from your long connection with it, nor even from its having been a stepping-stone in your onward and upward course, but from your learning, your

skill, your experience and your wise counsels, by which you have largely helped to make this Society the power for good which it undoubtedly is. It is, therefore, of great importance for the advancement of the principles you advocate, for the growth and well-being of this Society, and of our Hospital, with which many of you have been so actively associated for several years, that you should lose no opportunity of attending the various meetings of every kind, and giving your assistance in the several departments of work, although it will be at the sacrifice of your personal convenience and comfort. In the good old Spartan days of fifty years ago there was one law of this Society which bound every member who lived in London to attend every meeting under the penalty of a fine, the only admissible excuse for non-appearance being certified illness or absence from town. In process of time there was seen to be no need for the retention of that law, from the fact that the members showed that all were for the party and none were for themselves. The rule was therefore abrogated, and I do not think it would be of much service now. But it is only when the spirit of perfect willinghood and self-abnegation exists in a party that its strength can be maintained.

I have ventured to speak thus earnestly and pointedly not from my position in the chair, as I have said, but as an elder brother. Not that I doubt your loyalty to the cause, but because I know that in the very nature of things there is a great tendency in men who have toiled arduously and for a long time in any cause to become the happy possessors of some amount of their well-merited reward — a tendency and desire to “ease off” and rest, and which I am very conscious of myself. At the same time this is partly for the honourable purpose of giving place to the younger members of the Society and lifting them higher in relation to it. By following the patriotic course suggested you will not only enhance the value of the work here, but you will greatly encourage your younger colleagues to active and constant work in various departments, and, at the same time, preserve your own souls in the fulness of knowledge and power to which they have attained; and, as I intend,

health and circumstances permitting, to preside over your deliberation very often during the present session, I look to you for support on those occasions.

If I have exceeded the bounds of brotherhood in these words of exhortation, coming as they do from an old man and brother, I rely on your kind and patient forbearance.

We still have a long way to go in pursuance of our object before we can stay our hands. We are somewhat in the same position as the British and Egyptian armies were a short time ago in the valley of the Nile, with enemies in front and on both flanks. If we earnestly and steadily pursue our march as British soldiers, and with the well-organised commissariat that we have, our Khartoum is assured and Hahnemann avenged in a higher and nobler sense than was Gordon.

Finally, gentlemen, I thank you for listening so patiently to my remarks, and I trust you will find that I have largely shown the *raison d'être* of this Society, the growing of souls,—of which I hope you, one and all, will be partakers.

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## PERSONAL EXPERIENCES IN THE PREVENTION OF PHTHISIS.

BEING THE PRESIDENTIAL ADDRESS DELIVERED BEFORE  
THE LIVERPOOL BRANCH AT THE OPENING OF THE  
SESSION, 1898-99.

BY JOHN D. HAYWARD, M.D. LOND.  
*Surgeon to Hahnemann Hospital, Liverpool.*

GENTLEMEN,—It is but a few years since I occupied the seat of honour in which, by your renewed confidence, I again find myself to-night. Your kindness, unfortunately both for you and for me, entails a presidential address.

The president of a Society such as ours generally devotes his address to one of two classes of subjects: he may discourse upon some special disease, case, or operation,

some drug or appliance, to which he has particularly directed his attention, or which he has read up in his leisure and his library ; or he may dilate upon our virtues as homœopaths, and bewail our treatment by our professional brethren of the old school.

With regard to the former class of subject, I have already availed myself each session, for some years past, of the opportunity of discussing with you surgical and kindred subjects ; and with regard to ethics in all its forms, I have neither the inclination nor the capacity to enlarge.

The question of phthisis and of tuberculosis in general is at present occupying an exceptionally, but not unduly, prominent position in the thoughts, discussion and literature of our profession. Hardly a medical society can meet, or a medical journal appear, without reference to the open-air treatment of consumption. In directing your attention to some reflections on this subject, therefore, I can claim none of the novelty which our copy-books used to assure us was so charming. I shall endeavour, however, to present my subject in an original manner, for in this connection, I was a Platonist before Plato ; that is, I was convinced of the benefits of what is known as the open-air method in the prevention and cure of phthisis, and practised it in my own case, long before such was generally recognised, at least in this country, and before it was enthused over by the profession as something strange and rare. Taking it for granted that you are acquainted with the details of the method, I shall not confine my remarks to these, but will add some desultory reflections more or less intimately related thereto.

For a few minutes to-night I intend to consider the subject I have selected, namely, the prevention of phthisis in the individual, from the point of view of a patient rather than from that of a physician.

As many of you know, I have for many years past had repeated periods when I have apparently been threatened with phthisis. Such a personal interest in a disease leads one to pay special attention to its etiology, prognosis and treatment. It has therefore occurred to me, that some of

my experiences and observations might prove of sufficient suggestive interest to atone for the egotism displayed, or might at least serve to introduce points for discussion. I shall not attempt to keep personal references out of my remarks, but will endeavour to utilise my own experiences as pegs for more impersonal considerations.

In these days of wars and rumours of wars, a journalistic article, to ensure attention, should exhibit some bellicose headline. I might therefore entitle my paper: "The War with Phthisis, from notes by a combatant at the front!" In order to substantiate my claim to being a combatant and not merely a disinterested journalistic correspondent, such as I hope you all are, I must give a brief account of my previous history in respect to phthysical indications.

My family history is good, though I say it in presence of the author of my being. Its worst feature, in relation to our subject, is that my next brother, who closely resembled me constitutionally, in my relation to colds and coughs, died a few years ago, aged 34, of extensive phthisis pulmonalis, despite early despatch to such excellent climates as those of New Zealand and the Canary Islands. As a child and youth I was a frequent subject of coughs and bronchitis. As a medical student a series of winter coughs, with muco-purulent expectoration, evening rise of temperature, loss of weight, occasional night sweats, and so on, led me to consult Dr. Frederick Roberts, who examined my chest, spoke disparagingly of my right lung and recommended my departure to another climate, instead of to another world. On three occasions since then the recurrence of loss of weight and strength, with evening pyrexia and a cough, which for months would trouble me each evening and night, and lead to muco-purulent expectoration in the morning, have led my father and professional friends to counsel a winter abroad, which I have fortunately been able to secure on each occasion and with marked benefit. Pathologically I have had several attacks of right apical pneumonia, with some localised pleurisy over the right front, which has caused adhesions, of which I am painfully conscious when I catch cold or draw an extra long breath. I have had one slight hæmoptysis and expectoration repeatedly bloodstained. It is true that I cannot report bacilli in my expectoration, for I have been afraid to allow it to be examined for them. I had what is probably an exaggerated

view of the gravity of the tubercle bacilli, and feared the mental effect of a knowledge that such were present. Most of the other evidences of early phthisis I have had, and I give these few details to show that there have been grounds for suspicion, and that I have not been a subject of mere hypochondriasis. Five winters have I spent either at sea or on the Riviera, and I am myself convinced, that had I been condemned to an indoor life in bad air and unable to avail myself of the climatic changes I have enjoyed, I should ere this have developed and probably died of phthisis.

After this brief case introduction I may remark that I am to-night only concerned with the question of phthisis pulmonalis, the ordinary consumption, and do not consider other tubercular manifestations as they occur in the bones, lymphatic glands, brain, testicle and, indeed, nearly every organ and tissue of the body.

The consideration of the tubercular diseases is eminently worthy of our frequent study and discussion; much more so than the comparatively rare cases which so interest medical societies. The mortality from consumption in its various forms is appalling, and this disease constitutes *the* scourge *par excellence* of the human race, cancer, syphilis, and even the various plagues, lagging far in the rear. In this country the mortality from tuberculosis, though diminishing, is still enormous, amounting to one-seventh of all deaths. The disease is very common, even in countries that enjoy better climates than the depraved specimen under which we exist, and in France 150,000 die each year therefrom.

Even as homœopathic physicians, you experience daily how comparatively helpless medicine is to cure or relieve the disease when once it has become pronounced. But it would appear that this terrible malady, like many others, though so difficult to cure is comparatively easy to prevent; and that as its etiology and pathology are better recognised, so will its development be hindered by sanitation and other health measures. The emphatic necessity for such is patent, and an authority on the subject (Kelsch), as the result of extensive examinations with the X-ray screen and numerous *post mortems*, makes the assertion

that in young persons latent tuberculosis is present in at least two or three of every five cases. Many of the cases are disguised under the mask of anæmia, chlorosis, neurasthenia, dyspepsia and so forth. In this connection it is of good omen that an association has been formed in this country for the prevention of consumption. Some of the leaders of our profession are interesting themselves in the Society, from whose preamble I now quote:—

“ We desire to call public attention to this Association, which has been formed with the object of preventing the spread of the most fatal disease to which mankind is subject. It has gradually become definitely known that the tuberculosis disease, of which pulmonary consumption or phthisis is an example, is not inherent in the constitution, but is communicated indirectly from pre-existing causes, and the principal methods by which it is spread have been identified. Tuberculosis disease, which in one or other of its forms is responsible for at least one in ten of the deaths from all causes, and, according to some calculations, for one in six of the deaths among adults, is therefore preventible. For this the education of the public is needed in the methods of prevention and eradication, and the stimulation of individual efforts in carrying them out. The objects of the Association are the dissemination of information, the arousing of public feeling as to the necessity for defensive measures, and the provision of sanatoria, which will be both preventive and curative for the open-air treatment of consumption.”

Five shillings is the annual subscription, or five guineas for life-membership. The Prince of Wales, Sir S. Wilks, Sir W. Broadbent, Sir W. McCormac and others are concerned in the movement.

The points I wish more particularly to consider in connection with phthisis come under the head of individual prevention, rather than under the more important general measures, and include the anticipation of the declared disease, the treatment of what may be considered as the pre-phthisical condition.

Although the individual is not responsible for his parentage, a sentence or two may be devoted to this factor in the etiology. Since the influence of heredity upon the predisposition to phthisis is so marked, any history

of tubercular disease in the family is an urgent reason for unremitting and continued measures to prevent or check the development of the disease, by means of rules of life and conduct directed to this end. Although phthisis is pre-eminently a disease of early adult life, no age is exempt; and in the cases recently under my observation, where death has occurred from phthisis at an advanced age, I have remarked that a larger proportion have had a tubercular family history than with the younger cases. The individual with tubercle on his family tree cannot be said to be safe, until he is not only dead, but has been duly autopsied and certified "not guilty."

Now next with regard to "taking cold," which a well-known work assures us is "the cause of half our diseases." When we hear of a death from phthisis a popular verdict on the cause is that it was a neglected cold or series of colds, generally with the rider that the victim would not or did not "take care." Now what is this taking cold and how can care avoid it? I have been a sufferer from this mysterious affliction for over forty years, and I avow that I, for one, do not know. That either colds or their resultant coughs are not necessary preliminaries to phthisis is evident, many a consumptive patient remarking that, previously to the cough for which he has presented himself, he never remembers having a cold or a cough in his life. Nevertheless, there is generally some ground for popular beliefs, and there is little doubt that colds are frequently both exciting and predisposing causes of phthisis—the so-called winter cough developing into confirmed consumption. Certainly irritation to the lung and larynx, whether from catarrhal mucous membrane, from congested or pneumonic patches, or from mechanical particles, is a common predisposing cause of phthisis, hence the frequency of the disease in some trades and in the damp, variable climates of the temperate zone. Although the responsibility of colds and chills for consumption has probably been exaggerated, there remains enough to associate the prevention and cure of these with our subject in a very intimate manner.



All my life I have been subject to "colds," and of the great majority I have not an idea as to how I contracted, or as it is titled, "caught" them. Of this I am convinced, that in my own case the course of phenomena known as a cold did but rarely result from any chill or exposure, small or great, that I was able to recognise. When I have been particularly careful, and have avoided exposure to damp, draughts, or injudicious clothing, then have I caught, even in summer, some of my most vicious colds. On very many occasions in my favourite recreations—boating and camping out—I have suffered severe exposure, but I remember but once of a cold resulting. I have been wet to the skin for days together, in cold and windy weather and where exercise was impossible; I have slept out of doors or in wet blankets, I have dozed through the night with nothing but a lowered sail above me, and have been several times capsized with long periods in the water, and I do not recollect an occasion on which a cold or a cough even remotely followed such an event. But on a time when I have been especially cautious and careful a devastating cold will afflict me. Not only is such a state of affairs bewildering to the sufferer, but it is aggravating to his friends, who are robbed of the bliss contained in the remark "I told you so." There are fortunate individuals whose colds consist of a little coryza and sore throat, all over in a day or two. With me the course is invariably as follows. First a little chilly feeling, with some sneezing and a dry throat, then two or three days of profuse nasal watery flux, passing on into muco-purulent discharge and accompanied by a feeling of depression and misery; after this for a period of days, weeks, or months, there will be a painful dry cough, chiefly in the evening, with some pyrexia and, in the mornings, expectoration of muco-pus. For months I have had one after another of such "colds" without interval; of late years they have been much less frequent, especially during the last twelve months. That the winter cough, with which I have been so much troubled, has resulted from these colds I know, but to what the colds themselves were generally due, I am ignorant.

That "taking cold" is the result of some exposure to wind, damp, or a lowered temperature, in many instances is probably true; but once produced they are often infectious. Whether colds are due to the ubiquitous microbe or not, there is no doubt that the friend (or fiend) who, himself suffering from a severe catarrh, insists on button-holing one and on affectionately sowing his pestilent germs upon one's delicate and susceptible mucous membrane, should be treated as a mad dog, or a desquamating scarlet fever patient, and either slain or isolated. A course of compulsory notification and antiseptic muzzles might limit the pest. I have observed that sometimes, when a person is said to have caught cold, it is just as likely that he has caught hot. It would seem as if a sudden exposure to the hot, stuffy atmosphere of a room, after a period of breathing cold air out of doors, is very likely to start the circulatory and catarrhal changes in the respiratory mucous membrane which we know as a "cold." Another conviction to which I have arrived is, that the series of phenomena known as a cold is often the result, not of the slight chill or draught to which it is attributed, but to the prolonged breathing of hot impure air, especially air that has been respired over and over again, air deficient in oxygen, loaded with carbonic acid and other impurities and probably alive with germs. The catarrh following an evening in a stuffy theatre, or an ill-ventilated concert room, may not be due to the fresh air felt cool on coming out, or to the trivial draught on the neck, but to the prolonged antecedent irritation to the respiratory mucous membrane by the vitiated atmosphere.

In the out-of-door life of camping-out draughts and chills are common enough, but it is remarkable how few colds are caught, and how rapidly a cold brought to camp will pass away.

The prevention of cold-catching, being an element in the prevention of phthisis, shall receive attention at a later stage of this paper. The cure or shortening of the course of a cold is also of importance, and my personal experience is as follows. Firstly, I know of no drug that will render one insusceptible to colds, and I have tried many. I have

not, in my own case, acquired confidence in the various medicines recommended for the various stages of cold, stuffed or fluent. I believe the popular early hot bath and a night's perspiration, aided by hot alcoholic or other sudorific drinks, may often abort a cold, as may camphor in the chilly stage and aconite during the early feverish condition. Though my own colds prove refractory to treatment, I have more success with my clients. Aconite is always useful in the early stages, even if there be little actual pyrexia; it relieves the hot, restless feeling and the dry nose and throat. Belladonna and merc. bin. are of use for the stuffed nose and sore throat; arsenic, iodine and iodide of potassium for the coryza, and iodine, bryonia and phosphorus for the various coughs. Iodide of arsenic and hepar sulph. help in the later stages. Do not imagine that any drugs I do not mention have not been used by me; I have probably tried them all, and these I refer to are my favourites. It is remarkable how everybody knows infallible cures for a cold, except in their own cases; in this I resemble everybody.

Of course, the complications of colds, the bronchitis, pneumonia and pleurisy, &c., are eminently amenable to homœopathic treatment. I am here referring to the more miserable, but less serious, symptoms of a catarrh, and when attacked thereby I feel inclined to tallow my nose, exclaim "Kismet" and wait "till the clouds roll by." However, "hope springs eternal," and any unfailling cures you may mention will no doubt be tried next time the bulky silk handkerchiefs come out that I reserve for my periods of distress.

The homœopathic, or scientific, treatment of colds is so well known to you that I do not dwell on it; but there are two or three palliatives during the weary time that I have found of benefit. My own colds commence in the nose, and I believe that I have often aborted one by an early application to the nasal mucous membrane of a weak solution of cocaine. Whether this be so or not, the relief from this particular proceeding in my own case is so marked that I never spend a night from home unprovided with a solution

of cocaine and a small camel-hair brush. The relief obtained in the early stuffed-up stage is delightful, and, although I have occasionally used the method for several years past, I am conscious of no bad result and of the acquirement of no habit. Possibly colds are often local in the upper air passages before they spread to the larynx and bronchi, and so eucalyptus, thymol, camphor, menthol, hydrastis, hazeline, Ferrier's snuff, and other local applications, popularly considered beneficial, may have a similar palliative or abortive effect to that I attribute to cocaine. In all that I say of colds I expressly exclude hay-fever, but I believe the cocaine application has been found useful in the treatment of this malady. Even if the cocaine be merely palliative—

I bless the man, whoe'er he be,  
Who first found cocaine for me,

for in pre-cocaine days some of my most horrible reminiscences are of nights spent awake and in misery because I could not breathe through my nose. Even if I obtained sleep, I would awake choking and gasping from having closed my mouth, there being no nasal thoroughfare. The anæmia produced in my Schneiderian membrane is not the temporary affair one would expect from the short period of anæsthesia produced by cocaine; and I have experienced no loss of smell, palpitation, indigestion, or other undesirable effect. A nasal catarrh is robbed of half its terrors now that I can secure a right of way past my turbinated bones by the persuasive influence of cocaine.

For those who object to this alkaloid, or fear formation of a habit, a solution of hydrastis in water and glycerine will be found some sort of a substitute. If inserted at night on a brush or pledget of wool, or poured or snuffed up the nose, this solution will relieve the stuffiness, induce secretion, and ameliorate the inflammation. Some of it also gets into that post-nasal space so difficult to affect and so subject to chronic catarrh. The pathogenesis of hydrastis will show its relation to catarrh of mucous membrane, and especially to that of the nose and naso-pharynx, so that the

benefit it induces is probably in part due to its systemic action.

As I am relating my personal experiences, I may add that I have often obtained a good night, that otherwise would have been spent coughing and reading, by smoking a cigarette de Joie, only palliative if you like, but "for this relief much thanks." Perhaps I have given too much space to the question of colds, but their relation to our subject proper is acknowledged.

In connection with the prevention of phthisis in the individual it is necessary to consider a few of the early or premonitory symptoms of the disease, and their importance as indications of the onset or probable development of the affection in question, and of the urgency of preventive or curative measures.

Hæmoptysis is, in my experience, a common premonitory symptom in young adults. It is not by any means the sign of doom it used to be considered in my student days; but cases of early and free hæmoptysis, if they do go on to phthisis, are generally rapidly fatal. A true hæmoptysis in a youth points to the urgent necessity of prophylactic measures.

The evening pyrexia is frequently one of the earliest signs of threatening phthisis. Accompanying a dry cough, with debility and some loss of flesh, a temperature one or two degrees above normal about 7 p.m., and half to one degree below normal in the forenoon, is very suspicious; and is often so early a symptom in the disease as to be of great value in indicating when prophylactic measures of habits, climate, food, and medical treatment are called for, and with good prospects of success. Later on in the illness the evening rise of temperature becomes higher and the morning remission less marked, the fever taking on the hectic character of the developed disease.

The examination of the sputum of the individual subject to, or suspected of, phthisis, is of value for diagnosis and treatment. That there can be a true phthisis without the tubercle bacilli being present, a simple ulceration of the lung, appears improbable. The presence of the bacilli in the

expectoration is a grave sign, but its gravity seems to have been over-estimated. I learned somewhere that the presence of the bacilli indicated a hopeless prognosis ; for this reason I dreaded any discovery of these creatures in my own expectoration, and have carefully guarded my sputum from any test. This is rather the conduct of the ostrich, if this bird really does bury its head in the sand on the approach of danger ; but I must confess that I dreaded, what I endeavour to guard my patients from, the deleterious effect on the locally diseased condition of the mental depression caused by a knowledge of the gravity or hopelessness of one's condition. In early phthisis, as in many other diseases, one of the best therapeutic aids is an expectation of improvement and a determination to recover ; and a bad sign, fortunately peculiarly uncommon in this disease, is despair. However, it is of the first importance that the doctor should know whether bacilli exist in the patient's discharge, both for the subject's sake and for that of his attendants and relatives. In suspected cases the detection of bacilli may lead to prophylactic and other treatment long before there may be any physical signs in evidence. Given a progressive, if slight, loss of weight, with a little evening rise of temperature and some debility and cough, if there be no physical signs the diagnosis depends on an examination of the sputum, particularly that of the early morning. Perhaps it will be necessary for me to modify my acquired impressions as to the gravity of the presence of bacilli, for during the last twelve months I have observed several cases in which these were present in large numbers, who have markedly improved, three or four of them having apparently recovered, in so far as the disappearance of all symptoms can prove recovery ; others have greatly improved, although as long as expectorations could be obtained at all the bacilli were present.

The knowledge of the life history of Koch's bacillus is of great import in the treatment of, and especially in the attempt to prevent, phthisis ; in the individual and in the population generally.

The prophylaxis of phthisis demands a general recogni-

tion of the fact that, in the majority of cases, the disease is caused by the respiration of bad air as a predisposing cause and by the introduction of the germ by respiration or food as the exciting cause. Measures for guarding the public from these two factors by sanitation and by the inspection and regulation of the food supply, especially the meat and milk, and by preventing infection by efficient ventilation, the treatment of sputum and the isolation of the infected, will enormously reduce the mortality from phthisis. Even the public sanitary measures brought into action of recent years have reduced the mortality from phthisis in this country to one-third of what it was sixty years ago, while in New York and elsewhere more strict supervision has caused a still more marked decline. There are difficulties in obtaining any general isolation of the subjects of phthisis, however desirable theoretically; but as far as possible their separation should be arranged and their sputum should not be spread about, for the continued further propagation of the disease to susceptible subjects.

It is difficult to keep the more important general measures for the prevention of the propagation of consumption among the public at large from those which more particularly concern the individual; the former are incumbent upon the State, its advisers and deputies; the latter upon the individual and his medical man; while all can only obtain attention and acceptance by an educated opinion within and outside our profession. I shall endeavour rather to consider the individual measures, but most of these belong to both divisions.

The recognition of the contagiousness of consumption is of the first importance; indeed, it has become an axiom among those who have devoted special attention to the subject, that "every individual case of consumption originates from a preceding case." As the infection resides mainly in the dried sputum, various prophylactic measures arise directly from this axiom.

Firstly, as regards the patient:—At home he must expectorate into a cup, used only for this purpose, and containing an antiseptic solution. If he must occasionally

use a handkerchief, this should be dipped in the same fluid and well boiled, never being put away dry. A Dettweiler spittoon made of aluminium, or some similar contrivance, may be carried about and used out of doors, or the cheap paper serviettes, known as Japanese handkerchiefs, may be used and then burned. The individual should never spit elsewhere, and a phthisic who does should be liable to compulsory isolation. If he spit where animals are about they may become infected and so spread the disease—domestic animals, cows and fowls, are specially liable to become diseased in this way. If he spit on the streets the danger to the community is obvious. A tuberculous individual should sleep alone, should avoid swallowing his sputum, and should be sparing in kissing; while, if a mother, she should not nurse her baby.

Secondly, as regards those who come in contact with consumptives, and most of us do, they should avoid resorts where consumptives congregate, not occupy a house or room where such have been without previous thorough disinfection, should not use a table utensil, pipe or wind instrument directly after a consumptive; they should not kiss one on the mouth or share a bed with one. In childhood tubercular infection is probably chiefly incurred by the alimentary canal, and in adults chiefly by the lungs. In the former case the mesenteric glands become infected from the intestines, and the cervical glands from the tonsils and naso-pharynx, while secondarily the bronchial and mediastinal glands become affected, and then probably the lungs themselves. Where the infection is due to absorption from ingested food no doubt this is, in most instances, from tubercular milk, a large proportion of the milk supply being still, despite present measures of regulation, obtained from consumptive kine. The necessity of the boiling of milk by the individual and of the extended regulation by the authorities follow as corollaries.

Next to milk, beef, rabbits, and fowls are the most likely articles of food to prove tuberculous, and these should always be thoroughly cooked.

Incidentally may be mentioned the desirability there is



that women should give up the disgusting practice of wiping the streets with their skirts. These should be short enough to be well clear of the ground; otherwise, not only do they stir up the filth thereon, but they mop it up, to be spread about the home atmosphere when they are dried and brushed.

We now come to the most important factor in the cure of early phthisis and which, in the prevention thereof, is only secondary to the avoidance of infection, namely, a free and constant supply of pure air for respiration. This is closely connected with the contagion we have just been considering; for foul air is not only a lung irritant in itself, but is generally laden with germs, and, from the wide distribution of consumption, these germs consist in a large proportion of Koch's bacilli.

I cannot keep the question of *prevention* separate from that of the *cure* of early phthisis, in considering the so-called open-air treatment. Although there are many aids to the treatment and prophylaxis of phthisis—a few of which we may consider—the main factor of success is a constant and copious supply of good air, that is of air liberally supplied with oxygen [and ozone if possible] and not loaded with carbonic acid, germs and other products of previous respiration. Consider the suggestive fact, that the animals chiefly subject to consumption are rabbits and cows; the one naturally living in over-populated burrows, where the air must be stagnant and foul, and where one tubercular rabbit could infect the colony; and the cows artificially cooped in steaming ill-ventilated byres, where the same conditions prevail. It is not the cattle and monkeys of the fields and woods which are decimated by consumption, though possibly they catch colds, but it is those of the stuffy byre or menagerie of captivity. Amongst cows the experiment has been quite successful of stamping out the disease in certain localities, by isolation or slaughter of infected animals and improved sanitation of the others; while on the other hand, healthy sheep, goats and pigs have been kept in unhealthy sheds with infected cattle, and have all contracted the disease in from five months to two years.

Among human beings also, consider the frequency of phthisis among printers, clerks, tailors and dressmakers; and previous to recent sanitary legislation, among mill and factory hands, all of which classes commonly enjoy the sanitary advantages of rabbits. Open air, and that of the best obtainable, is the basis of the satisfactory treatment of early or threatening phthisis. I have proved it in my own case, and the recognition thereof abroad has only recently influenced us in this country. Even in advanced cases this method offers improvement and occasionally cure, and it is to be hoped we shall rarely again see the early phthisic spending months in warm, moist, stuffy rooms, coddled from those bugbears, draughts and colds, developing his disease unhindered and passing it on to his unfortunate relatives and attendants.

To refer again to my obtrusive self. My first serious threatening was when finishing my medical studies, after a period of sedentary and unhygienic existence in hospital and lodgings. As soon as I obtained a registrable qualification [the L.S.A.] I took a post as ship-surgeon and made the admirable climatic voyage to China. When I left England I weighed about 11 stone and was constantly catching colds. For over four months I lived and slept in the open air and I did not get one cold, lost all cough and weighed 13 stone. Some of this increase of weight was no doubt due to lack of sufficient exercise, and I soon lost two-thirds thereof.

On four other occasions in the last twenty years, one so recently as the winter before last, I and my friends have been conscious that I was pointing phthisis-ward; my weight declined, colds were frequent, evening temperatures were present and night cough constant. On each occasion I was fortunately [for me at least] able, through the assistance of friend-patients, to go to the Riviera and live out of doors for periods of from two to four months. The prompt and marked change in my appearance and condition on each occasion was noticed even by the people I met and by the hotel-keepers; as well as, on my return, by my relations and friends. I immediately ceased to catch colds, lost cough and gained strength and weight; while on one occa-

sion only did the evening pyrexia persist for two or three weeks. By carrying out this outdoor life in this country I am trying, and apparently with at least temporary success, to keep the ground gained. Fresh air and sunlight have been my means of grace.

The question of where to send patients threatened with phthisis is constantly coming before us. There is no lack of suitable places, the main thing being to secure a locality where the air is pure, dry and free from irritants, and where the variations of temperature are not too sudden or severe; somewhere where the life can be mainly out of doors, as in the Riviera, the Tyrol, the high Swiss tablelands, Algiers, Egypt, the Canary Isles, Madeira, the Cape, Mexico, New Zealand, and many others. I myself have a warm feeling for, and owe a debt to, Mentone, Bordighera, San Remo and other places on the Riviera sea-board.

Having sampled many of the regions referred to, I must again refer to one serious drawback in their usefulness, namely, the crowding together in the reading-rooms, drawing-rooms, gambling-rooms, and places of entertainment of large numbers of people, many of them affected with advanced phthisis. On a sea voyage a roomy, well-ventilated cabin should be selected, and used as little as possible. At places where consumptives resort, a villa or private lodgings being unavailable, and it being necessary to stay at one of the palatial, comfortable, and expensive hotels, the indoor society of consumptive patients, and they are generally quite obvious, should be avoided, and the public rooms used but little. Should the bedroom have been occupied by a phthisic, it ought to be washed, disinfected, and repainted and papered before use.

Although this open-air treatment for threatening or early phthisis can be most satisfactorily carried out at high altitudes, such as at Davos and St. Moritz, which are about 5,000 feet above sea-level, and next best at some of the favoured climates of the world to which I have referred, were it confined to such it would be out of the reach of the greater proportion of sufferers. It can, however, to a sufficient extent, be followed even in this country. At many

places on the coast of Cornwall and Devon, especially, perhaps, at Falmouth, the winter temperature is remarkably high and constant; but almost anywhere in our country, or in any other, the open-air treatment is better than any yet discovered. In a modified manner it can be carried out at the homes of patients, but it is urgently necessary that institutions facing south and specially prepared for the treatment should be erected all over our land, wherever a dry soil and a fresh supply of good air can be secured. Here the patients, even when advanced in the disease, can, if well wrapped up and sheltered from wind and rain, lead an out-door life in all the sunshine that can be obtained. In addition, special feeding, exercises, and drug treatment can be carried out. Abroad, such treatment has well justified itself by results, and in this kingdom, at Edinburgh, Bournemouth, Cromer, and elsewhere it has been very satisfactorily tried.

Incidentally, I may refer to the relation of this open-air life to colds, which we have seen are so frequently fore-runners if not actually one of the causes of phthisis. Our preconceived ideas and those of our clients as regards colds require revision. The great difficulty in getting patients threatened with phthisis to view with favour and to adopt the open-air life is the fear of catching colds, whereas the reverse is the case. Not only so, but a cold may be coddled and air-poisoned into more serious troubles, where judicious exposure would have taken it away. I am of course referring to the ordinary colds of youths and adults, especially of those threatened with tuberculosis, and not to the bronchitis of young children and of those advanced in life. Where the thermometer or the other symptoms and physical signs point to a grave localised inflammatory condition, of course a different and somewhat contrary management is called for. Aids against the catching of colds are the daily cold or nearly cold bath, swims, especially in salt water, flannel worn next the skin, the habit of nose-breathing, a diet containing a sufficiency of carbo-hydrates, especially oils, daily exercise out of doors, and a constant supply of fresh air. Alcohol should be avoided before and during exposure to

cold, and is indeed best omitted altogether, except when prolonged exposure has caused a shivery condition, when it may be used after the exposure is over. There are many adjuvants to the open-air treatment of early or threatening phthisis to which I can merely refer, such as exercises, especially lung gymnastics, massage, daily bathing, suitable clothing, oil inunctions, rest in the horizontal posture for those with pyrexia and defective circulation, and so on. Two of such aids I must in conclusion briefly discuss, namely, food and drugs.

Attention to the digestive organs, including the teeth, and to the regulation of the bowels, is of great importance, as dyspepsia has been observed to be a very frequent antecedent of tuberculosis. Possibly this acts in two ways, partly by depressing the strength and vitality of the patient, and partly by lessened resistance to infective material ingested. Defective digestion is a serious handicap in the prevention and cure of phthisis, as the diet should be exceptionally full and even forced, meat, eggs, milk, and cod-liver oil being of especial value. With the open-air treatment, especially in cold regions, this forced diet does not seem to cause the indigestion it might otherwise do, and the appetite soon increases so as to lead to its enjoyment. Some of the most remarkable cases I have met with in my continental wanderings have been of individuals who have been at one of the special establishments in Germany, the Tyrol, or the high Swiss plateaux, where the out-door treatment is fully carried out, with the obligation to eat the food ordered by the medical superintendent. At first the quantity of food makes the patient disgusted, and even vomit, while the severity of the open-air discipline is unpleasant and dreaded. Very well, if they won't carry these out they must leave the institution, and this rigour is justified by results.

And now we come to the question of drugs. What can they do in the prevention and cure of phthisis? Dr. Richard Hughes, in his classical "Therapeutics," says that when a patient comes to us with the signs of developed phthisis we can do little with drugs to stay the course of the disease. I am sure your experience agrees with this verdict, and I

have still to see evidence that, other circumstances being unchanged, any drug in any potency can act as a cure for phthisis in any reliable number of cases. And yet that phthisis is a disease commonly recovered from we know, from what is so frequently seen at autopsies, where the scars of cicatrised cavities and cirrhotic patches with pleuritic adhesions are frequently met with. Again, that persons apparently developing the classical symptoms can be stopped in their downward career we often notice, as in the individual before you—*moi qui parle*.

In talking of the cure of phthisis, we need only consider that of the more or less chronic consumption; the rapidly ulcerating cases, the galloping consumption, whether due to miliary tuberculosis or not, may possibly be prevented, but probably cannot, as yet, be cured. Even in ordinary phthisis it is only in the early stages that measures of cure can be adopted with reasonable hopes of success.

Tuberculin, both old and new, has grievously disappointed a credulous profession, and the X-rays seem to offer little aid in the slaughter of bacilli. As to whether dilutions of tuberculin internally administered do any good, I have not been able to convince myself.

The treatment of symptoms by medicines can be carried out in conjunction with the other procedure I have advocated, according to any pathy, any system, or any eclecticism. I leave this to your discussion, merely adding that my most frequently used drug in this connection is arsenic, especially in the form of the iodide, while I often resort to phosphorus, sanguinaria, hepar sulph., iodine, kali carb. and others. It would not be honest for me to omit to add that I have seen more benefit in my own case and others from the use of guaiacol and creasotal, and their carbonates, than from any other drug.

When a suspected case comes before me I have the sputum examined for bacilli and lung tissue; should such be present, I arrange for as much of the general treatment I have described as I can persuade the patient to adopt. In addition, I order guaiacol in 1 to 4 drop doses on sugar or in capsules, two or three times a day as can be tolerated,

or creasotal in doses of half a teaspoonful, or carbonate of guaiacol in cachets containing 3 to 10 grains.

A mixture that undoubtedly benefits many cases both of early and advanced phthisis is that of creasote and cod-liver oil, with or without the addition of malt extract. I have witnessed such benefit, and at the City of London Hospital for Chest Diseases it has been extensively and successfully employed. From 5 to 40 drops of creasote in a dessertspoonful of the oil may be given three times a day after meals, or, as creasote is soluble in alcohol, a mixture or emulsion may be prescribed.

I also frequently order a mixture of equal parts of creasote and oil of eucalyptus to be dropped on the sponge of a simple open respirator made of perforated zinc, to be worn each day for longer or shorter periods. I have slept many nights with this on, and so have some of my clients. These drugs, with the rare use of small doses of opium, I have observed to do good, even where the open-air method is not adopted, both in threatened and declared phthisis. There is a phosphite of guaiacol, of which I have no experience, but which, containing a small amount of phosphorus, may be expected to prove of value.

I endeavour to practise homœopathically and, to the best of my lights, my everyday and all day practice is founded on the law of similars; but I do, and shall, use other means where occasionally I find them of benefit. I do not think the most enthusiastic follower of Hahnemann can honestly claim great success in the treatment of phthisis with his potencies; in the meantime, I recommend to him the treatment I have sketched.

I will refer to one or two cases very briefly where the patients have greatly improved under the guaiacol treatment and as much of the open-air treatment as I could persuade them to adopt.

*A lady, middle-aged*, whose family history is distinctly phthisical, had the symptoms of early phthisis:—cough, hæmoptysis, night sweats, loss of weight, &c., was declared consumptive of the right lung by eminent London physicians, and treated for considerable periods by members of both schools.

She went to the Riviera and improved under phosphorus and iodide of arsenic, but next summer became much worse after an attack of influenza. A course of guaiacol and another winter in the Riviera made a wonderful change. This is now four years ago, and she has apparently quite recovered.

*A stout, florid gentleman, aged 50, came to me with cough and loss of flesh three years ago. He had been under medical treatment, but without benefit and apparently without correct diagnosis. I found a considerable cavity in the right upper lobe. He had profuse expectoration, especially in the mornings; it has been examined many times at our local bacteriological laboratory and always reported, "loaded with tubercle bacilli." For two years I treated him to the best of my ability, and he got worse; he lost 3 st. in weight, and the symptoms and physical signs became worse. The winter before last he spent at the Canary Islands with some benefit, but soon after his return had a severe attack of pleurisy, which put him back. He lives away from Liverpool, and the doctors who attended him through this attack only gave him a few months to live, and one wrote me to that effect. On his visiting me later I found him really in a serious condition and not fit to be at his duties. I described the open air necessity to him and put him on guaiacol and the creasote inhaler. His improvement has been remarkable, he has gained one-third of the weight lost, his cough is much less; his temperature, which for two years was carefully taken morning and evening, and was rarely normal in the morning, while in the evening it was always between 100° and 102°, is now generally normal; he now never has night-sweats or blood-stained sputum, and looks and feels nearly well. Through last winter he attended daily to an arduous business in Liverpool, and he purposes doing the same this winter. He is still rather short of breath, partly from the pleurisy which has crippled his good lung; the cavity is still obvious, and there is morning expectoration full of bacilli. He rarely comes to see me, but has a firm faith in the guaiacol and the inhalations; these he continues, with an occasional interval when he will take the iodide of arsenic for a month. I may add that this gentleman has the advantage of living at West Kirby, where the open air can be safely enjoyed all the year round. I consider this locality the best we have in this neighbourhood for lung cases, and not beaten by many in the south; it would be very suitable for a large consumption establishment.*



A *lady*, who had profuse hæmoptysis early this year, with cough and free expectoration full of bacilli, pyrexia, night-sweats and other classical symptoms of early phthisis, and who was condemned to an early death by a physician of this city, has, under this treatment, gained weight from 9 st. 8 lbs. to 11 st. 8 lbs.; she looks well and jolly, has lost her pyrexia, and has little cough or expectoration. Where a case of phthisis progresses favourably, the symptoms will naturally improve before there is any obvious change in the physical signs. In this case, except for a little shortness of breath, there are no symptoms remaining, and to look at the woman, the verdict of phthisis would appear ridiculous. The bacilli have disappeared from what little expectoration still occurs, yet at the right apex there is increased vocal resonance and bronchial, cog-wheel breathing; while there is obviously a cavity in the left upper lobe, with râles and rhonchi. Recently a friction sound has developed over this apex. I have induced her to remove to West Kirby, and have every hope of an eventual closure of the cavity and practical recovery of the patient.

A *young man* with all the same conditions has improved in like manner. He has no cough or pyrexia remaining, but as there are still a few bacilli in his morning expectoration, I have persuaded and aided him to obtain a post in the Canary Islands, where he will probably remain for two or three years.

Other recent cases have improved, though not to the same extent, and some advanced cases have died notwithstanding the treatment. Unfortunately the stomachs of some resent the guaiacol.

A close personal friend of my own was many years ago sent to Mentone to die; he had recurrent attacks of hæmoptysis and was declared consumptive by eminent consultants of this city. As he understood that he had to die, he determined to spend his money in having a good time, so lived out of doors careless of catching colds. Instead of decently expiring as directed he got quite well. This was long before the promulgation of the open-air method; but my friend, who is now exceptionally vigorous and athletic, became so convinced of what he owed to the plan, that up to the present day he lives and sleeps all the year round with his windows wide open; whenever away on holidays

he sleeps out in the open, and even in London, on dry and warm nights he sleeps in a hammock slung across the back yard. I will not report his name and address as I understand that "sleeping-out" is a serious offence against the law of these realms.

I have read of a New York doctor, condemned to the death of a phthisic, who resigned his practice, said good-bye to his friends and went off to the woods, with a gun, a dog and a portable tent; desirous, like Ajax, to die in the sunshine. He recovered completely and returned to the metropolis to lecture on his cure.

To sum up, in conclusion, we have seen that anything that lowers the general health predisposes to phthisis—exhausting diseases and habits, insufficient and unsuitable food, over-work, lack of exercise and pre-eminently bad air. We have also seen that the individual desirous of escaping phthisis should be careful in the selection of his father and mother, should avoid infection from food and from the secretions of tubercular subjects, should attend to his digestion and cultivate good hygienic, dietetic and moral habits, especially avoiding alcoholic excess, the taking of colds and the acquisition of syphilis. Above all, he must secure sunlight and fresh air.

These directions can of course be most satisfactorily carried out by those who have the means, the leisure and the good fortune to secure them, and to pursue them where they can be found; but to a fairly satisfactory extent they are within the reach of everyone in every climate, to a degree which this generation has only recently recognised. It is a well-known fact that phthisis is more certainly and more rapidly a fatal disease with the poor than among the well-to-do, and it is our duty as doctors and as citizens to secure the advantages of suitable treatment to our poorer fellow-creatures.

Gentlemen, I know that my personal experiences form a trivial incident, except to me, in the war which each of us, either in his practice or his person, is waging day by day against consumption. At present there seems an armistice in my own little struggle, and I feel less under the cloud

thereof than I have been for twenty odd years past. Therefore am I tempted to review the field. Far be it from me to boast of a victory; too many of my best friends have fallen in the fight, and the time is not yet for the taking off of the armour. My report is necessarily an inconclusive one; however, my defeat, if such occur, cannot of course be recorded by me, though it may be observed by those who now hear me. Be assured that I should not have intruded my personality so much into my remarks, did I not feel myself among friends as well as colleagues.

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## HOW TO BRING OUR MATERIA MEDICA UP TO DATE.<sup>1</sup>

BY JOHN W. HAYWARD, M.D.

*Consulting Physician to the Hahnemann Hospital, Liverpool.*

ON September 24 I was delighted on learning through the Secretary of the Materia Medica Section that, to use his own words, "the meeting on November 3 should be given up to a discussion on the best means for bringing our materia medica up to date, by some work such as the unfinished 'Materia Medica, Physiological and Applied,' and to a discussion on the proving and reproving of drugs." I quote the words used in the Secretary's letter, because the remarks I am about to make are based thereon, and were written before receiving the notice calling this meeting.

I readily acceded to the request that I would open the discussion by a few remarks on "The systematic and scientific development of the material now at our disposal;" because materia medica is our special province—the specialty of the homœopathic body.

Now I presume that by "the material already at our disposal" is not meant only Hahnemann's "Materia

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, November 3, 1896.

Medica" and "Chronic Diseases," and the "Cyclopædia of Drug Pathogenesy," because however this material may be "developed," it can of itself never be made into a "scientific materia medica," or a "materia medica up to date." Something more is needed. A scientific, an up-to-date materia medica, must of course embrace not only pathogenetic material but also all the relationships of all medical materials; and I hope that the production of such a work is the object the section has in view. A scientific, up-to-date materia medica, cannot be simply a collection of the pathogenetic effects of drugs; it must also point out what are medical materials, where these are to be found, when and how to collect or obtain them, and how to prepare and preserve them, as well as suggest the purposes for which they are to be used and how to use them — whether homœopathically, allopathically or anti-pathically.

A materia medica constructed on these lines is required for the needs of our own body, but it will also meet the requirements of the whole profession and fill a gap in our professional literature. Such a materia medica can, however, emanate only from the homœopathic body; it could not possibly be prepared by either one man or a body of men unacquainted with the homœopathic uses of medicines.

I am therefore very pleased that the British Homœopathic Society feels itself called upon to furnish the profession with such a materia medica, and is willing to undertake its preparation. This is certainly the best work it can do, and the sooner and more earnestly it sets about it the better for its own reputation and for the profession at large.

By those who are content with our present separate and isolated position it may perhaps be objected that, having the "Cyclopædia of Drug Pathogenesy" and Hahnemann's "Materia Medica" and "Chronic Diseases," we possess all that is needed for applying medicines in the cure of the sick, at least homœopathically; and having the "Index" that is being prepared for us, we possess also about all that is necessary to enable us to use this

material in practice; whereas all the other parts of a complete materia medica may be found in such works as Pereira, Christison and Brunton; whilst for the interpretation of the pathogenetic and therapeutic spheres of the actions of drugs we have such works as Hughes, Dunham, and Farrington; and for the clinical confirmations we have our periodical Journals and Hospital Reports. All this is very true, and no doubt these serve very well in our present position, but neither one nor several of them together can possibly form a scientific materia medica, bring our materia medica up to date, or have us before the profession as a scientific body; it would take all of them together to do so, and as we now are we need to use all these separate works. Besides, it is one of our duties, as custodians of *the* truth in medicine, to bring our profession as well as our materia medica up to date. This duty we may attempt to discharge by laying before the profession, in a form not repulsive or irritating, but attractive and convincing, the homœopathic contrasted with the allopathic and antipathic uses of medicines, by means of a materia medica that they may be prevailed upon to make use of.

When I promised to open this discussion I intended to do so by pointing out the lines on which a systematic and scientific materia medica—a materia medica up to date—should be constructed; but on looking the subject up I found that this had been so well done already, that it would be mere repetition and unnecessarily occupying the valuable time of the meeting; so, through the post, I have drawn attention to some of the already published proposals, plans and arguments which have been advanced in previous discussions of the subject.

My own ideas were fully expounded in a paper on "The Materia Medica of the Future," a reprint of which I have forwarded to the members of this materia medica section. Perhaps the best discussions of the subject were at our Congresses in Edinburgh in 1882 and in London in 1884. In Edinburgh it was on the proposed Materia Medica of the Hahnemann Publishing Society, the "Materia Medica, Physiological and Applied," and a report of it will be found

in the *Monthly Homœopathic Review* for 1882, p. 622. In London it was on Dr. Hughes's paper on the "Cyclopædia of Drug Pathogenesis," and will be found in the *Monthly Homœopathic Review* for 1884, p. 613. It was also discussed at this Society in a paper by Dr. Pope, as reported in the same *Review* for 1884, p. 286 : also pp. 196-200 : and 278-285. It was also further exhaustively treated in the "Introduction" to the "Materia Medica, Physiological and Applied," pp. xxii., *et seq.*, in 1884, which I trust we all possess and use. It was again discussed at the Congress in 1885, a report of which will be found in the *Monthly Homœopathic Review* of that year, p. 681 ; and again during the remarks on Dr. Hughes's arrangement of belladonna for the "Hahnemann Materia Medica" of the Hahnemann Publishing Society : see *Monthly Homœopathic Review*, 1886, p. 519 ; and again by Dr. Ellis, in his presentation of colocynth : see JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, vol. i., p. 97.

So that the subject has already been so well discussed and such a variety of plans have been exhibited, that nothing now remains but to decide on some one particular plan and set to work. I hope the gentlemen present have looked over these past discussions and come to this meeting prepared with definite opinions and proposals, and an earnest and sincere intention for practically taking the matter in hand.

I will now simply state that the published volume of "Materia Medica, Physiological and Applied," was, in reality, only a sample volume, produced in response to the call formulated at the Edinburgh Congress. It was not intended to fix hard and fast lines on which our materia medica should be framed ; each worker was left to his own devices and his own plan and treatment, so that it might be seen what were our ideas and our needs in this matter : hence the diverse presentations.

At the time of the Edinburgh Congress it was hoped that such criticisms and advice would follow as would settle the plan and set gentlemen to work. If such had been the case, and only so few as thirty of our body had

each prepared one single medicine during these sixteen years, what volumes we should have had by now!

It must perhaps be confessed that some of the medicines in the sample volume were too elaborately done, and so perhaps frightened gentlemen from undertaking the work. If so, a much simpler treatment may be adopted. Perhaps Dr. Drysdale's plan with kali bichromicum is the best, but some may prefer Dr. Dudgeon's with aconitum, or Dr. Hughes's with belladonna, or Dr. Black's with digitalis, or Dr. Ellis's with colocynth, or some other, or some combination out of these plans. Anyway, it would be well now if some one plan were selected and agreed upon. Perhaps what should be done is to elect a small sub-committee, entrust it with the determination, and then for all loyally to accept the plan, encourage and help the workers, and purchase and use the book.

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## THE NECESSITY FOR SYSTEMATIC AND SCIENTIFIC REPROVING OF BOTH OLD AND NEW DRUGS.<sup>1</sup>

BY EDWARD M. MADDEN, M.B.

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It would almost seem at first sight that there is no need to argue in favour of this proposition, that in fact it is self-evident, and that we must all be agreed upon it.

And indeed, I am inclined to think that we are all agreed upon it as a theoretical proposition, but that hitherto most of us have added a mental rider in the words "if somebody else would be kind enough to do it for us."

It is therefore in the hope of arousing a sufficient amount of enthusiasm among our all too small body to

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, November 8, 1898.

persuade us into actually taking the matter in hand, and doing our level best to supply the obvious defects in our present *Materia Medica*, that I propose to lay before you categorically some, at least, of the reasons why we should no longer delay an attempt to bring this department of our work up to the same level as that now attained by our knowledge of disease and its various manifestations, and with all our modern methods of investigation.

“Right here,” as our American friends say, it would seem desirable to say that the statement of the necessity for new provings, even, or perhaps especially, of our most used and best trusted drugs, does not in the very least imply that the provings of our master, Hahnemann, and his contemporaries, nor those of the Austrian Proving Society and of others whose labours have enriched our *Materia Medica* up to the present day, were in any degree defective so far as they went, and with the means which were at that time available.

It is universally admitted that for the full and satisfactory carrying out of the principle of homœopathy in practice, it is necessary to be able to cover *all* the symptoms observed in a patient by the same or very similar symptoms produced in the provings of, or in cases of poisoning by, some one or more drugs, preferably of course by one.

In the days of Hahnemann, and for a good many years later, a clinical picture of a patient's case consisted almost entirely of those symptoms observed by the physician by the unaided use of his own five senses, specially trained to this end, supplemented by the subjective symptoms reported by the patient as observed by *his* own five senses, for the most part specially *untrained*, and in many cases of course disordered by his disease. Morbid anatomy, such as there was, was of the crudest description, and the pathology, so called, of the day resolved itself into more or less fanciful theories which the Master had the intuition to see had no real bearing on therapeutics, whether they were true or false. Inevitably therefore, the results of provings were the record of the same two methods of observation upon people who, instead of suffering from disease, were suffering



from the effects of drugs taken accidentally or as intentional experiments.

Hence it came that the physicians in those days did have a fairly full record of drug symptoms, sufficient to enable them to cover pretty well all the disease symptoms they had any means of knowing and examining.

Unfortunately, however, and inevitably as much now as then, the deliberate provings upon human subjects could not be carried so far as to produce the coarse pathological changes, recognisable as such in those days, or indeed to produce many definite objective symptoms of any kind, recognisable by the unaided senses of the observer, and hence the subjective symptoms reported by the experimenters (and therefore much more liable to error) fill by far the larger portion of these records as originally drawn up, *and remain so to this day.*

From this fact, it would seem, there grew up a feeling among the earlier practitioners of homœopathy that, in selecting a remedy, the subjective symptoms are the most important, and some would even appear to have gone so far as to believe they are the only important symptoms to be covered by the remedy, and that the pathology or true inwardness and real starting point of such symptoms is interesting no doubt, but of no importance so far as selecting a drug to cure the patient is concerned.

Such, I fancy, was the mental attitude of not a few of the apostles of homœopathy, and may to a great extent be explained and excused by the state of pathological knowledge of their day, and especially so when they found that by following out this theory into practice they cured an infinitely larger proportion of their patients than their unhomœopathic colleagues.

I fear there are a few who still hold this theory, apparently viewing homœopathy as a form of religion, and hence necessarily complete and unalterable as given to us by the Master, and as practised by his immediate disciples; instead of being, as it really is, a guiding principle capable of indefinite extension with the ever enlarging area opened out to us by scientific investigation.

This implied limitation of homœopathy to the treatment of subjective symptoms has been sedulously fostered among the opponents of our system, and has done as much or more than the use of the infinitesimal dose to bring discredit and ridicule upon our whole body, and to prevent a fair enquiry into the practical methods of the system; and so long as our materia medica lends a reasonable colour to such a charge by not providing us with the means of covering the objective and pathological changes of disease with similar changes produced by drug effects, who can wonder at the ridicule and opposition continuing?

This feeling, then, of the need for new provings with the especial aim of adding to their objective results by making use of all the numerous scientific means of research, whether chemical, electrical, or mechanical, by using the microscope, spectroscope, stethoscope, ophthalmoscope, sphygmograph, &c., &c., nearly all of which were practically unknown at the time of the original provings; the feeling, I say, of the need for new provings has been gaining greater and greater force with every advance in the scientific means of investigating disease, and is now simply overwhelming.

We cannot afford to stand still in this matter any longer; the question is crying aloud for solution; for years past hardly a congress or presidential address has passed without its being put in the fore-front of our duties, and I am delighted to see it has been done so again by our good friend Dr. Arthur Clifton, who now so ably fills the chair. If we are to keep ourselves at all abreast of the medical science of the day, and if we are to attract any of the best sort of students to our system, this question has to be practically met and solved, and though, with our small and scattered body in this country, it is by no means easy to see how we can organise a scheme sufficient to fully satisfy our requirements, yet we can at all events make a beginning and do something towards it, and I hope we shall not separate to-night before a practical foundation is laid whereon the entire edifice we hope to see some day may safely rest.

I would suggest, for instance, the appointment of a Committee of three, say our President and General Secretary, and the Secretary to the *Materia Medica* Section, to organise the details necessary, and that all here who are willing to help should give in their names towards the formation of a Proving Society.

One word more. I hope no one will think that in pleading for new provings to enable us to cover objective symptoms more fully than has been hitherto possible, I seem to be in any way undervaluing the use of the subjective symptoms with which our *Materia Medica* is so rich; these have been, are, and always will be of the greatest possible value in choosing a homœopathic remedy; and I have the greatest confidence that, when the objective simillimum is found, it will be the subjective simillimum also; but for our own sakes, and more than all for the sake of the future of homœopathy, we *must* be able to find the objective simillimum for every case where it is possible, for then, and not till then, can we feel we have reached our ideal of covering *all* the symptoms.

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## PROLEGOMENA OF MODERN PROVINGS.<sup>1</sup>

BY C. J. WILKINSON, M.R.C.S., L.S.A.

To desire that provings made in the present day should differ widely in many respects from the provings with which we are (or ought to be) familiar, involves no disrespect to the material with which we have been working. On the contrary, the wide-spread wish for re-provings and new provings argues loyalty to the principles of homœopathy as well as respect for that ever-restless struggle for improvement which has characterised the science of medicine in all time.

<sup>1</sup> Presented to the Section of *Materia Medica* and Therapeutics, November 3, 1898.

A retrospective glance at the means of observation in the age of Hahnemann can only deepen our sense of wonder and admiration at the results which he and his immediate disciples achieved. Put as briefly as possible, the means of observation available in those days were strictly limited to the unaided use of the five senses *plus* the power of recording the sensations of the subject of the experiment. Nothing is easier than to jeer at the results of work so undertaken; it is a cheap recreation which our opponents have enjoyed without stint for a century. We have, most of us, ourselves been tempted to indulge in it when in a captious mood. The results of systematic introspection by men and women confessedly in an artificially morbid condition need a kindly and sympathetic analysis. There must have been points of view from which Narcissus himself looked somewhat ridiculous, as he stooped over his pool. There were, too, temptations to fraud in work which was, in its very nature, incapable of check and revision, and we may fear that the temptation was not always resisted successfully. But, in the main, the results made good under the limitations imposed are the results of honest, self-denying, and persistent work. At the least, we have been content so far to make use of them, and if at last we are dissatisfied with them, it is not ours to cavil but to replace them by others more to our minds.

One complaint against the old provings is that an enormous percentage of their material consists of a record of mere internal sensations described more or less impressively. They are *subjective*: the rationale of them it is always difficult, and too often quite impossible, to discover; the underlying pathology of them is obscure and tangled. The modern teaching of medicine more and more bases a consideration of symptoms on a knowledge or hypothesis of the pathology of the disease. Consequently modern medicine increasingly uses methods which reveal *objective* symptoms, and the modern physician is by his training decreasingly in sympathy with methods of cure based on a consideration of subjective symptoms. If homœopathy is to retain its hold upon the modern physician who has been attracted to it; still more if it is to attract those who are being, and who

shall be, trained in modern science, it can only do so by a translation of the old subjective work into terms of the objective. The symptoms of the new provings must, so far as it is possible, be such that the eye can see them, that the touch can verify them, that the test-tube can analyse their resultant perversions of secretion; they must be physical signs recognisable by the stethoscope, the ophthalmoscope, and laryngoscope, by the speculum or the electric test, or by any or all of the modern weapons of precision in the armoury of diagnosis.

Subjective symptoms are very necessary to us. As guides to a prescription, with a knowledge of the circumstances which modify, ameliorate, and aggravate them, they cannot, and must not, be dispensed with. But the new provings must, so far as may be, help to redress the balance. They must strive to substantiate the subjective by a statement of the objective. Where there is a shadow, the substance which casts it must be sought for.

And this search for the objective offers certain difficulties. It will in most instances involve the use of methods with which we are at least not fully familiar. Supposing that a drug which affects the circulation is being proved, it will be quite necessary that the sphygmograph be brought in to render graphic the effects it produces—even, perhaps, to demonstrate that any effect is produced. The sphygmograph is an instrument which many (perhaps most) of us seldom use, and its ways have to be learnt. The estimation of urea is not commonly a matter of daily routine, but it may be necessary in proving many drugs. Similarly there are many methods of clinical *technique* which are new to all of us, and which can readily be learnt and applied. I am told that there is great danger of risking a refusal of help by insisting that such trouble is necessary. This fear seems to me to be based on too low an opinion of human nature. That the work is a necessary one is generally conceded. If it is to be done at all it must be done well, as thoroughly as possible, and the men who realise the necessity for the work will be the last to refuse the trouble of learning a little on the way to its successful performance. This consideration

may be added, that the grasp of such methods as a thorough proving demands will not be useful only for purposes of proving, but will be available always for the work of practice, and that there is nothing like a new method of looking for symptoms to stimulate a new energy and interest in the work of every day. Speaking for myself, I may say that so far as I possess a widened view and an increased interest in the problems of medicine, I owe it to the attempts (poor and incomplete as they have been) which I have made in the direction of proving drugs, and my hope is that I may deserve and find fresh interests and a wider scope by further attempts.

Before a proving is begun a small note-book should be taken, small enough for the pocket, and in it should be entered the prover's name, his age, and his weight, together with a short statement of the minor ailments to which he considers himself specially liable. It would be manifestly unfair to charge attacks of such ailments to the account of the drug without allowing for the constitutional liability. I fancy that sufficient care has not always been taken in this direction, and that considerable deletions might be made from accepted provings if there were more information on such subjects. The variation to be allowed for can only be recognised at a glance in such an arrangement of provings as was proposed by Dr. Ellis (who treated the provings of colocynth as a specimen) a few years ago. Such an arrangement is only possible where a considerable number of provings is under consideration; and a transcript of the prover's original notes (always a valuable document) will become all the more valuable in its individuality from its possessing such a statement as I propose. In the case of reproving it is also of the highest importance that certain other data should be presented to prove the individual norm of the prover in that field where previous experience has led us to expect the drug to manifest its activity. It is only by means of such a precaution that later deviations from the normal can be precisely determined and the duration of the pathogenetic action demonstrated. In the case of one drug the pulse-tension, in the case of another the power of vision,

in a third the output of urea, in a fourth the blood-coagulability may become the important centre of a proving, and it will be too late to seek for the individual norm when that has been already upset for a period of unknown duration. While it is too much to expect a complete anthropometric formula of the prover, it will be wise to provide data, which are likely to be wanted in each case. Moreover, the work done in establishing such data will ensure all the necessary preparations for the several works in the provings themselves. With regard to the analysis of secretions, &c., it is to be hoped that arrangements may be made for the work being done at a centre for those who desire it. The notebook is destined, of course, to be the diary of the prover's experiences, with a record of the doses taken. This should be full and detailed. "The little more" is easily excised; "the little less" may be irretrievably lost. The symptoms should be entered at once, as far as possible, with the hour of their occurrence. The exact anatomical position of every pain should be carefully noted, and also the side of the body on which it occurs. Attempts should be made to discover modifications of symptoms, as by eating and drinking, by heat and cold, by pressure and posture. A sharp look-out should be kept for any periodicity in the symptoms.

Should a prover know what drug he is taking? This, I think, is a question which is open to debate; it is certainly one that will have to be decided by the voices of the volunteer provers themselves. I am inclined to answer the question affirmatively, after careful consideration. The fear of "auto-suggestion" in the mind of the prover would not be obviated by his ignorance of the drug which he was taking, and his own private benefit from the proving would be diminished, since he would be deprived of the power of constantly referring to the underlying reasons for his symptoms as they developed. Much gain should accrue to us all from the fact that the minds of several men are perforce concentrated on the action of one drug during a proving. It will be strange, indeed, if some light is not thus thrown upon the long-sought but still unexplained rationale of the Hahnemann law. I need not point out that it is the want

of this explanation which has retarded the growth of homœopathy in the acceptance of both the profession and the public.

There is one other point upon which some anxiety may naturally be felt by those who intend to undertake provings, namely, the amount of disturbance to work and comfort which is likely to be involved by this undertaking. It is an amount which is very greatly exaggerated in the minds of most people. At this late hour it is inexpedient that I should quote at length from Carroll Dunham,<sup>1</sup> and I hope that it is unnecessary in the case of a work which must be known to all of us. I may remind you, however, that he classifies the symptoms produced by drugs on the healthy body as being either chemical, mechanical, or dynamic, and that he points out that the mechanical effects, "consisting chiefly in violent efforts on the part of the organism to eject from its cavities the offending substance," are the last which a prover is anxious to establish. From which it follows that a prover should commence by "a trial of the higher potencies first, and afterwards, if necessary, proceed to take the lower dilutions and triturations, or the crude substance or tincture, if satisfactory results are not obtained with the attenuations."<sup>2</sup> For the sake of harmony and for other reasons, it is likely that a Committee supervising provings, either in this country or in the United States, would adopt a rule similar to the ninth recommendation to the editors of the "Cyclopædia of Drug Pathogenesis,"<sup>3</sup> namely, to "include symptoms reported as coming from attenuations above the 12th decimal only when in accord with symptoms from attenuations below." There can be few (even in this day of the "conscientious objector") who would hesitate to undertake a proving which began at the 12th decimal, if he had full liberty (as would, of course, be the case) to interrupt or abandon it at any stage of the proceedings. The danger would be rather of failing to find effects to record than of being oppressed by their number or

<sup>1</sup> "Homœopathy the Science of Therapeutics," p. 137, *et seq.*

<sup>2</sup> *Ibid.*, p. 141.

<sup>3</sup> *Op. cit.*, vol. i., p. x.



magnitude. I know that in provings of a much less cautious spirit no extreme or terrible consequences were encountered. The doses to be taken must manifestly vary with the known powers of the drugs under consideration, but caution would be necessarily the first note of any supervising body; and this system of feeling our way from the infinitesimal to the material has a double recommendation, as commanding the approval of the greatest authorities from Hahnemann downward, and also as giving an assurance of safety sufficient to satisfy the most timid student of drug action.

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Dr. CLARKE regarded Dr. Hughes' "Pharmacodynamics" as the ground-work of pretty nearly all practice, and the only complaint he had to make was that Dr. Hughes had done his work too well. A good deal had been said about the necessity of provings. The point of view from which the homœopath started his work was the phenomenal point of view, the symptoms. The comparison was to be made between the disease symptom and the materia medica symptom, and if a man went in for pathological explanations of those symptoms he would pretty soon get lost, for pathology was constantly changing. It seemed to him that it was not so much new provings and re-provings that were wanted as a practical arrangement of the materials already in existence. First of all, it was necessary to define what was meant by materials. There was Hahnemann's "Materia Medica Pura" and Hahnemann's "Chronic Diseases." He (Dr. Clarke) had come to the conclusion that clinical symptoms, which were supposed to vitiate the "Chronic Diseases," were just as good as any other symptoms. As a case in point, he mentioned that he had a case of venereal warts, due neither to gonorrhœa nor syphilis, appearing on the glans penis. He tried thuja, but it was of no use, and sepia seemed rather to favour the growth than otherwise. He had recourse to Hering, and prescribed antim. tart. on the symptom (not found in Allen), "warts at the back of the glans," and it cleared up the case in a very short time. That was a clinical symptom, and it was probably a case cured. With regard to high dilutions, he did not think it was becoming in a scientific man to sit down with an opinion when it was possible for him to verify the fact. He had high dilutions put to the test, and soon came to the conclusion that they did act, and not only cured, but developed, in some cases, their own symptoms. Another thing

he had to say about the "Pharmacodynamics." Dr. Hughes naturally approached his subject from the nosological standpoint, and he (Dr. Clarke) had done the same thing, only it was necessary to remember that it was only a convenience, and not the essence of the thing. For instance, it was stated that bryonia was the medicine for pleurisy. It was true that more cases of pleurisy corresponded to bryonia than to any other remedy, but there were cases that bryonia would not touch. He noticed that in a patient he had suffering from pleurisy there was especial intolerance of lying on the affected side, and he therefore gave belladonna, which cleared up the case almost at once. What was required, he maintained, was not so much new provings as a practical arrangement of the material we already possessed. For upwards of twelve years he had been busy at this work, and he hoped that within the course of the coming year the Society would be able to judge for themselves what the work was worth. He first of all named the medicine and gave it its position in the world of nature, then he gave an alphabetical list of the names of diseases it had been used in, then he gave a description under the head of "Characteristics" as graphic as he could make it. Finally, there was a schema, which was an absolute necessity for genuine homœopathic work. He almost thought that the homœopaths who had to dig their homœopathy out of Jahr made better practitioners than homœopaths of to-day.

Dr. ORD had listened with great pleasure to the concluding remarks of Dr. Clarke with regard to the practical steps he was taking in solving a very complex problem. The subject so ably brought forward in the papers read divided itself into two heads: first, the method by which a suitable materia medica for daily work could be formed; and, secondly, the method by which the materia medica could be enriched by new provings. He thought it was necessary to decide how to deal with the material already possessed before they could know how best to dispose of material to be obtained by future provings. Confining his remarks chiefly to the improvements by which the present materia medica could be most usefully presented, he thought they should commence by taking as a model the "Materia Medica, Physiological and Applied." The work then divided itself into two great sections—first, the pathogenetic material; and, secondly, the equally important clinical and pharmacological matter. As a practical aid in prescribing for patients the "Cyclopædia of Drug Pathogenesis" was a failure, because it was not adapted to the needs of the busy practitioner. Undoubtedly it was a magnificent work of reference

for *materia medica* experts, but one could not utilise it with any advantage in treating a case or looking up symptoms of patients. The men who went in for symptom-covering were now amply provided for by Dr. Hughes' splendid Index, with Hahnemann's or Allen's schemata. But what was wanted for busy men was to pluck the gems out of the material of the provings in which they were found, much as diamonds were taken out of the Kimberley mud, and presented no longer in the rough, but skilfully cut and set. He had worked for two years at the problem, and a specimen of the result of that work—the drug *conium*—was published in the *Monthly Homœopathic Review* four years ago, a copy of which he sent to many of the members. After preparing some twenty drugs in that form he had given the method up, as he felt convinced that only what was *absolutely reliable* from narrative provings could be admitted with safety in a reliable *materia medica*. He now saw how this could be obtained. For the last fifty or hundred years magnificent clinical material of cured cases had been accumulating, but no attempt had been made to use it as a check on narrative provings, or, rather, to test pathogenic material in the light of cured cases. The time had come to make use of this accumulated experience. He therefore advised that all reliable pathogenetic material be divided into two parts: (1), the symptoms experienced by two or more provers; (2), the remainder, which might be called doubtful material. This should be compared with and verified by the cured symptoms that could be found in the records of clinical work for the last fifty years, and only such pathogenetic material as passed such a test should be admitted in a new *materia medica*. Part of that work would be greatly facilitated by the publication of the Index of cured cases which had been prepared by a Special Committee of the Society. By comparing the narrative provings of the *Cyclopædia* with records of clinical cases it would be found out which of the pathogenetic symptoms had proved reliable and useful in practice, and hence deserved to occupy a permanent place in the "*Materia Medica*" of the future. With regard to re-proving the older drugs, he maintained that they had no need of further subjective symptoms than those they had used for the last fifty years successfully, nor was it probable that any other reliable *subjective* symptoms could be obtained; but he was cordially in favour of re-provings for *objective* symptoms, such as could be observed by the stethoscope, sphygmograph, urinary analysis, and other modern methods.

Dr. DYCE BROWN said he was struck with the tendency

to rather put in the back-ground the subjective symptoms, the provings of Hahnemann and those who immediately followed him, and the wish to go more for what might be called the rougher developments, the more crude results of drugs, and get them to be produced to correspond with medicinal uses. If such a thing could be obtained it would be exceedingly valuable, but he was afraid that the efforts to do that to any extent would be chimerical. He did not wish to throw cold water on any investigations, but Dr. Lauder Brunton's "Pharmacological Experiments" were an example of what that sort of thing would lead to. The book gave particulars of a most elaborate series of experiments made on the lower animals with nearly every drug, and he would ask anyone who had read the book if those experiments were worth anything whatever? It would be a waste of time to go into such investigations. Experiments on the lower animals were worth very little, because although they might corroborate what was known of the action of drugs on the human body, yet he maintained that by themselves they were worth very little, as the action of drugs on animals was different from that on men. They could not expect a prover to go on taking medicine which was making him ill. Past provings, although chiefly subjective, were wonderfully accurate guides to the active diseases they represented symptomatically. It would be a great pity to waste time on experiments which would be of no value in therapeutics.

Dr. HUGHES said there was a time when Dr. Hayward and he were opposed as to which was most needed on the part of homœopathic literature. Dr. Hayward was then, as now, advocating a series of monographs on drugs such as were in the "Materia Medica, Physiological and Applied." He (Dr. Hughes) was advocating the presentation of a genuine and intelligible pathogenesis of drugs, making that the first aim, and letting the other come subsequently. His view had prevailed, and that work had been done. They had now, *pace* Dr. Ord, in the narratives of the "Cyclopædia of Drug Pathogenesis" a genuine and intelligible presentation of the physiological actions of drugs. Dr. Hayward and he agreed that the time had come to utilise this material by a series of studies, more or less exhaustive, such as were in the "Materia Medica, Physiological and Applied," of individual drugs. What Dr. Clarke had said about clinical symptoms being useful practically he could not deny, but his great desire was that the original homœopathy of Hahnemann should be worked much more than it had been of late years. They ought to be using from time to time the "method of dis-

covery," as Drysdale called it, and not merely the method of repeating other people's experiences. If Dr. Clarke went on advocating clinical symptoms in the way he did, the vantage-ground we had in using the symptoms observed upon the healthy for the choice of remedies would tend to be lost, and "similia similibus" would become conspicuous by its absence in the literature of homœopathy. With regard to what Dr. Ord had said, he thought the Index did make the *materia medica* contained in the "Cyclopædia of Drug Pathogenesis" valuable for every-day use. The contention was that the narrative form was the only one in which the action of drugs on the healthy could be properly understood by the student; for those who read through the narratives read typical cases of drug-disease, and from them learnt the true action of the drug and the connections and sequences of its symptoms. He believed that if Dr. Ord took these diamonds out of the Kimberley mud and exhibited them separately they would lose one half their value. The narrative was not mud on one side and diamonds on the other. What had been said by Dr. Madden and Mr. Wilkinson with regard to provings was unexceptionable. They all assented, also, to Dr. Dyce Brown's view that the subjective symptoms were excellent. They were not to be thrown overboard, but used with the others. He trusted that good practical work would result from this discussion. Those who were literarily inclined could work at the monographs on drugs, and those whose sympathies were more with practical work could prove drugs; and between the two there would be an increased store of medical knowledge.

Dr. FISHER (Chicago) said there was need for new work in *materia medica*. In his own practice he followed more nearly the old Jahr and Hahnemann's "Chronic Diseases" than any other works, and with greater satisfaction than when he ran after Farrington and newer works. Young homœopathic physicians found themselves in a more difficult position in the field of practice in the present day than formerly. It seemed to him there should be something between the symptom codex and the crudity of the old school, something in the line mentioned by Dr. Ord, a verified *materia medica*. He agreed a good deal with Dr. Clarke with regard to a good many clinical symptoms. Some of the best remedies afforded better or more clearly-defined clinical symptoms than pathogenetic symptoms, but they could hardly be sustained on the ground of thorough, systematic, and scientific proving. The basis of all homœopathy was thorough proving.

Dr. PULLAR said that if the intention was to bring homœopathy

into line with recent pathology and all the refinements of modern diagnosis, he was afraid it was almost impracticable, however desirable such a consummation might be. He could quite understand the position of those who desired to embody in the provings data which might be called scientific, but for most drugs he was doubtful whether such additional matter would be accessible at present. He sometimes thought the high scientific training of the schools was rather an impediment than otherwise to a man who preferred to work purely on homoeopathic lines. The elaborate monographs of Dr. Hayward and others in the "Materia Medica, Physiological and Applied" were typical examples of how such work should be done, but it would be impossible to obtain similar presentments of each medicine, and in the meantime we had to make the best of the material within our reach. The scheme sketched by Dr. Clarke would be very useful to working practitioners, and he looked forward to his forthcoming "Materia Medica" with great expectations.

Dr. GOLDSBROUGH, speaking especially on the practical bearing of the discussion, suggested that volunteer provings would be difficult to obtain, and that Mr. Wilkinson might have to put a good deal of pressure upon men to take up the work. And could the work be done without money? A very large scheme had been foreshadowed. It would take a great deal of time and attention and care, quite as much as a scheme of bacteriological or pathological experiment undertaken in a laboratory. The Society had to face the difficulties as well as the desirability of having a materia medica. With regard to the desirability of letting the provers know the drugs they were taking, Mr. Wilkinson had put that very clearly, and he (Dr. Goldsbrough) commended his point of view. Of course the final revision of the material would rest with the Committee who were responsible for beginning it, and the Committee would no doubt act as a check against any false material entering into the results. Dr. Clarke rather deprecated anything like the nosological plan; but in the materia medica, in his (Dr. Goldsbrough's) opinion, the nosological plan helped them to fix on a group of remedies from which one could be selected which would be indicated in a given case. For instance, in the "Cyclopædia of Drug Pathogenesis" a group of remedies for epilepsy might be found, and there were ten or a dozen such which had decided indications for use in that disorder. One particular remedy for each case might have to be selected, but without the nosological grouping in the first place the single remedy would be very difficult to find.

Dr. BURFORD pointed out that there was no finality in human knowledge, and that the very essential of the existence of homœopaths as a scientific body was that they were constantly investigating in order to discover what was unknown. The covers of the "Cyclopædia" contained only a fraction of that knowledge which would be in the possession of the successors of the Society some hundred years hence. He thought Dr. Ord's contribution was an exceedingly luminous one. Those who had worked, as he had done, painstakingly and diligently with the "Cyclopædia" must have been a little at a loss sometimes by the strictly academical character of the materials. Dr. Ord had said that he would not put in his *materia medica* any symptoms that had not the verification of cure in practice or appearance in the record of two provers. Such a *materia medica* would carry out the first scientific canon, that of the possibility of repeated verification of every statement made. Moreover, homœopathy must be sufficiently flexible to absorb new facts, or three parts of modern medical progress was a sealed book. Their allopathic friends had been working night and day and had accumulated an immense amount of material applicable to the treatment of disease, bacteriological, pathological, and microscopical, and so forth. He maintained that every homœopath should start with the canon that there is no item of information concerning the process of disease but what is germane to the treatment of disease, and if it had not been made germane it was because their ambition had been faulty or their methods defective. To put an artificial limit on discovery and experiment and observation was not to go to work in a scientific way. There were a great number of men who prescribed homœopathically on what was called pathological lines. They had no warrant for it within the four corners of the provings, but every warrant in the success of their practice. Some endeavour to find the objective undercurrent for that which they had already in the subjective element in the provings was one of the next duties which was laid upon them, and if they did not do it they would go by the board. He regarded Dr. Ord's suggestion as a most fertile one, and would do his very best to second any effort Dr. Ord might make in the direction of a book which should consist of material derived, in the first place, from symptomatological records, every item of which had been verified by independent provings, or in the case of single observations by their homœopathic cure in disease, or from the record of their repeated recurrence in disease and their removal by homœopathically prescribed remedies.

Dr. NEATBY said they were all looking forward to the works which had been suggested by Drs. Hughes, Hayward and Clarke, and they would all gladly welcome Dr. Ord's proposal if it could be carried out. The re-arrangement of existing material was of importance. It seemed to him that the most urgent subject for consideration was that which had been dealt with in the two papers on which little discussion had taken place, viz., the improvement of the materia medica and additions to it. The support which the idea of re-proving received that evening would cause untold influence upon the future of homœopathy. He was surprised, with Dr. Madden, that it should be necessary to emphasise the necessity for that. To give an illustration, it was quite enough, a few years ago, to state that a urinary deposit was of a certain colour and consistence, because little more was known than that, either on the side of a natural or a drug-disease. It was enough then; it was not enough now, because they knew a good deal more about urinary sediments. Unless they went on those lines their knowledge of disease would outstrip their knowledge of pharmacodynamics, and there would be no possibility of a true simile being established at all. They must not be deterred at all by remarks such as those of Dr. Dyce Brown. There was certainly no necessity of going to dangerous and difficult provings; they could get changes such as had been alluded to, in secretions and in the blood, which could be detected by the microscope, sphygmograph, and other instruments, without seriously interfering with their daily work. Grosser changes could be observed in animals and in cases of poisoning. There was no reason why they should not all do something to help on that great work. He thought one of the crying needs that they had at the present time was for women provers. He had looked over the four volumes of the "Cyclopædia" and had marked every single proving, whether it was a man or a woman, and the very small proportion of women was something astonishing; and the still smaller proportion of symptoms which had been obtained with respect to the reproductive organs was still more surprising. A very large proportion of patients were women, and especially with something either primarily or secondarily affecting the reproductive sphere, and he thought for that reason they ought to introduce provings, especially with old and well-known drugs, on those lines, with, of course, the previous history of the experimenters' condition. It was not necessary that the observers should be medical men or medical women. He thought they could train



observers to work under their own eye, and carry out provings that were very useful. They wanted to be very precise about the terms, both symptomatological and anatomical, and a careful scheme must be drawn up as to what terms should be used, analogous to those adopted by Dr. Berridge in his repertory of the eye. One term should be used for a definite symptom; for instance, a shooting pain should be described as such, and a region should be determined by a proper anatomical or colloquial expression. It was no good working on a small scale, or to have a little board to carry on the laboratory work. What was required was a very large number of different men, some of whom would carry on the examination of the blood, others the examination of the urinary constituents, &c. A very large and carefully thought out scheme was required. As Dr. Burford had said, practically their whole existence depended upon their attitude towards the reprovig of the materia medica, and if this particular opportunity was let slip they would probably let their whole position as defenders of the truth of homœopathy go by the board.

On the motion of Mr. DUDLEY WRIGHT, seconded by Dr. MOIR, it was resolved "That the President, Secretary, Mr. Wilkinson and Dr. Ord be constituted a Committee to consider the question of the Improvement of the Materia Medica, and that they should report to the Society at its next meeting what arrangements they would propose that we should adopt."

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REPORT OF THE SPECIAL COMMITTEE OF  
THE BRITISH HOMŒOPATHIC SOCIETY  
APPOINTED TO CONSIDER THE BEST  
SCHEME FOR A NEW MATERIA MEDICA,  
INCLUDING THE PROPOSED PROVINGS OF  
DRUGS.<sup>1</sup>

PART I.

SCHEME OF NEW MATERIA MEDICA.

GENTLEMEN,—Under the reference concerning "The Best Scheme for a New Materia Medica," your Committee, after careful consideration, recommend the adoption of the

<sup>1</sup> Presented on December 1, 1898.

following plan, which is intended to present everything essential and of practical use to the physician in a convenient form for rapid reference, as well as for careful study. It is not thought advisable to include in such a work material of doubtful utility, or that has not proved reliable in the past,—partly through exigencies of space and also because it is available for reference in other works,—and thus it has been found necessary to abandon the form of exhaustive monographs adopted by the authors of the “*Materia Medica, Physiological and Applied.*” Especially has it been deemed of importance to present the mass of proved material on which the foundation of homœopathy has been laid, in such a form as to carry conviction of the value of the “law of similars” to every unbiased student of *materia medica*. For this purpose your Committee recommend the use of confirmatory evidence from other than strictly homœopathic sources. The scheme herewith described is one that presents no insuperable difficulties in execution, but one which they are convinced can be accomplished successfully in a reasonable period by at most six workers. They are gratified to announce that four members out of the number required have already expressed their readiness to commence the undertaking. The dimensions of the proposed work have received the careful consideration of your Committee. They do not recommend that a decision as to the number of volumes or form of publication should be arrived at until some progress has been made with the work, but it has been estimated that probably two, or at most three, volumes of a convenient size will contain all the drugs usually resorted to in the practice of homœopathy presented in the form herewith recommended—in number from three to four hundred. Your Committee desire that if their report be adopted by the Society they be re-appointed as an Executive Committee, with power to add two members to their number, and to at once proceed with the work.

I. Introduction : comprising :—

- (A) A brief history of the origin and progress of Homœopathy ;
- (B) The present position of Homœopathy in relation to the progress of modern medicinal science ; and

(C) The objects and necessity for a new presentation of "The *Materia Medica*."

II. Drug-action and its effects in health and disease—

- (a) Drugs to be presented in alphabetical order.
- (b) Each drug-study to be presented in four sections.

### SECTION I.—CHEMISTRY, PHARMACY, AND HISTORY.

*(To be comprised in five paragraphs for each drug).*

Paragraph (a) Name and synonyms of drug.

Paragraph (b) Source and characteristics of drug-substance.

Paragraph (c) Chemistry of drug-substance, its essential ingredients and derivatives.

Paragraph (d) Pharmaceutical preparations and dosage—homœopathic and allopathic.

Paragraph (e) History—with special reference to its first introduction into homœopathic and old-school practice.

*(Note.*—Allowing an average space of ten pages to each drug, not more than one page to be allotted for Section I.)

### SECTION II.—PATHOGENETIC SUMMARY.

*(The action of the drug in health—pathogenetic effects).*

This section will comprise a brief sketch of the pathogenetic effects of the drug on the body as a whole, as evidenced in (1) provings; (2) cases of poisoning; (3) *post-mortem* examinations; (4) physiological experiments. The object of this section is to indicate the general sphere and nature of the drug-action, with special reference to effects that have suggested and confirmed the leading clinical uses of the drug, in accordance with the law of similars, also it is intended as introductory to the detailed pathogenetic symptoms to follow in the succeeding section. An average space of one page to be allotted for this in each drug-study.

### SECTION III.—REGIONAL PATHOGENESY.

*(Materia Medica and Therapeutics).*

This section will comprise the bulk of the space allotted to each drug. In this the pathogenetic effects with therapeutic uses and clinical cases will be presented in *Regional Sections of the Body*. These to be:—nervous system, head, digestive

system, pelvic organs, respiratory organs, circulatory system, back and limbs, skin, and generalities. Regional sections may be divided into sub-sections, as required, according to the sphere of drug-action, in the manner devised by Dr. Hughes in his "Repertory to the Cyclopædia," part I., pp. 19-29.

Each regional section to be divided into paragraphs arranged as follows :—

*Paragraph I.—Pathogenetic symptoms :* comprising :—

- (a) Symptoms occurring in two or more provings or poisonings.
- (b) Symptoms experienced by single provers only, provided that these have been endorsed as reliable drug-indications in the clinical records published of cured cases.

*Paragraph II.—Clinical symptoms and therapeutic commentary :* comprising :—

- (a) Any clinical symptoms not occurring in pathogeneses which have proved reliable drug-indications in the opinion of two or more recognised authorities in homœopathic therapeutics.
- (b) The therapeutic uses of the drug in diseases affecting the regional section or sub-section, with the indications found most reliable for its use in these conditions, giving also the characteristic modalities compared with and distinguished from those of other similarly acting drugs, quoting authorities and sources.
- (c) Confirmations from the works of such old-school writers as Ringer, Lauder Brunton, &c., when obtainable.

*Paragraph III.—Brief examples of cured cases :—*

A selection of two or more cured cases illustrating the therapeutic effects of drug-treatment, suitably condensed, with special reference to indicating symptoms which may have led to the selection of the remedy. When possible, cases from old-school practice may be included.

(*Note to Section III.*—Your Committee are aware that it will prove impossible to carry out the above arrangement completely in the case of every drug. Those drugs recently introduced and those imperfectly proved will be dealt with on the above lines, but modified as occasion may require. The suggestions made are specially adapted for polychrest drugs).

#### SECTION IV.—GENERAL CLINICAL, AND THERAPEUTIC SUMMARY.

This section will present a concluding summary of the clinical and therapeutic uses of the drug as affecting the body as a whole.

As a model your Committee recommend a condensation of the paper on Causticum by Dr. Cowperthwaite, appearing in the *Monthly Homœopathic Review* for November. The section should conclude with a brief notice of the usual old-school uses of the remedy, whether considered as a tonic, alterative, &c., giving the diseases in which it is so used. In the case of poisons a reference to antidotes should follow. An average space of one page to be allotted to this section.

## PART II.

### A SCHEME FOR NEW PROVINGS.

With regard to the reference concerning provings, your Committee deem that they will best consult the wishes of the Society by presenting proposals which (if they meet with approval) can be directly put into action.

Considering that a first attempt in this direction should not be of too wide a scope or involve too much trouble for individual provers, your Committee recommend—

(1) That a proving be undertaken of the drugs used in the treatment of diabetes, such drugs comprising acidum phosph., uranium nitricum, phloridzin and phloratin, rhus aromatica, syzygium jambolanum. While they recognise that there are other drugs, such as curare and somatose, which have been credited with the power of inducing glycosuria, your Committee consider that the above list of drugs present a field sufficiently large for a first investigation.

(2) That the provings be under the direction and supervision of your Committee, reappointed for that purpose, with power to add to their number as the exigencies of the work may dictate.

(3) That the following instructions be handed to your Committee so constituted:—

(A) The primary object of this investigation is to discover what effect (if any) is produced upon the quantity and quality of the urine secreted under the influence of the above drugs. At the same time, all effects whatever, whether subjective or objective, are to be carefully noted, and the results set forth—where possible, by means of charts and tables.

(B) Provers to be instructed to take careful notes of the quantity and quality of the urine secreted before, during, and after the actual proving, together with all other particulars which you consider necessary.

(C) The drugs named to be taken by provers, at your discretion, beginning with the higher dilutions or attenuations (the

12th decimal being the limit of attenuation), the doses being increased as may seem to you safe and necessary. Every prover to be informed of the drug and dose which he is taking.

(D) Provers to send samples of their urine to a person or persons, to be appointed by you, for examination, in order that uniformity of method may be secured and trouble saved to the prover.

(E) Every prover to keep a journal of the effects observed by him, such journals, together with the results of urinary examinations, to form the basis of a report to be drawn up by you for incorporation in the Journals of the Society.

Your Committee further recommend—

(4) That a list be at once opened and a circular issued to members, inviting members and other voluntary provers to undertake provings upon the above lines.

Your Committee believe that such provings can be conducted without any considerable call being made upon the funds of the Society.

(Signed)

JAS. JOHNSTONE.

W. THEOPHILUS ORD.

C. J. WILKINSON,

*Hon. Secretary.*

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Dr. MOIR thought the Report was the most complete which had so far been brought before the Society; it was most thorough, and included everything the members would want in a "Materia Medica." With regard to the new provings, he hoped the Committee would not allow that question to interfere with the production of the "Materia Medica," as there were plenty of provings to go on with. He proposed that the Report be adopted.

Dr. DAY seconded the motion.

Dr. DUDGEON thought that in the introduction to the "Materia Medica" there would be no particular need to give the history of homœopathy, that had been previously so often brought before the members. Under any circumstances a "Materia Medica" must be long, and everything superfluous should be omitted. The Berlin Society at the present moment was engaged in doing exactly what the British Homœopathic Society was going to do. An account of their mode of procedure was given in their journal, some numbers of which Dr. Dudgeon presented to the Society.

It was very much on the same lines as those detailed by Mr. Wilkinson, but there were some points in the Berlin plan which he did not think were advisable in the present "Materia Medica." The Germans proposed in their account of the physiological action of medicines, which had been arranged in schema form, to include clinical symptoms by a particular sign, after the fashion of Allen, and also the physiological symptoms that had been proved clinically, distinguished by another sign: in fact they seemed to take the "Encyclopædia of Materia Medica," by Allen, as their guide, and also professed to be guided by the perfect system adopted by Dr. Hughes in the "Cyclopædia of Drug Pathogenesis." Examples were given in the journal referred to completely worked out according to that plan. The Materia Medica Committee would do well to examine the specimens of the Germans, as a great many of them might be employed with advantage by the Committee.

Dr. JAMES JONES asked if any idea could be given as to the cost of the "Materia Medica."

Mr. WILKINSON said the idea was that progress should be made with the work in order to see how large a space it would occupy, and specimens having been submitted to the Council it should estimate for itself the probable cost, and the reasonableness of laying it before the Society at its annual meeting.

Dr. HUGHES said the Report was well thought out and gave promise of very good work. He knew from past experience how differently things sounded theoretically as compared with what they did when exhibited practically. That was the case with the Cyclopædia.

He proposed as an amendment to the resolution for the adoption of the Report: "That the Report be accepted with the Society's sincere thanks to those who have drawn it up, and that the Committee be asked before taking action thereon to furnish a specimen medicine prepared on the plan suggested, and that it be discussed at the earliest Society's meeting after its printing."

Dr. BLACKLEY seconded the motion.

The amendment was put and carried, 17 voting for, and 12 against. It was then put as a substantive motion and carried.

Mr. DUDLEY WRIGHT proposed that Dr. Madden and Dr. Goldsborough be added to the sub-committee.

Dr. WYNNÉ THOMAS seconded the motion, which was adopted.

HYDROPATHIC APPLIANCES AS AIDS IN  
THERAPEUTICS.<sup>1</sup>

BY JOHN W. HAYWARD, M.D.

*Consulting Physician to the Hahnemann Hospital, Liverpool.*

As therapeutists, medical practitioners are concerned rather with the cure than the prevention of disease: according to Hahnemann the physician's chief mission is to cure disease quickly, pleasantly and permanently. In order to enable himself to do this the earnest conscientious physician will, as far as possible, acquaint himself with and make use of any and every means that experience has shewn to be of service towards this end, whether these are medicinal or not: and he will not refuse to consider the feasibility of using any suggested on merely theoretical grounds. Now experience has abundantly demonstrated that many of the means made use of by the so-called "hydropathists" are really powerful aids in the diminishing and the curing of disease, and theory amply justifies their use. As a matter of fact, indeed, all thoughtful experienced practitioners do use many hydropathic appliances almost in their daily work: for instance, hot water bathing in cases of inflamed eyes, hot fomentation in cases of phlegmon and inflamed joints, steaming in inflamed fauces and tonsils, in croup and bronchitis; the compress in quinsy and other inflamed glands; also baths, the hot water, the shower and the vapour, the general, and the partial, as the sitz bath and the foot bath; also douches, to the spine, the nares and the os uteri; the spray to the fauces and nares: also injections of hot water, into the vagina, the bowels, the bladder; and hot poultices, which are really the application of hot water, to almost any part of the body. As we all know, the hot sitz bath is of very real service in uterine, bladder and rectum inflammations, and inflamed hæmorrhoids; and also in retention of urine, whether from organic stricture or not;

<sup>1</sup> Presented to the Liverpool Branch, November 8, 1898.



and, as Dr. Storrar points out, as a means of recovery *post partum*. Hot water injections are of real service in inflammatory dysentery, in cystitis and inflammatory leucorrhœa. The local hot bath is of immense service in recently sprained ankle and other joints, and in rheumatic and gouty inflammation of the feet and hands; also to the feet in cerebral congestion and inflammation, and in infantile convulsions dependent thereon. The therapeutic uses of hot fomentations and poultices are really too numerous to attempt to specify. On the same lines with hot fomentation and injection is hot water drinking in gastritis and gastric irritation and ulceration; in dyspepsia, vomiting, nausea and acidity; a tumblerful of nearly boiling water repeated frequently will often arrest a vomiting that has resisted specific medication and epigastric poulticing, and it will much more rapidly and effectually quench the thirst of fever patients than will cold water drinking or ice-sucking.

But the great reputation of hydropathy is a result of the use of the pack and the compress. Of packs there are two principal varieties, viz., the complete and the partial; and of the compress, the large and the small.

#### PACKS.

*Complete pack.*—The complete pack, called also the wet sheet, is when a calico or linen sheet is dipped in water, cold, warm or hot, and wrung out, and then spread on a bed on the under blanket which is made to cover the bolster as well as the bed: the patient is then stripped and placed on the sheet, which is rapidly rolled round him up to the ears and including the feet; the under blanket is then quickly brought over and tucked in underneath; other blankets are laid on, and perhaps finally an eider down quilt. The patient is allowed to lie there for a quarter to one or two hours according to the effect produced. A nurse watches and supplies him with water to drink and encourages him to do so copiously, and she wipes the perspiration from his face. After the patient has been in the pack the desired

time the coverings are removed, and he is wiped and perhaps well rubbed with towels, perhaps at first damp and then dry. The patient is then placed on another bed in dry sheets, not cold but cool, and lightly covered if it is not desired to prolong the effect, but if it is desired to prolong the effect the sheets are warm, and perhaps an eider down quilt used. The room in which the packing and unpacking are performed should, if possible, have a temperature not lower than 65° F. The process may be repeated two or three times at short intervals if the temperature of the patient continues over 103° F., especially if the pulse is full as well as rapid. The temperature of the wet sheet may vary from ice-cold in very high fever and robust constitutions through different degrees of warmth to nearly hot in the less robust and in delicate women and in children; in fact it is perhaps best nearly hot in all cases. The effect of the full pack usually is general and profuse perspiration, with redness of skin: it relaxes the blood vessels and other structures of the skin of the whole body, and thus causes increased flow of blood to the surface, which of course diminishes the internal blood pressure, and thus tends to relieve congestion and inflammation of internal organs, including the brain and in it the heat centre. This increase of blood in the skin also stimulates and increases the cutaneous secretions and excretions, and thus relieves the system of morbid materials such as are present in rheumatism, gout, jaundice, anasarca and the eruptive fevers. The general or full pack, with its copious water-drinking, is found to be of immense service in all kinds of fever, even if hyperpyrexial; in rheumatic fever, measles, enteric fever, bilious remittent, yellow fever, black-water fever, puerperal fever, and all other fevers when the temperature is high. If therefore a temperature above 103° F. does not speedily give way under proper medication the pack should be used, with copious hot water drinking. Of itself it will frequently bring down the temperature from 106° or 107° to 103° or lower by one, two or three applications, and this not merely for the moment but somewhat permanently; it is in many ways preferable to the general hot bath, whether of water or vapour. Of course the

scientific physician will not neglect to at the same time administer the proper medicine, as indicated in the particular case. With a properly managed pack, copious hot water drinking and the appropriate medication together, it will be extremely rare that fever, however high at first, will remain abnormally high for forty-eight hours. The pack is also of essential service when eruptive fevers delay or are checked; also in some cases of specific influenza, in acute albuminuria, in peritoneal and hepatic dropsies: also in acute inflammation of large internal organs, especially if there be much vascular or nervous commotion; in pneumonia, bronchitis, pleurisy, peritonitis and nephritis, for instance. If thought desirable the effect may be hastened and augmented by placing hot water bottles at the sides and at the feet of the patient whilst in the pack. The pack is of such general and effective usefulness that it is to be regretted its use is somewhat difficult and disturbing, and that the necessary means are not always at hand in the sick room, hence it is not employed as frequently as its efficacy warrants. But similar difficulties attend many other really useful therapeutic means: readiness at hand and ease of application are valuable qualifications of therapeutic means, and in this respect none can compare with medicines; hence the use of medicines will perhaps hold the field as the physician's means of relief and cure as long as mankind require his attention. How much more promptly can the doctor take out his little pocket case and drop a few drops into a tumbler of water! And what a saving of valuable time and of anxiety in acute diseases, by beginning the treatment without the delay of visiting a dispenser.

*Partial Pack*—called also the body pack—is when a large or a roller towel is used instead of a sheet. It is employed when the disease, though severe, produces only moderate systemic disturbance; when it is so localised that part only of the body need be enveloped, as the chest, leaving out the upper extremities; or the abdomen, leaving out the lower extremities. In this way it is used in cases of congestion and inflammation of large internal organs, such as the lungs, pleuræ and peritoneum; that is, in

bronchitis, pneumonia, pleurisy, pericarditis, gastritis, peritonitis, nephritis, lumbago, sciatica, &c. The general result of the partial pack is similar to that of the full pack, but of course less extensive, that is, more confined to the organ underneath the pack. The effects usually are speedy relief of pain and marked diminution of congestion or inflammation, particularly if the proper homœopathic medicine is exhibited at the same time; these effects are especially noticeable in such painful affections as pleurisy, peritonitis, lumbago and sciatica. The partial pack is all the more indicated when great local heat is present. Though not so difficult or impracticable as the full pack, still it is inconvenient, and generally necessitates the patient being lifted and moved during its application, so that it is not so frequently resorted to as it otherwise would be; a large compress is often used instead. As with the complete pack, the effects may be hastened and augmented by the application of hot-water bottles.

#### THE COMPRESS.

The hydropathic compress is when two or three folds of lint are wrung out of water, generally cold, and applied to a part of the body and covered with thin mackintosh or gutta-percha tissue a little longer than the wet lint, and then bound down so as to keep the edges of the mackintosh or tissue in close contact with the skin. It is used of different sizes and over almost any part of the body, when either it or the underlying parts are congested or inflamed. The usual effect of the compress is similar to that of the partial pack, but somewhat more circumscribed. When properly applied it becomes hot, and it tends to remain so; it acts like the old-fashioned hot poultice or fomentation, but more definitely and more permanently. It is employed when the parts congested or inflamed are somewhat circumscribed, as in threatening abscess, furuncle, carbuncle, quinsy, whitlow, inflamed bunions and corns, and in local peripheral neuritis and inflammatory neuralgia; also with arnica in severe bruises; rhus in sprains; with calendula, after amputations

and other clean cut operations and wounds, and even in lacerated and profusely suppurating wounds; also with hamamelis and pulsatilla in phlebitis; and with other medicines in other diseases. My own experience coincides with that of Dr. Tod Helmuth, that *succus calendulæ* on a wet compress is the best of all applications for inducing union by first intention after all clean cut operations. In consequence of its being able to be employed without much disturbing the patient the compress is frequently used in place of the partial pack in severe pericarditis, pleurisy, pneumonia and inflamed joints. In some cases, such as acute myelitis, a long hot poultice is used instead, and in pneumonia a jacket poultice. Over poultices, however, the compress has many advantages; it is more easily and rapidly applied, it does not wet the clothes, and instead of becoming cold it tends to become hot and to remain so; it is also lighter than a poultice, and in this respect is superior in cases of pneumonia, bronchitis and peritonitis. In all the instances above named the compress affords immense help to the homœopathically selected medicines, and will often be the means of these acting rapidly and successfully when otherwise they would not. As with the pack, the effect may be hastened and augmented by applying over the compress the hot water tin, or india-rubber bottle.

It will be observed that all the appliances above named are *hot*, that is, moist HEAT is used in all of them; but hydropathic appliances may be used *cold*, that is, as moist COLD; moreover, like other therapeutic measures, they may be employed under the guidance of either of the two great laws of therapeutic action; that is, under either *similia similibus* or *contraria contrariis*. (1) It is under *similia*, for instance, that hot applications are used where there is already abnormal heat and increased vital action, as in congestion, inflammation and fever; and that cold appliances, such as the cold bath, cold injection, cold douche, cold shower, cold plunge are employed in cases of diminished vital activity, where there is tendency to chilliness, coldness, torpor; in these latter instances, acting under the rule of

*similia*, they rouse up and stimulate vital activity; for example, the cold douche to the right hypochondrium in torpid liver, to the epigastrium in dilated stomach, to the abdomen in torpid bowels, and to chronic infiltrations, indurations, varicose veins, &c., also cold douche to the spine in chronic paraplegia, cold shower to the whole body in chronic hemiplegia, and so on. (2) It is under the rule of *contraria* that hot appliances, such as hot poultices and the compress, are used to chronic œdemas and indurations and other torpid conditions; and that cold appliances are used where there is active inflammation, such as cold bathing in acute ophthalmia and inflamed or recently sprained joints, the cold starch poultice to incipient furuncles, the evaporating lotion to erysipelas, and to the head in encephalitis, ice bladder to the head in meningitis; so also with the ice-sucking in gastritis, cold affusion and ice-water drinking in fever, and the ice-water bath in hyperpyrexia.

Now I wish to draw attention to two important facts which come out forcibly in the foregoing investigation, viz., (1) That where hot appliances are used when there are abnormal heat and vital activity, and cold when there are subnormal activity and heat, the results tend to be permanent and curative; (2) That where hot appliances are used when there are subnormal vital activity and heat, and cold when the heat and activity are abnormally high, the results tend to be merely temporary and palliative.

All the foregoing instances confirm the above statements, but I will repeat just a few examples. (1) As illustrations of the permanency of the results under the rule of *similia similibus*, I will name hot water drinking in gastritis; hot bathing in acute ophthalmia; hot fomentation in local inflammations; the complete pack in hyperpyrexia; the partial pack in pleurisy; the hot jacket poultice in pneumonia; the large compress in peritonitis, and the small compress in phlegmon and quinsy. (2) As showing the merely palliative effects under the rule *contraria contrariis* I will name ice-sucking in gastritis; evaporating lotion in erysipelas; cold bathing in acute ophthalmia and inflamed

and recently sprained joints, and in phlegmon and furuncle; and the ice-water bath in hyperpyrexia. I scarcely need mention the risk and danger of cold applications in pleurisy, pneumonia and bronchitis. We are all familiar with the dangerous reaction that sometimes follows the ice-water bath in hyperpyrexia, and the risk of collapse if this be attempted to be prevented by prolonging the bath; and we all also know the cooling effect of a warm bath when we are in a state of perspiration, and the warming effect of a cold bath when we get up in the morning.

It is certainly true that the cooling effect of the ice-water bath in hyperpyrexia, when the temperature is dangerously high, is sometimes so immediate that its prompt employment may occasionally be the means of saving a life that would otherwise be lost. And the homœopathic physician will no more refuse to use it in such cases than he would refuse an angina pectoris patient temporary relief by nitrite of amyl. But I think the foregoing considerations, as to the relationship evidently existing between morbid states and the means of relief and cure, prove conclusively that the rule *similia similibus* is that on which all true cures are and must be effected—at any rate, that it is the most likely one that has yet been discovered.

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Dr. STORRAR remarked on the extreme diversity of the methods of applying hydrotherapy, and also on its very marked beneficial results. These effects were most evident in fevers and acute cases generally, where the temperature of a patient, he found, could be more rapidly and effectively controlled by hydro-pathic measures than by drugs; but he also emphasised its usefulness as an eliminator of morbid poisons in such cases as gout, rheumatism, &c. In his experience the only contra-indication to the use of the complete wet pack lay in the presence of organic heart disease, as in that class of case the shock incident to the treatment might prove fatal.

Dr. HUMPHREYS concurred in the superiority of the wet pack as an antipyretic over drugs, and gave an illustrative case. He also stated that since adopting it as a routine method of treatment in cases of typhoid fever, he had met with much better results than formerly.

Dr. C. W. HAYWARD disagreed with the essayist in the subdivision of hydropathic measures into two classes, homœopathic and antipathic. Of the benefit to be derived from calendula compresses in wounds, surgical and accidental, he was fully convinced, but in his experience the use of hamamelis and other medicated compresses in cases such as phlebitis, which present an unbroken cuticle, was quite ineffectual.

Dr. CAPPER pointed out that the latest treatment of ophthalmia neonatorum consisted in the persistent use of ice-cold bathing, and that this method, contrary to the opinion expressed in the paper, yielded the best results.

Dr. HAWKES mentioned a case of typhoid fever, complicated with pregnancy—fourth month and onwards—and albuminuria, where the use of tepid baths had been successful.

Dr. GREEN gave an illustration of the beneficial effect of the wet pack in bringing out a badly developed or re-percussed exanthematous rash. Commenting upon the question of the proper temperature of packs, compresses, &c., he said that it was a matter of comparative insignificance, as all applications directly applied to the skin sooner or later came to be of the body temperature.

Dr. ELLIS said that, contrary to the generally expressed opinion, he was in favour of the use of the wet pack in cases of pneumonia and broncho-pneumonia.

The PRESIDENT (Dr. John D. Hayward) commented upon the prominent position which balneology, a combination of hydro-pathy with massage, was assuming in the medical schools and teaching of the day.

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**SOCIETY NEWS.**

At the first meeting of the session, held on October 6, the following presentation was made to Mr. Knox Shaw on his retirement from the office of Secretary of the Society :—

In opening the proceedings in the evening, Dr. Clifton said : “ Before I proceed with my Presidential address, I must depart from the usual course and perform a very agreeable and important function. During the lifetime of the Society it has had many secretaries, who, by reason of their personality, diligence and knowledge have largely contributed to its growth and well-being ; and if time permitted, it would be due to their memory and worth to mention them individually, but unfortunately that is not the case this evening. Its last Secretary, as you are aware, was Mr. Charles Thomas Knox Shaw—*alias* ‘ Noxious ’ by telegram—a designation in that respect adopted by himself, whether out of regard for medical ethics or otherwise, deponent sayeth not, but a designation certainly erroneous in relation to this Society and its several members. After six years of active and honorary service, during which time, to his great honour, he lengthened the cords and strengthened the stakes of the Society, he has retired. Gentlemen, the executive of this Society have thought the present opportunity ought not to pass without presenting Mr. Knox Shaw with a testimonial of their esteem and their appreciation of the services which he has rendered to the Society.”

Addressing Mr. Knox Shaw, Dr. Clifton said :—

“ Dear Mr. Knox Shaw and Ex-Secretary,—It is my privilege and great delight to present you with this illuminated address, setting forth in small measure the appreciation by this Society of your valuable services. It will, I feel sure, be a source of gratification to you to receive this testimonial to your worth and work, and that in future years your children will be proud of knowing how highly you were esteemed by us.”

The following is the text of the address :—

“ The Fellows and Members of the British Homœopathic Society, desiring to record their sincere appreciation of his services, present this address to Mr. Charles Thomas Knox Shaw upon his retirement from the office of Honorary Secretary after six years of unremitting and self-sacrificing labour.

“ By his enthusiasm, his exceptional skill in organisation, and his self-denying devotion to its interests, the Society has gained new life, as shown by the doubling of its membership and the high tone of its proceedings. In addition, Mr. Knox Shaw, by his uniform tact and unfailing geniality, has secured for himself the hearty esteem and personal friendship of his *confrères*. This address is accompanied by the warmest good wishes of the Society, and by the hope that, though regretfully relieving him of his arduous labours, the Society may count upon his undiminished interest and support.

(Signed)

A. C. CLIFTON, *President*.

J. GALLEY BLACKLEY, *Treasurer*.

JAMES JOHNSTONE, *Secretary*.”

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Mr. Knox Shaw, in replying to the address, said it was not often he had been so completely taken by surprise as he had been that evening. He found it almost impossible to express, on the spur of the moment, in any really adequate manner, his sense of the kindness shown by his old friend the President in presenting the address. He felt how little he deserved all the flattering things he had said about him. He (the speaker) was only one of the many in the Society who had worked for it during the last few years ; and without the loyal help and support of his colleagues, assistance always rendered most cordially, his labours would have been as naught. There were many ways, he said, of advancing the knowledge of homœopathic therapeutics. Some could write, others read papers ; he himself felt he might be able to do something by reorganising the British Homœopathic Society, and so he considered it to be his duty to take up that work. His six years' work had been of great interest to him, and he should always look back with pleasure to his official connection with the Society. He had made many friends and received a great many acts of kindness. He should always value the address as the outward expression of approval of and sympathy with his aspirations for the Society. Though he was seated on the other side of the table, he was not going to lessen his interests in and zeal for the work for which the Society existed. He was afraid that his old habits had caused him to usurp some of the duties that evening of his able successor, Mr. Johnstone, who he felt sure would receive the same courtesy that had always been extended to himself. Words did but too feebly express his

feelings that evening, or, rather, he felt unable to make proper use of them, but he would assure those present, one and all, how heartily and sincerely he thanked them for the cordial greeting awarded to him, and for the gracious manner in which the President had made the presentation.

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At the meeting in November Dr. Burford reported that he had recently seen Dr. Cartier in Paris, the Secretary of the movement for reinstating Hahnemann's Memorial at Père La Chaise. The state of the fund established for this purpose was languishing. Out of the required 18,000 francs only 10,000 francs had been promised, and as a portion of this was coming from Spain, it was unfortunately considered to have depreciated in value owing to the effects of the late war. Dr. Cartier was very anxious that the memorial should be finished by the time of the International Congress in Paris in 1900. Dr. Burford endeavoured to ease Dr. Cartier's sense of responsibility a little by promising to bring the present state of the fund before the notice of his brethren in England. Unfortunately the French sculptors would not begin the work until they had cash in hand.

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At the meeting in December, on the motion of Dr. Neild (Tunbridge Wells), the following resolution was passed:—"That the Council be instructed to take into consideration the practicability and advisability of bringing under the notice of the younger members of our profession the existence of this Society, and the fact that those of them who desire to look into the principles and practice of Homœopathy would be welcomed at our Meetings; and if, in its opinion, such a course be found to be both practical and advisable, it is hereby empowered to take the necessary steps without further delay."

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At the meeting on December 1, Miss Edith Neild, L.R.C.P., L.R.C.S.Ed., and Mr. William Clowes Pritchard, B.A., M.R.C.S., L.R.C.P., of the London Homœopathic Hospital, were elected Members of the Society.

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The Council have appointed Dr. Goldsbrough Assistant Editor of the Journal of the Society.

## SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

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“GATHER UP THE FRAGMENTS, THAT NOTHING BE LOST.”

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SEPTEMBER—NOVEMBER, 1898.

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### PHARMACODYNAMICS.

**Acidum Fluoricum.**—Dr. McLachlan gives, as the distinguishing mark between the two main remedies for whitlow, fluoric acid and silicea, that with the former there is relief from cold and aggravation from heat, while with the latter it is just the other way. He praises the acid also in onychia.—*Hahn. Monthly*, October, p. 668.

**Amygdalus Persica.**—Dr. J. K. Ebertz finds that a tea of peach-leaves or -bark is an esteemed domestic remedy for the vomiting of pregnancy, and has tested it with advantage. [The hydrocyanic acid which would be contained in such a preparation is possibly the active agent. ED.]—*Amer. Homœopathist*, October 15.

**Antitoxin.**—A case where this preparation, injected for diphtheria, seems undoubtedly to have caused collapse and death in a few hours, is extracted from the New York *Medical Record* in the October number of the *Homœopathic Recorder*.

**Arnica.**—Dr. M. A. Wesner supplies a new field of action for arnica, in the shape of acute tonsillitis. If the swelling, he says, is of a light red colour, involving the soft palate and uvula, arnica 6x every hour will abort the inflammation and matter will not form.—*Amer. Med. Monthly*, September.

**Arsenicum Stibiatum.**—In an article on inflammation within the chest occurring in children, Dr. F. F. Williams writes:—“The remedy which I use most frequently, and with the most satisfactory results, is ars. stib., or tartrate of arsenic,<sup>1</sup> in the 3x trit., four grains dissolved in half a glass of water, a teaspoonful every two hours. I usually begin its use about the third day. Its indications are those given by both ars. and tart. emetic. There is the restlessness with thirst and prostration of arsenic, together with the loose mucous cough, great oppression and haste in respiration, and crepitant râles, of tart. em.”—*Hom. Journ. of Obstetrics, &c.*, November.

**Asafœtida.**—Dr. Belle Gurney has verified, in a nervous subject, the usefulness of asafœtida in deficient lactation; but has found the 30th dil. sufficient. — *Amer. Homœopathist*, October 15.

**Borax.**—In treating (successfully) a case of sore mouth with borax 30, Dr. Belle Gurney found a troublesome symptom clear away which had long annoyed the (nervous) patient—a sensation as of cobwebs on the face.—*Ibid.*

**Calcarea arsenica.**—Dr. Majumdar has written in the *North American Journal of Homœopathy* for September a study of this drug, of whose virtues he has a high opinion. Masked malarious fever, lingering intermittents, but especially the enlarged and indurated livers, with cirrhosis, so strangely common in children in India, are its chief spheres of action. It will also, he says, modify favourably some renal conditions associated with albuminuria.

**Cannabis indica.**—Dr. Bioknell calls attention to the muscular contractions following large doses of this drug, going on to convulsive movements, evidently due to action on the spinal cord. Aside from acceleration of pulse-rate and fulness of the artery at the wrist, there has been, just previous to the occurrence of unconsciousness, a sense of extreme tension in the abdominal blood-vessels; they felt distended almost to bursting. After some hours the urine was markedly increased in quantity. No constipation resulted; and there was no foreboding or fear of impending death.—*N. Am. Journ. of Hom.*, Nov., p. 689.

**Cina.**—Dr. Boffenmeyer, in cases of enuresis nocturna, when the disorder has been due to worms, with rubbing of the nose

<sup>1</sup> Probably a double tartrate of arsenic and antimony.—Ed.

and emission of a clear urine which on standing becomes milky, has found *cina* 1x, in 3 or 4-drop doses several times a day, a sovereign remedy.—*Hahn. Monthly*, Sept., p. 605.

**Clematis.**—“Clematis is very useful in dental caries; a piece of cotton soaked in the tincture and introduced into the tooth will often relieve the most severe suffering.”—*N. Am. Journ. of Hom.*, Nov., p. 719.

**Colchicum.**—Dr. Bonino relates a case of chronic diarrhoea, where, after sulphur had failed, the detection of shreddy mucus in the stools led to the prescription of *colchicum* 3x, which in two days restored the stools to the normal state.—*Hahn. Monthly*, Nov., p. 735.

**Cuprum.**—The *Eclectic Medical Journal* warmly commends Rademacher's preparation of acetate of copper in anæmia (not chlorosis). “It is a better blood maker,” it is said, “than iron, the hypophosphites, or any other remedy or combination of remedies known to us.” Ten drops of the solution are added to four ounces of water, and a teaspoonful of the mixture given every three or four hours.—*Med. Century*, November, p. 351.

**Echinacea.**—Dr. Fahnestock writes upon this remedy in the number of the *Journal Belge d'Homœopathie* for Sept.-October. He has experimented with it upon himself, and finds it to cause a marked trigeminal neuralgia, with p.m. aggravations, and an erythema of face and neck. Besides the septic conditions for which it has been hitherto recommended,<sup>1</sup> he finds it useful in boils, erysipelas, the ulcers of decubitus, and many rheumatic and neuralgic pains.

**Epiphegus.**—To a case of recurring headache cured by epiphegus 30, the remark is appended: “The key-note of the remedy is this—headache brought on by a mental strain, whether shopping or visiting, or by any other mental exertion, as teaching.”—*Med. Century*, September, p. 274.

**Ferrum muriaticum.**—Dr. Pritchard extols the old tincture of the chloride of iron in chronic interstitial nephritis. He gives 1-5 drops three times a day. “It causes the specific gravity to creep up, the digestion to become better, the pale cheeks to take on colour, the albumin to become less and less, the casts to grow

<sup>1</sup> See our fifth volume, pp. 195 and 286.

less numerous and finally to disappear, until only a few epithelial masses are observed."—*Hahn. Monthly*, Nov., p. 735.

**Ferrum phosphoricum.**—Dr. Bonino records a case of acute congestion of the lungs, occurring in a man of 74, who had albuminuria. Everything was threatening a fatal termination, when ferrum phos., a dose every hour (potency not stated), initiated a welcome change of condition, which went on to complete recovery.—*Hahn. Monthly*, Oct., p. 671.

**Filix mas.**—We have noted from time to time toxic phenomena induced by oil of male fern, when given for tænia. The observations of this kind have been collated in the *Revue internationale de thérapeutique et de pharmacologie* for Oct. 17, and an account of the essay is given in *L'Art Médical* for November. Nor, it seems, is more safety ensured by substituting the old-fashioned pomegranate root. It also has caused encephalopathies, and amaurosis from optic nerve atrophy.

The amaurosis caused by the male fern has hitherto been connected with changes in the macula lutea and optic nerve entrance; but Dr. de Kegel has communicated to the *Cercle Médical Homœopathique de Flandres* a case in which he saw panophthalmitis and cataract develop in both eyes under the use of this tænicide.—*Journ. Belge d'Homœopathie*, Sept.-Oct.

**Fraxinus Americanus.**—"After reading Burnett's book on 'Organ Diseases of Women,' I have used with most gratifying results fraxinus americanus in 3 to 5-drop doses three or four times a day in cases of displacement, particularly where congestion or sub-involution exists."—R. H. Stevens, *Medical Counselor*, Nov.

**Gelatine.**—This substance having been found hæmostatic when applied locally, Dr. Poliakov, of Moscow, tried a 10 per cent. solution in a case of obstinate hæmatemesis from a gastric ulcer. Two hundred c.c. of the solution were given three times a day, and the effect was most satisfactory.—*L'Art Médical*, Sept., p. 235.

**Icthyol.**—Dr. P. J. Slough reports great relief in two cases of senile prostate, with even considerable diminution of the enlargement and hardness of the gland, from rectal suppositories of ichthyol.—*Hahn. Monthly*, Oct., p. 169 of Appendix.

**Iodine.**—"I had recently a very severe case of membranous

croup, which recovered under one-third-drop doses of the tincture of iodine every half-hour and intubation. The intubation was of minor importance, as the tube was coughed out after a few hours, and, indeed, it gave more distress than aid. That there was a distinct, tough, pearly-white membrane was evidenced by two large strips detached by the tube, which was inserted after three difficult attempts."—F. W. Pritchard, *Ibid.*, Oct.

In the November number Dr. W. J. Laird contributes his experience with this drug in pneumonia. He can say nothing as to Kafka's use of it in the first stage of the typically "croupous" form, but can strongly confirm Bähr's recommendation of it in the second and third stages, when imperfect resolution threatens pneumonic phthisis. He gives drop-doses of the tincture.

**Kali iodatum.**—"A little girl of nine years began with an impetigo contagiosa, which, after running untreated for several weeks, developed swelling of hands, feet, and eyelids, with occasional eruptions of purpuric blotches over the whole body almost as thick as that of measles. At the same time there were numerous wheals of urticaria, which itched distressingly. Apis 2x seemed to aggravate. The whole eruption disappeared in less than two days under kali iodatum, ten grains in four ounces of water, half a teaspoonful every two hours. All works on dermatology mention the 'purpura iodique.' I have seen iodine develop urticaria in one woman, which was very persistent and distressing, for over a year passed before it finally disappeared. Merely touching a little tr. iodine to the skin would bring on an attack."—Pritchard, *Ibid.*, Nov., p. 726.

**Myristica Sebifera.**—Following the lead of Dr. Olivé y Gros, of Barcelona, Dr. Cartier is pushing forward the use of myristica sebifera in whitlow and in osseous affections. He gives two good cases of purulent joint inflammation which seem to have yielded with marvellous rapidity to its use in the 3rd dil.—*Revue Hom. Française*, November, p. 425.

**Natrum Muriaticum.**—Practising in a locality (Kiel) formerly the seat of much malarial disease, Dr. Wassily finds that numbers of obscure complaints are due to a slumbering influence of this nature, and all find their remedy in natrum muriaticum, which he gives in the higher potencies.—*Hom. Physician*, September.

**Phaseolus.**—Dr. Cushing reports continued success from phaseolus in weak and fluttering states of the heart, although he



has been gradually raising his dilutions. "An old school doctor wished me to send him some, as he had some bad cases on hand. I sent him pilules medicated with the 21st decimal by myself. Some three weeks later he sent for more, saying that it was doing wonderful work."—*Med. Century*, September.

Dr. F. S. Piper reports a case of cardiac dropsy in which digitalis alone was doing little, where alternation of phaseolus 1 with it effected a speedy change and entire disappearance of the œdema.—*N. Engl. Med. Gazette*, September.

**Phosphorus.**—An editorial in the November number of the *North American Journal of Homœopathy* notes the curious fact that while consumptive patients look anæmic enough, their blood when tested is found with corpuscles and hæmoglobin up to and even above the normal. It goes on to point out that acute phosphoric poisoning presents the same peculiar quality of blood; and infers accordingly the homœopathicity of phosphorus to early phthisis, and the danger of too free or persistent administration of hypophosphites in this disease.

**Plantago.**—Dr. Bonino states that a series of cases lately observed go to prove that plantago is useful in prosopalgia supraciliaris whenever this assumes a periodical character, beginning daily between 6 and 8 a.m. and declining by 2 p.m., and being accompanied with photophobia, lachrymation—the pains being violent and radiating. The action of the remedy is strikingly sudden, and there is no relapse if it is continued for twenty-four hours from the beginning of the attack. He gives the 6th dil.—*Hom. Recorder*, September, p. 400.

**Pulsatilla.**—Dr. Walter Sands Mills relates in the *North American Journal of Homœopathy* for October his experience with pulsatilla. He esteems it the chief of remedies for diarrhœa, from whatever cause originating and in whatever subject appearing. It has also "given him more satisfaction in simple anæmia than any other remedy." He gives the dilutions from the 1st to the 3rd.

**Senega.**—"I have found senega, either in tincture or fluid extract, five drops to four ounces of water, a faithful remedy which has never failed me in the asthenic bronchitis of old people, with chronic interstitial nephritis, or with chronic emphysema, where it acts best; and in old asthmatics with congestive attacks."—F. H. Pritchard, *Hahn. Monthly*, Oct.

**Sepia.**—A physician of Baltimore gave his wife, for a headache, *sepia* 6x. Three days later she reported that she was having leucorrhœa, which came from her in long, stringy ropes; that there was a feeling as if all her internal organs were falling from her, and that she wanted to sit with her limbs crossed to prevent the organs falling out. The physician assures us that his wife is perfectly healthy, never had leucorrhœa before, that the remedy she took cleared up the headache, and that she has no knowledge of *materia medica*.—*Amer. Homœopathist*, Sept. 15.

**Snake-venom.**—An interesting account of the *post-mortem* phenomena observed in animals bitten by venomous snakes is given in *L'Art Médical* for November. Intense congestion of the spinal cord (grey matter) and acute fatty degeneration of the liver are among the most noteworthy effects of the poison.

**Sodium bicarbonate.**—Dr. Wilbur writes to commend a 2 per cent. solution of this salt as a surgical dressing. In wounds or abscesses it checks suppuration and promotes healing; in superficial and even phlegmonous inflammation it affords relief and disperses hyperæmia. He suggests its use in erysipelas.—*Hahn. Monthly*, Nov.

**Wyethia.**—Dr. Selfridge, who some years ago published a schematic pathogenesis of *wyethia helenioides*, gives some new provings of the plant—chiefly in the dilutions—in the *Homœopathic Physician* for September. Mental depression and irritability were marked in one prover; and in another two attacks of fever occurred.

**Xanthium spinosum.**—This plant, the “cockle” or “clotbur,” is warmly commended by an “eclectic” writer for chronic cystitis in women.—*Medical Century*, November, p. 326.

## THERAPEUTICS.

**Cancer of Pylorus (?)**.—Being called to a case of chronic vomiting and pain at the stomach, Dr. Müller Kypke found a tumour in the pyloric region about the size of half an orange. The patient was greatly emaciated, and her face was sallow and hollow-eyed. Bismuth and belladonna did no good; but under calc. fluor. and *nux vomica* (6x) improvement gradually ensued, and went on to complete recovery, the tumour having disappeared.—*Hom. Recorder*, Oct.

**Cancer of Mammæ.**—Dr. Thomas Simpson reports a case of hard swelling around the nipple, with pains of a shooting, burning nature, and continual exudation of sanious fluid from the nipple. Patient's mother had died at 55 from a similar affection. Conium 6, followed by carbo animalis 6 and 12, dispelled the whole trouble in about five months.—*Monthly Hom. Review*, Oct.

**Chordee.**—Dr. G. W. Ely finds anointing the glans penis freely with vaseline give almost immediate relief to this distressing affection.—*Amer. Homœopathist*, Sept. 15.

**Helminthiasis.**—Vermeulen reports a fatal case of "worm-fever" in *La Belge Médicale*. Chauffard has described a typhoid form of lumbricosis, and Tanchon has collected three cases of it. Marie published a case in a man of 54, where it was impossible to exclude typhoid fever with certainty; and Loi one in a child of 6, where all the symptoms of meningitis were present. In the latter case the diagnosis was made by finding ova in the stools, typhoid fever being excluded by the serum test. Marie observes that in the case of worms quinine has no anti-pyretic action, while *santonin* has, even though its administration is not followed by the expulsion of the parasites.—*Calcutta Journ. of Medicine*, Nov., p. 428.

**Indurated glands.**—Dr. W. Boericke has written some useful notes on the remedies for the above. They are translated from the *Pacific Coast Journal of Homœopathy* (a publication which has not of late reached us) in *L'Art Médical* for September. He places conium first, and says that it has, in the 30th dil., a "marvellous action." Next come lapis albus (of which he recommends the third trit.), the salts of barium, and calcaria fluorica.

**Ingrowing toe-nails.**—Dr. Majumdar claims to have had good success from internal medication in this troublesome affection. Silicea where there is much sensitiveness and pain, graphites and hydrocotyle in chronic cases with much thickening and induration of the surrounding tissues, are his principal remedies.—*Indian Hom. Review*, July-August.

**Paralysis.**—Dr. Elias C. Price communicates some experience with progressive paralysis to show that it may occasionally be arrested by homœopathic medication. His first case seems to have been an instance of the general paresis of the insane, with the usual delusions of magnitude. It recovered under plumbum

and zincum 24-30. Then follow two apparently of ascending paralysis; and here gelsemium 3x, with or without the continuous galvanic current, proved curative.—*Amer. Med. Monthly*, Sept.

**Sweat glands, diseases of.**—In the October number of the *American Medical Monthly* Dr. M. E. Douglass begins an interesting study of maladies of the sweat glands. He classifies them as functional and structural—the former embracing hyperidrosis, dysidrosis, anidrosis, osmidrosis, and chromidrosis; the latter miliaria and sudamina, lichen tropicus, strophulus, hidroadenitis, and cysts. The indications for remedies contain nothing new.

**Tubercular laryngitis.**—Dr. Bartus Trew relates a case of this disease, so diagnosed by its former old-school attendants, and presenting, indeed, all the features of the malady, which got quite well under causticum 6 and calcarea 30.—*Amer. Medical Monthly*, Oct.

JOURNAL  
OF THE  
**British Homœopathic Society**

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No. 2.

APRIL, 1899.

VOL. VII.

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DIET IN GOUT AND ALLIED DISORDERS.<sup>1</sup>

BY W. THEOPHILUS ORD, M.R.C.S.ENG., L.R.C.P.LOND.

IN speaking of gout and allied diseases, I include not only the maladies always recognised as gouty, but especially the vast number of disorders which are now largely admitted as caused and maintained by the same condition, which only occasionally develops into true gout. These have recently been described in the *Monthly Homœopathic Review*,<sup>2</sup> and the ideas there explained are no doubt familiar to us all. It is in the treatment of these diseases, as well as in true gout, that diet should occupy a predominant place, in order that our remedies may act to the best advantage.

DIET IN THE ELIMINATION OF URIC ACID.

It has long been recognised that gout, rheumatism, and many allied diseases are connected in some mysterious way

<sup>1</sup> Presented to the Section of General Medicine and Pathology, Dec. 1, 1898.

<sup>2</sup> September, October and November, 1898.

with the production of uric acid and its salts within the body and their elimination by the kidneys. Although many are ready to maintain that the relation of uric acid to such conditions is one of cause and effect, other observers consider this non-proven, regarding uric acid more as a by-product in that defective metabolism which underlies this train of diseases. All, however, agree that the so-called gouty diathesis, with its protean manifestations, is usually accompanied by an increased production of uric acid, and further, that gouty symptoms can in these cases be aggravated, and even induced, by the same causes and conditions that lead to an increased formation and subsequent out-put of uric acid and urates. Most of us will accede a further point, that gouty symptoms are seldom relieved until the process of elimination by the kidneys is completed, and the scanty urine, heavily laden with urates and uric acid, typical of gouty conditions, has given place to a flush of clearer water of lower specific gravity. For this reason, and because accumulations of gouty matter in the system can only be rapidly excreted by the kidneys, quantitative analysis of the urine is an invaluable guide in treatment. Evidently then we ought to know what effect various diets have upon the urinary excretion, before we can intelligently adapt them to such cases. As homœopaths, we shall be the first to admit that experiments to ascertain this should be conducted on healthy subjects. This paper contains a contribution to our knowledge of these facts.

#### THE URINE IN GOUTY CONDITIONS.

It is to the urine then that we must first look for evidence as to the elimination or retention of gouty matters in the blood. It has been abundantly proved, and is now generally accepted, that scanty, very acid urine, of high specific gravity and deep coloured, is suggestive of retention of gouty matters in the blood. This usually precedes acute gout, and also any acute attack of other maladies due to the same cause, as well as those which occur in earlier life, such as a sick headache, an attack of asthma, or even an epileptic fit.

When the blood endeavours to relieve itself by discharging the poisons, the urine often becomes loaded with lithates, and sometimes with sand, gravel, or uric acid crystals. Relief is followed by a much freer flow of limpid urine, less acid or even neutral, and of low specific gravity. From this we know that the blood is now cleared, the constricting influence of uric acid on the kidney vessels at an end, and excretion no longer inhibited. It is this that indicates a normal condition of the blood, during which no deposition or accumulation of urates can be taking place. True, many painful maladies may remain unrelieved after this change in the urine, but this is due to storage of gouty poisons in the affected parts, the blood itself being now free and ready under favourable conditions to wash out these stores. It is under such circumstances that our remedies act most effectively, and until this condition has been achieved they often fail to benefit.

That a highly concentrated acid urine exists before and during an attack of acute gout is known to us all, and the same is more or less true in the various maladies mentioned. This urinary condition reflects the state of the blood, the normal alkalinity of which is probably diminished when the urine is very acid, and increased when it is neutral or alkaline. It is now pretty certain that a diminished alkalinity of the blood favours retention of uric acid and its storage in the system, whilst a higher alkalinity of the blood favours elimination and washing out of the stores. Our guiding principle in diet must therefore be to maintain a free flow of urine of low specific gravity, and, if possible, of neutral or feeble acid re-action. When this is achieved we shall have placed a patient under the most favourable conditions for elimination and washing out of gouty matters. It can hardly be a coincidence, but is, at least, a welcome fact, that the diets which best accomplish this end are also those which keep the production of uric acid and gouty matters at the lowest ebb possible. Now it has long been known that a vegetarian diet renders the urine less acid and even alkaline, whilst nitrogenous food increases its acidity, as do malt liquors, wine, and alcohol.

## MEAT AND SUGAR IN THE GOUTY DIATHESIS.

It is the usual custom to forbid or diminish the ingestion of meat and sugar in gouty persons. A highly nitrogenous diet with concentrated hydro-carbons, especially starch and sugar, is notoriously injurious. Especially is this the case when by acid wines and malt liquors the alkalinity of the blood is still further diminished. It is only recently that the reason for this has become known. Such a diet is not only the one under which the largest amount of gouty poison is produced, but also that by which the elimination and excretion of uric acid is chiefly retarded, leading to storage in the system with the various results referred to. Luff tells us that the saline constituents of vegetable foods tend to eliminate gouty matter and prevent its deposition, whilst the saline constituents of nitrogenous foods have the opposite effect. Haig says that uric acid is produced directly from meat and extractives, and its excretion hindered by the increased acidity it causes; that the least possible amount of uric acid is formed from vegetable diet and excretion facilitated by its increasing the alkalinity of the blood and urine. Let us then consider the three types of diet and their effect upon the condition of the urine.

## THE THREE THEORETICALLY POSSIBLE DIETS.

I. *Carbo-hydrates and Hydro-carbons.*

These can all be obtained from the vegetable kingdom, and, as is well known, a strictly vegetarian diet will maintain life. But a certain amount of nitrogenous matter is contained in all grains and cereals, and without this life would be impossible. Sugar, fat, and salts alone are insufficient. Rice contains least nitrogen of all starch foods, and although the Irish peasants flourish on potatoes, and Hindoos and Chinese on rice, such a diet is impossible for us, and it is very doubtful whether it would eliminate gout effectually.

Probably the compromise adopted by Haig, with the addition of a moderate quantity of chicken, tea, and eggs, is the nearest approach to vegetarianism which we ought to



attempt. The most generally useful form of this diet, in which nitrogenous foods are largely reduced, would be somewhat as follows, but it must be moderated to meet the needs of different cases :—

*Breakfast*, 9 a.m.—Oatmeal, or other cereal, with milk, bread, toast, butter, preserves, and weak tea.

*Dinner*, 1.30 p.m.—Soup made from bone stock and vegetables, a little fish or chicken, and perhaps twice a week mutton or lamb, preferably boiled or cold. Plenty of vegetables, potatoes and bread. Farinaceous or suet puddings, cheese and fruits. Beverages: aerated waters, milk, cider; or, if required, Scotch whisky freely diluted.

*Supper*.—Between 6.30 and 8 p.m. A little fish, poultry or game (whichever has not been taken at dinner), varied by occasionally a poached egg, or sardines, or a slice of boiled pork or ham. Toast, bread, potatoes—fried or chips, vegetables, salad, cheese and butter, milk puddings, cream, stewed fruits. For beverages, the same as at dinner, or, if desired, *café au lait* or weak tea with plenty of milk, or cocoa.

As an extra, *afternoon tea* may be taken at 4.30 or 5, consisting of tea, milk, or cocoa, with bread and butter and cake. Sugar is absolutely prohibited; saxon or saccharine if desired. Rhubarb and spinach are forbidden. Tomatoes are good, and especially raw fruits and vegetables. Milk in moderation may be added as required.

Such is a diet in which the gout-producing foods are reduced to probably the lowest point practicable for most persons. The essential features are the absence of excess of meat and sugar and the adoption of a farinaceous breakfast. I am convinced that the ordinary mixed breakfast of eggs, bacon, fish, &c., is most pernicious; and generally the substitution of such a meal as I have suggested will alone do a great deal towards placing the patient in a better condition. The modern custom of allowing children such mixed breakfasts, I believe to have a great deal to do with the prevalence of gouty tendencies showing at an early age; by eczema, asthma, nasal and bronchial catarrhs, enlarged tonsils, constipation and bilious headaches, &c. Especially does it

seem to do harm in those of a tubercular as well as of a bilious tendency. Haig's dietary is more strict than mine, meat, poultry, eggs and tea being mostly prohibited. I believe it is often most efficacious, perhaps more so than the above. But it is more difficult to get patients to adopt it. The diet advised I have found very successful in many cases, and have for long adopted it myself, with resulting freedom from severe uric acid headaches and various bilious symptoms, which on a return to mixed diet usually reappear in a week.

## II. *The Nitrogenous Diet.*

Until a few years ago this was unknown, but was then introduced as a special treatment for obesity by Dr. Salisbury. In its strictest form it consists of finely-minced beef-pulp cooked in several ways, a very small quantity of baked bread (about three ounces per diem) being allowed; and hot water is the only beverage, three or four pints being taken daily, and preferably an hour before meals. As a diet for obesity it is most successful, and may safely be resorted to. But it was soon found that immense relief to all gouty and rheumatic symptoms, to which the obese are so liable, was also obtained under its use. Urates and uric acid are, in such patients, excreted in great quantities in the urine, and freedom from gouty symptoms, often for a long period, follows a course of such diet. This is now becoming well known, and as a result dietary homes for the treatment of gout, rheumatism, obesity, dyspepsia and other conditions depending on lithæmic states, are springing up in many places. A vast amount of testimony is accumulating as to the great benefit resulting from such diet in cases which had resisted all other modes of treatment. Sometimes when a semi-vegetarian diet (often ill-borne by the obese) has completely failed, a course of Salisbury mince and hot water has worked wonders. I frequently use it myself with great success, and many colleagues have told me of equally good results in their experiences. It is not necessary to resort to so strict a dietary as Dr. Salisbury advises. Fish may be taken freely, and all forms of beef and mutton, with occa-

sionally game and poultry, provided only that all farinaceous food is prohibited. Weak tea and aerated waters are permissible in moderation; but a large quantity of fluid is essential, and hot water should always be included. The diet is not adapted for very thin persons who have no reserve of fat to fall back upon, but in fairly fleshy and fat cases it never disagrees—if they will eat enough of the meat. Those who at first are unable to take more than four or five ounces at each meal should be helped by beef-tea and meat extracts between.

### III. *The Mixed Diet.*

Little need be said under this head. It is the ordinary diet of civilised men, and the one under which gout and allied disorders are most readily developed, even in those who have no hereditary tendencies to such diseases. We have not sufficient evidence to determine as yet whether strict nitrogenous diet would produce gout of itself if persisted in. Few would care to continue it long enough to ascertain this, but it seems unlikely that such would be the case.

We have then empirically discovered these facts as to diet in gouty states:—(1) That a mixed diet is the worst and that which most tends to produce gouty poisons; (2) that a semi-vegetarian diet is the best and that which most tends to prevent gout and eliminate such poisons; and (3) that a strictly nitrogenous diet in persons saturated with gout more rapidly and effectually clears out the system and relieves gouty symptoms than any other.

This remarkable effect of Salisbury diet appears to be directly opposed to all our preconceived theories as to the formation and retention of gouty matters, especially to the views of Haig, and I am told that Haig, whilst not denying the results of this diet, confesses himself as unable to explain it. It therefore occurred to me that the solution of this problem, and perhaps other helpful facts, might be brought to light by a quantitative examination of the urine during a course of experimental diet in a healthy person.

Arrangements were therefore made with Mr. Tanner, of the Physiological Laboratory, Bournemouth, whose skill as an analytical chemist and pathologist is well known to many practitioners in the southern counties, for daily estimation of the urea, uric acid, and degree of acidity of the urine passed, and the results are shown graphically in the diagram before you. The urea was estimated by the hypobromite method, the uric acid by the Gowland-Hopkins process, and acidity by a standard solution of caustic soda, of which 1 cc. neutralised '063 grm. of oxalic acid.

#### THE FIRST WEEK'S ESTIMATION UNDER NORMAL DIET.

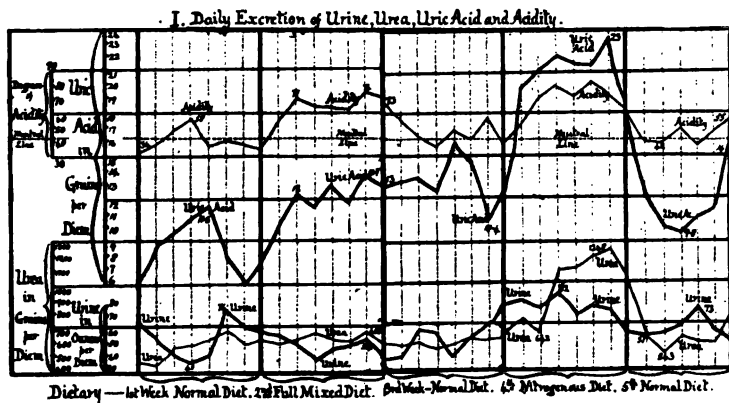
Having for many months adhered to the non-nitrogenous diet described above, no alteration was made, and the averages for this week were taken as normal. The reaction of the urine to test paper was alkaline, except on two days. This week, and throughout the experiment, I remained in excellent health, taking a fair amount of daily exercise, amounting to about 100 miles' cycling each week. Special precautions were taken to ensure every drop of urine being saved and measured.

*Daily averages for first week.*—Urine, 53·87 ounces. Fluids drunk, 53 ounces. Urea, 577·25 grains. Uric acid, 8·38 grains. Acidity, 41·74.

#### THE SECOND WEEK UNDER FULL MIXED DIET.

This diet included eggs and bacon for breakfast, meat for luncheon, with cider the first four days, and beer the last three. Dinner of fish or soup, meat or chicken with sweets, cheese, and claret. Afternoon tea, and coffee in the evening.

The resulting change in the urine is shown in the diagram. There is a steady daily increase of uric acid, rising to 5·4 grains above the average of the previous week. With this is a decrease in the urine of 6·73 ounces per diem, although 16 ounces more fluids were drunk daily. Nor was there any increased exercise or perspiration to account for the differ-



ence. The urine became acid to test paper at once, and remained so, averaging 24 points of acidity above the normal under non-nitrogenous diet. Urea increased by an average of 32.32 grains per diem.

*Daily averages for second week.*—Urine, 47.14 ounces. Fluids drunk, 69 ounces. Urea, 609.57 grains. Uric acid, 12.09 grains. Acidity, 65.71.

### THE THIRD WEEK UNDER NORMAL DIET.

This return to normal non-nitrogenous diet was made for two reasons—(1) that a better comparison might be made of the results of strictly nitrogenous diet, which next follows, and (2) that the time taken by each factor to resume the normal out-put might be ascertained. To this latter point I direct special attention as indicating the amount of storage of gouty matter laid up under the full mixed diet. Thus the urine rose to normal on the second day; urea fell at once. Acidity decreased to normal in three days, taking one day longer to fall than to rise the same amount. This suggests a possible storage of acid salts absorbed under the previous week's diet, and being slowly eliminated, especially as the average acidity is 10 points above the normal for the week. The excretion of uric acid is instructive and peculiar. Although there is a

fall for three days, it is followed by a rapid rise for two days, then a drop. The total amount excreted is greater by 1.05 grains per diem than even during the previous week, in spite of the changed diet, and 4.76 grains were daily excreted in excess of the normal of the first week. This probably shows that considerable storage of uric acid takes place under a full mixed diet, and in this experiment the excess stored was apparently not excreted entirely even by the end of the third week. We have here the explanation of the effects of such diet in gouty persons, and also in gradually producing gouty symptoms in those who, under a less nitrogenous diet, would altogether escape them. It confirms Haig's theories as to storage, and shows that he may be correct in stating that a year of such diet may add an ounce of uric acid to the gouty stores of such a patient, which presently will appear in enlarged joints or other effects.

*Daily averages for third week.*—Urine, 54 ounces. Fluids drunk, 54 ounces. Urea, 555 grains. Uric acid, 13.14 grains. Acidity, 50.76. All factors (except uric acid, which had touched a point two grains above) having returned to normal, the fourth week's experiment was commenced.

#### THE FOURTH WEEK UNDER STRICT NITROGENOUS DIET.

This consisted of Salisbury mince, roast meat, fish and chicken, with white of poached eggs, and four ounces of dry toast per diem. Hot water was not taken, as advised by Dr. Salisbury, the fluids being only slightly increased, my object being to avoid confusing the issue. Some observers have stated that the results of this treatment are due to the hot water more than to the nitrogenous food. This is evidently untrue, as a glance at the diagram will show. There we see an enormous rise of uric acid and of urea, both being nearly double the normal. The former touches 23.4 grains on the sixth day, urea reaching 1,248 grains. Acidity is also increased to the highest point reached during the experiment, although no acid drinks were allowed as during the second week, the average being five points above that period, but thirty above

the normal of the first week. A far larger quantity of urine passed than in any previous week. Although the fluids taken were six ounces per diem less than the second week, the urine was increased by nearly a pint daily. Nor was there any diminution in exercise or perspiration, nor increased fluids contained in the food. This effect upon the urine is a well-known result of Salisbury diet, although usually attributed to fluids imbibed. The urine was, in my case, clear and with no deposits of lithates or visible uric acid, although with those who are full of gouty stores in joints, &c., copious lithates usually are seen under this treatment. In this co-incident increase of urine passed and uric acid excreted we have a clue to the remedial action of the diet. It shows that there is no accumulation of uric acid inhibiting the kidneys by vaso-motor contraction of their arterioles, but that in spite of the greatly increased quantity of uric acid caused by the diet, it is rapidly and completely excreted. Not only so, but the old stores in joints, liver, and elsewhere, are also freed and got rid of at the same time, as they are gradually dissolved into the circulation. In my case the sense of well-being and freedom from headaches or other gouty symptoms during the diet also confirmed the fact of free excretion of uric acid and absence of storage. The same quantity of uric acid under other conditions, I know from experience, would have produced unmistakable symptoms. The fact of this free excretion is also confirmed by the rapidity with which all factors fell to the normal on the diet being changed again, showing that storage was not taking place as under mixed diet. The usual mental and bodily vigour was experienced, especially in cycling; one felt as if it would be impossible to get tired. This was partly due to previous careful dieting, having in my own case eliminated old stores beforehand; gouty persons commencing nitrogenous diet often suffer from great depression, headaches, malaise, &c., from old accumulations being too suddenly washed out during the first few days of treatment.

*Daily averages for fourth week.*—Urine, 68·85 ounces. Fluids drunk, 63 ounces. Urea, 943·43 grains. Uric acid, 21·01 grains. Acidity, 71·63 points.

## THE FIFTH WEEK—NORMAL NON-NITROGENOUS DIET.

On the last day of the previous week a decided drop in uric acid, acidity, urea and urine is seen. This is due to the concluding meal of that day, owing to a domestic accident, having been partly non-nitrogenous. At once on returning to normal diet there is a great change, as might be expected. Urine dropped to normal in thirty-six hours, and for the week averaged three ounces above the normal of the first and third weeks. Since the fluids taken were practically the same (fifty-four ounces), this suggests that the kidneys had been more completely freed by the Salisbury diet, probably through the thorough clearance of uric acid induced. The uric acid fell to normal in twenty-four hours, whereas after mixed diet (second week) it took more than seven days to do so. This I consider a point of great importance, and clearly proving the complete excretion taking place under meat diet, leaving no uric acid in hand to hinder the kidneys when the food was changed, as occurred after mixed diet. Acidity fell to normal in two days, as compared with three days after mixed diet. Urea took only three days for the great fall of 650 grains.

*Daily averages for fifth week.*—Urine, 57 ounces. Fluids drunk, 54 ounces. Urea, 616 grains. Uric acid, 11·7 grains. Acidity, 46·58 points.

## CONCLUSIONS.

We have, I think, in these experiments, clear evidence that the production of gout and gouty poisons does not so much depend upon the actual quantity of uric acid produced by the food as upon the presence of certain factors which prohibit its elimination by the kidneys, and lead to its storage in the body. There can be no doubt that it is the products of the ingestion of non-nitrogenous food that have this effect. How or why carbo-hydrates and hydro-carbons act in this way in digestion we do not know. But the fact remains that when they are excluded a diet producing even double the quantity of uric acid tends to free excretion and cleansing of old stores, whilst in a mixed diet the smaller quantities of uric acid tend to be stored up and produce



gouty conditions. Hence we can meet the difficulty in two ways: (1) by reducing to the lowest possible point the foods producing uric acid, as by semi-vegetarian diet, or (2) by removing the factors inducing storage and inhibiting excretion of uric acid by an exclusively nitrogenous diet.

Other important facts brought to light or confirmed by my experiments, I have tabulated as follows:—

(1) That the daily excretion of uric acid is a very variable quantity, and that certainly no less than seven successive daily estimations can be accepted as affording a reliable average.

(2) That under all mixed diets the excretion of uric acid is roughly inversely as the quantity of urine passed, but that the opposite obtains under a strictly nitrogenous diet.

(3) That of all diets the ordinary full mixed diet, especially with acid drinks, is the one that most tends to the storage of gouty products in the system.

(4) That of all diets the strictly nitrogenous is the one that most effectively and rapidly eliminates these stores.

(5) That an almost vegetarian diet is that which produces least uric acid and gouty matter, and also lessens storage by decreasing the acidity of the urine.

(6) That the causes of storage of gouty matters are the products of the digestion of non-nitrogenous foods; and that these are aided by all factors that increase the acidity of the urine, and that these causes seem to act more effectively the greater the quantity of uric acid there is free in the circulation for them to act upon. It appears probable that this effect of carbo-hydrates is exhibited not directly upon uric acid, but upon nuclein, from excess of which after its passage through the spleen uric acid is probably produced.

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Dr. BURFORD (from the Chair), after thanking Dr. Ord for his exceedingly interesting and lucid paper, said that if there was a latter-day widespread besetting sin from the physician's point of view, it was that of the gouty diathesis. It was found increasingly in men, women and children; but there was every reason

to hope that from experiments and reports such as those made by Dr. Ord, homœopathic practitioners would have new weapons placed in their hands with which to safeguard more completely the interests of their patients. He invited full discussion of the subject.

Mr. WILKINSON said he was especially grateful to the author, not only for the excellence of his paper, but also because it gave him (Mr. Wilkinson) an opportunity for making a confession. Some years ago he brought before the Society the results of experiments which, to a certain extent, were similar to those of Dr. Ord, the results concerning immediately the effect of drugs from a homœopathic point of view upon the healthy body. Not long after he had laid his figures before the Society he discovered they were erroneous, and this was his first opportunity for acknowledging it. The mistake he made was in his use of the Haycraft method. The Gowland-Hopkins (?) method recommended by Dr. Luff, as opposed to the Haycraft method recommended by Dr. Haig, was undoubtedly the one which should be followed, and Dr. Ord had followed it. He wished to strengthen Dr. Ord's remarks as to the great normal fluctuation of uric acid. This necessitated estimations of uric acid for a considerable period before one could be satisfied that a representative normal figure had been obtained. Had Dr. Ord been taking minute doses of some drug and looking for pathogenetic effects, he might easily have imagined that he had obtained important results, when he had really only been recording his normal out-put under his modified vegetarian diet. It was interesting to notice that the trouble in the uric acid diathesis was not so much the over-igestion of nitrogenous matter, as the use of mixed diet. Under either the purely vegetarian diet, or the nearly pure nitrogenous diet, the excretion of uric acid was steadily and comfortably carried out; but on coming to the mixed diet, one thing interfered with another.

Dr. GALLEY BLACKLEY said that the paper was particularly interesting to those who had read Dr. Haig's lectures published in the medical journals; in fact, it reflected perhaps a little too faithfully Dr. Haig's views on many points. He (Dr. B.), suggested that if Dr. Ord would read Sir William Roberts' article on gout, in Allbutt's "System of Medicine," and the little book of Dr. Luff, just published, he would modify his views very considerably. Both Sir William Roberts and Dr. Luff had practically buried the theory of storage altogether, as it was shown to be absolutely untenable. Uric acid in health

was never found in the blood, and if it were stored in the way Dr. Haig suggested it would inevitably be found in the blood. Dr. Ord's diagrams were extremely interesting in their way, but he had not mentioned the amount of liquid ingested with the food, and it was very well known that those who took a vegetarian diet consumed, as a rule, a larger quantity of liquid than those who partook of meat diet; therefore the quantity of urine was very easily accounted for. As to the storage idea, in the fourth week on the diagram just shown, he thought the diagram explained itself. When a man was living on "Salisbury" diet the quantity of urea and uric acid excreted went up with a bound. Why were they not stored, if storage was to be made to account for everything? Although the quantity of both was very high they were got rid of as quickly as possible, the amount of urine being at the same time very small. He had not read the Salisbury books sufficiently well to argue about them, but certainly both Salisbury and Haig could hardly be right. Dr. Luff was very strong upon the necessity for recognising that there was a double source for uric acid. There was the visceral source, the liver, spleen, and kidneys, and there were the white cells of the blood, which were two totally different things. In leucæmia and many severe anæmias, the quantity of uric acid eliminated was very large indeed, but gouty symptoms never by any chance supervened. Dr. Luff suggested that uric acid was formed from urea in the kidneys, and the kidneys, as both he and Sir William Roberts thought, not being thoroughly competent, refused to eliminate the uric acid; or rather it did not pass through, but was sent back to the system. That was very different indeed from Dr. Haig's suggestion that the uric acid was formed in the liver or in the spleen and stored up there or in other places. The suggestion that alkalies favoured the elimination of uric acid from the system was quite untenable. Alkalies directly favoured the retention of uric acid in the system. The more alkali there was in the blood the more liable was bi-urate of sodium to be formed. Dr. Luff had made some very interesting experiments with regard to the alkalinity of the blood and had found that the state of alkalinity had no relation whatever to the elimination of uric acid, either in health or during an attack of gout. He gave most exhaustive experiments on the point, which were absolutely conclusive.

Dr. Dycæ Brown said that although theoretically Dr. Haig's view seemed almost incontrovertible, it was found that a certain number of patients recovered under his treatment, and also a

certain number from Dr. Salisbury's diet. Therefore it struck him (Dr. Dyce Brown) that the individuality of the patients had not been sufficiently estimated. Garrod stated that only 25 per cent. of gout patients were benefited by the Salisbury treatment. His own experience was that many persons were not benefited by it, and that those who were not benefited by it were those who do well on vegetarian diet, and *vice versa*. The patients' likes and dislikes were indications of the proper diet for them. Many patients abhorred the idea of eating meat, and such patients would never do well upon the Salisbury diet, but would do well upon the vegetarian. Those who did well on the Salisbury diet were those who had a craving for meat and did not care for fruit and vegetables. It was extremely difficult to understand theoretically why the two different modes of diet should both be successful, therefore the individuality of each patient must determine the proper treatment in each case. The individuality, constitution, likes and dislikes of their patients should be watched, in order to determine the diet suitable to each particular case.

Dr. GOLDSBROUGH said the facts which Dr. Ord had brought forward would stand as a contribution to the subject, but he thought the author had somewhat prematurely arrived at his conclusions. It appeared to him (Dr. Goldsbrough) that a longer estimation of the normal condition would have to be taken into account, besides other factors in the life of the individual likely to influence the excretion of various matters from the urine. For example, the degree of mental strain a medical man would be subjected to from week to week must make a difference in the excretion of matters from the urine as well as in excretion from other organs. In the instance of the third week of the experiment brought before them, there was a slight excess of secretion of uric acid, which Dr. Ord attributed to storage during the previous week. That might be a wrong conclusion to draw from a single fact; it did not necessarily prove that there had been a storage; there might just as well have been some other undiscovered factor to account for it. Then during the fifth week, when the diet was altered, it might be that the alteration in the amount of secretion of uric acid was really due to a reaction on the eliminating power of the kidneys, owing to the alteration of diet. A large number of facts were required to prove the point of storage or otherwise, not only from one individual at different times of the year and under different circumstances, but from various individuals under different circumstances.

Dr. ROBERSON DAY said he had a case of uric acid diathesis in a child twenty-two months old. There was always an excretion of uric acid crystals in spite of every treatment. Naturally, in a patient of that tender age, it was impossible to deviate greatly from the ordinary diet of a young child. At the same time he was trying what could be done by a modification of the diet, and the diet he was now using comprised, amongst other things, spinach, and he hoped to be able to reduce the uric acid. The diet the child had been having was the usual one for a child twenty-two months old, milk and farinaceous foods, with occasionally beef-tea and mixed foods; but these always enormously increased the uric acid. Even fish and chicken would do so; but particularly meat extract, such as beef-tea, which would always bring on a large excess of uric acid. Uric acid is far more often excreted by children than by adults, and the reason for this difference is not apparent.

Dr. MOIR said he had seen several children who excreted uric acid who had never tasted any meat. He remembered the case of a boy who had been brought up as a vegetarian until he was eight or nine years of age, and who continually passed uric acid without any other diet.

Dr. ROBERSON DAY said that uric acid was a far more common deposit in the urine of children than in adults. That was a question that needed clearing up.

Dr. McNISH wished to make a remark with regard to the nitrogenous diet and the Salisbury treatment in the fourth week. He quite agreed with Dr. Moir that the only people it benefited were those suffering from obesity, because the diet was practically a starvation diet. One could practically kill a person on the strict Salisbury diet if it were continued long enough. If Dr. Ord had continued the Salisbury treatment for a few weeks longer probably some more changes would have been seen. He did not think the Salisbury diet depended upon the amount of water taken; it would be just as well without the water as with it. A purely nitrogenous diet is insufficient to maintain health.

Dr. JAMES JONES said that the only patient he knew of who had been under the Salisbury treatment was a very thin person, and had been under very strict treatment for more than a year with great benefit. She suffered from the most terrible attacks of spasmodic asthma, and until lately whenever she gave herself a little more liberty in the shape of taking more starchy food, there was an aggravation of the suffering. He was certain that the Salisbury diet had done her an immense amount of good in

keeping the asthma in check. Thin as she was she got much thinner. At her thinnest she could run about quite easily because her breathing was relieved. He could therefore say it was not only fat people who obtained benefit from the Salisbury diet, though he could quite understand that fat people would obtain a good deal of benefit from it.

Dr. WASHINGTON EPPS said he had a patient, 55 years of age, with chronic gout, whose hands were so stiff that he could not play his 'cello. The patient was put on a diet of meat and hot water—a good deal of hot water—and he lost 3 stone in weight, and the whole of his rheumatism. His joints became quite natural, so that he could play his instrument. For six or eight weeks he continued on the strict Salisbury diet, after which he resumed the mixed diet. He afterwards kept on with the hot water, taking two or three tumblerfuls extra, and he had had no return of his rheumatism, but regained the greater part of his weight. In the Salisbury treatment he thought it was not so much the meat as the hot water that did the good. Dr. Epps had also treated two ladies by the Salisbury method, one lost 3 stone, reducing her weight from 15 stone to 12 stone; and the other patient, who weighed 15 stone, also lost 3 stone by the Salisbury treatment, but she had discontinued the treatment and would eat all sorts of sugars and had consequently gone back to her old weight.

Dr. SPENCER COX said that with regard to the effect of the Salisbury diet, it must be acknowledged that it reduced very considerably the weight of the patients, and as he thought, quite irrespective of their likes or dislikes. He had recently had a good example of that, a very stout woman indeed, who could hardly get about, she slept in a chair, being too frightened to go to bed, because she was afraid she would die if she lay down. He put the patient on the Salisbury diet against her will, and after a month or so her weight was reduced very considerably, she had been able to lie down, and was in every way better.

Dr. BURFORD (in the Chair) said he scarcely remembered a paper which had evoked so interesting a discussion, and not only that, but nearly every speaker had spoken from his own personal experience, which was of the primest value and importance. He had a little experience of the effects of diet on young children. One of his own family, a small boy who had given a considerable amount of anxiety on account of his uncommon pertinacity in having repeated crises of uric-acidæmia, was fed at various times in various ways. Finally, acting upon the suggestion of Dr.

Moir, it was found that nothing did the child so much good as a mixed animal and vegetable diet. He had also had several patients whom he had occasion, from time to time, to put on Salisbury diet. One, a lady suffering considerably from the physical effects of fibroid of the uterus, including hæmorrhage and local pains, persistent headache and weariness of existence, adhered to the Salisbury dietary for a period of six weeks, and he was bound to say that no remedial measures previously devised were of nearly so much service to her as the six weeks' course of Salisbury diet. While that diet was employed, her ailments, to a very large extent, disappeared. On its cessation some of them ultimately returned, but not nearly to such an extent as before. He had had another case of a young girl of 22, who was scrofulous to the backbone, and the only thing that was of lasting service to her was a course of Salisbury diet. He saw the young lady a few days ago, and she had been for one-and-a-half years much less harassed by her former troubles, including headaches, leucorrhœa, and inability to get about easily. A few years ago he took a very great interest in the analysis of urine of patients after abdominal section. He found out one fact which might be of importance to the members, namely, that when urine was excreted, becoming turbid from the deposit of urates, the quantity of deposited urates bore no relation whatever to the actual amount of uric acid present. All that the deposit meant was an alteration in the solvent properties of the urine. With regard to Mr. Wilkinson's statement, he thought the members would look for a revision of the original experiments rectified by a newer and better system of analysis.

Dr. ORD, in reply, thanked the members for their criticisms. It was impossible to lay down a law with regard to gout. He had only put before the members the deductions he had made from the experiments in so far as they had coincided with the observations and experiences of others. So far as they had done that he ventured to consider them as genuine; they had, to a very large extent, confirmed the conclusions of Haig and cast doubt upon many of the conclusions of Luff. He had read carefully all that Dr. Luff had written and had also studied Dr. Haig. The best way of looking at the question was from a practical point of view, in order to find out which was the most likely theory to succeed as a working hypothesis in practice, and when he looked at the question from that point of view, he found it best to put Luff's ideas on one side and follow Haig. Luff told them little which was really practically useful, he had nothing better to

suggest in gout than the rest, warmth and colchicum of fifty years ago, whereas Haig's book and the facts which he there brought forward to support his theory were exceedingly helpful by the bedside. He knew of nothing in recent pathological research which had so assisted him in practice as the hypotheses and the facts which Dr. Haig had presented. With regard to the storage of urea, he had not said anything about that because he did not believe that urea was stored. The urea of one day represented what was taken in the food and derived from tissue metabolism the day before. But the more important question was, whether uric acid or not was stored in other than strictly gouty deposits. That was a very difficult and complex question, but the evidence at present was distinctly in favour of its being gradually stored in the system; and the phenomena of gouty diseases could not be explained at present on any other hypothesis. With regard to the question of the Salisbury treatment, he wanted to make it clear in his paper why Haig's views were not contradicted by the results of strictly nitrogenous diet. The experiments described to-night corroborated Haig's views as to storage, and threw light on the manner in which these stores could be eliminated. They also showed that Haig was right in insisting that the uric acid taken into the system was strictly proportionate to the amount contained in the food taken. Some almost amazing differences of opinion, with regard to the Salisbury diet, had been heard that evening; but the fact of its success in many almost hopeless cases remained to witness against them. There was one thing about the Salisbury treatment which he had omitted to mention, namely, that it was not necessary to keep people on minced beef. It did not matter what meat or fish they took, so long as they took nitrogenous food alone. He had kept people with good results on joints and fish for dinner, with game, poultry, an *entrée*, and even curry with no rice. Better results, however, were obtained by commencing with a strict Salisbury diet. Fat must be eliminated as far as possible. After the first few weeks of the Salisbury treatment a little butter might be eaten with each meat meal. He was sure that, in spite of the present difficulties of the question of gout, the true explanations were being evolved, and that they would prove to be on the lines he had indicated.

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THE CLIMACTERIC PHASES OF LIFE.<sup>1</sup>

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

As a prologue to my paper I cannot do better than quote the extract from Mr. Ruskin's writings where he says :—

“Certainly it is excellent discipline for an author to feel that he must say all that he has to say in the fewest possible words or his reader is sure to skip them ; and in the plainest possible words or his reader will certainly misunderstand them. Generally also, a downright fact may be told in a plain way, and we want downright facts at present more than anything else.”

I trust that in echoing the sentiments contained in this passage, you will not consider that I thereby impeach either your faculty of attention or your faculty of comprehension. It is introduced as it sets forth, in a peculiarly concise and appropriate manner, my reasons for taking up such a subject as “The Climacteric Phases of Life,” whilst at the same time it accurately expresses the method I have adopted in attempting to deal with it.

The life which we daily see manifested in and around us has most naturally formed the theme of very many and very varied expositions.

To the poet and the philosopher, to the novelist and the playwright, life with its vicissitudes and its problems, with its tragedies and its comedies, has proved itself a mine of inexhaustible wealth, some of the products of which rank amongst the finest and purest of our literary gems.

For the purposes of this paper, however, we must set aside the wider view of life and its attributes and confine our attentions to the relatively narrow though still complex exemplification of it as seen in the life-history of each individual.

The elements, or as I should rather term them, the stages which go to make up this life-history you are all

<sup>1</sup> Presented to the Liverpool Branch, December 8, 1898.

thoroughly conversant with. No better epitome of them exists than the one with which the melancholy Jaques regaled the feast of the banished Duke and his followers, in the Forest of Arden. According to Jaques—

“One man in his time plays many parts,  
His acts being seven ages,”

which he then goes on to describe in the rapid epigrammatic style of Shakespeare's genius.

The different stages are not of course sharply marked off from one another. Nature never does things by leaps and bounds. Hence it comes about that, though we may talk and write of them as separate and distinct entities, they do not exist as such, but insensibly merge the one into the other, together forming a connected whole. This may be diagrammatically represented by a “Curve of Life.” Mr. Chiene, in his “Lectures on the First Principles of Surgery,” uses this figure and thus describes it:—

“The ascending part of the curve represents the time of growth and development, from conception to manhood, a more or less level portion then represents the period of maintenance; and this is followed by a portion downward in direction, signifying old age and decay, ending in death.

“During the first period we have the deposit in the tissues in excess of the removal, and we have on the one hand an increase in the bulk of the organism which is growth, and on the other, an increasing complexity of function which is development.

“During the second period we have maintenance and the deposit in the tissues equal to the removal. During the third period—that of decay—the removal from the tissues is in excess of the deposit.”

For the needs of the student such a graphic representation of life and concise epitome of its physiology is eminently suitable. In the light of later experience the figure seems to me to fall short of full practical value, in that it does not indicate the presence of climacteric phases in life, which by their effects alike on the bodily and mental health of the individual come to rank in the minds of all careful practitioners as of paramount importance.

An analogy which, I think, more fittingly illustrates this

point, may be drawn between life and a river. At its commencement small, fickle and unsure, gradually gathering volume, force and character and losing itself at last in the abyss of the infinite deep; just as the steady, placid flow of the river through the plain gives place in the narrows to angry, rushing torrents, so the even tenor of our life is shattered here and there by the events of these climacteric or developmental periods.

I have introduced a fresh qualifying term, viz., developmental, for we must not lose sight of the fact that each of these periods is associated with the evolution of some physical or mental change which is calculated to impart to the individual new and fuller powers, or, as in the case of the Grand Climacteric, whilst diminishing functional activity to ensure to the individual better health in the later stages of life.

My endeavour is to pass in review the more prominent of these climacteric phases, discussing mainly the physiological conditions present and the changes produced by each and secondarily, though very briefly, the perversions attendant on each.

Infancy, which we may roughly describe as extending up to the 6th year, is characterised by a special susceptibility on the part of the organism to disease.

The period of infancy with which we are here specially concerned is that of dentition. That so necessary and so physiological a progress should have come to assume the position it now holds in the minds of the profession and of the laity, is in itself worthy of note. Is it to be explained, as some authorities would have us believe, as evidencing the transmission of a deteriorated constitution? The alternative solutions of associated errors of diet or of non-hygienic surroundings scarcely redound to the credit of the medical profession at large, and may, I think, be discredited on the whole.

It is to the stage associated with the eruption of the milk teeth I wish to refer. The process, I may remind you, begins at or about the sixth month and is usually completed about the end of the second year. Coincident with its

inception, we find that a marked development of the functional activity of the salivary glands takes place; this development is evidenced not only by the production of an increased secretion—giving rise to the well-known “drivelling” at the mouth—but also by an increase in the chemical activity of the salivary ferments, especially of the ptyalin, the starch-decomposing ferment. This fact is mentioned as having important practical bearing on the successful management of the artificial feeding of infants.

The chief interest, however, of this stage lies in the condition of the central nervous system, as it is through it, as an intermediary, that most of the troubles attendant on the process are developed.

I do not propose to enter on a consideration of the psychical state in infancy; quite apart, however, from the functions of mind or of consciousness, the inception of which can be but vaguely determined, there remain many other points of interest connected with the brain and its workings which are capable of being experimentally demonstrated; of these points the following are the most important and characteristic:—(1) The relatively rapid development and extreme acuteness of the senses of touch, temperature, and pain. (2) The instability of the motor cells of the cerebral cortex.

Many instances might be cited as illustrating these characteristics, but it is in what I may term the Pathogenesis of Dentition that they receive their most marked embodiment. A description in any detail of this pathogenesis is outside the scope of this paper; for present purposes a brief reference to two of its most important clinical manifestations must suffice.

(1) The gastro-intestinal group of symptoms has, as you all know, for its chief features, diarrhoea and vomiting. That such phenomena should occur during the period of dentition is, when we consider the anatomical continuity and physiological relationship which exist between the different parts of the alimentary tract, only what one might anticipate. But the degree of their severity in many cases passes far beyond the limits accounted for by such physiological considerations, and together with their persistence over pro-

tracted periods of time, renders them a very formidable menace to life.

(2) The cerebral group of symptoms specially illustrates the above-mentioned peculiarities of the central nervous system in infancy. Much divergence exists in its manifestations, according to the temperament and constitution of the child.

In all cases we find the well-known crossness and irritability more or less marked, associated usually with some degree of feverishness, whilst, in the graver cases, delirium and convulsions are very often met with.

Before leaving this part of my subject I would like to enter a *caveat* against the hasty and indiscriminate diagnosis of "teething" as explanatory of ailments at this period of life. In the clinical picture of restlessness, feverishness with vomiting, and convulsions, a careful examination will very often reveal quite another etiological factor, *e.g.*, meningitis, on the early recognition of which too much importance cannot be placed.

Of the eruption of the permanent teeth, which commences about the sixth year, little need be said. By this time the nervous system has become more set, and is able to appraise the various stimuli at their correct value. As a result we find an almost complete absence of the convulsive disorders which characterised the primary dentition.

We pass on now to consider the physiological and psychical conditions attendant upon the development of the procreative powers. Hitherto, our remarks have been applicable equally to either sex; when, however, we come to the times of puberty and adolescence, mental and psychical traits appear which lead to a divergence of the sexes to the full, as pronounced as the contrast afforded by mere bodily constitution.

What, in the first place, is the significance of the terms puberty and adolescence? Dr. Clouston, in his work on mental diseases, thus defines and distinguishes them:—

"I would restrict the term puberty to the initial development of the function of reproduction, to its first appearance as an energy of the organism, whilst I would use the term adolescence to denote the whole period of twelve years from the first evolu-

tion up to the full perfection of the reproductive energy, when the bones are finally consolidated and the full growth of the beard and sexual hair takes place, and there occurs the perfect assumption of the manly form in the male, and the full development of the adipose tissue and of the mammæ gives to the female form its perfect grace of contour."

This subdivision is, I think, from the standpoint of the general practitioner, needless. I propose, therefore, to adhere to the more popular use of the term puberty, in which it is considered as embracing the whole period connected with the appearance and establishment of the reproductive powers.

That a period wherein such new and vital influences are brought to bear upon the physical economy should rank as one of life's climacterics need not surprise us. The instinct of self-propagation is characteristic of all the higher order of beings, and in its inception is associated with the evolution of functional activity in many parts of the brain hitherto lain dormant, and it is in this way that on the threshold of this new experience fresh emotions and impulses thrill the mind and body, and novel views of life stir the imagination.

In the female, upon whose economy the propagation of the species is destined to make such heavy demands, the more characteristic changes consist in an increased susceptibility of the emotions—the hysterical phenomena occasionally met with being merely an exaggeration of the normal state, together with the development of a self-consciousness and modesty very different from the frankness and innocence of former years. In the male the change is harder to define; it takes place more slowly and, as a rule, at a decidedly later date, and tends, perhaps, more in the direction of an ever-increasing sense of the seriousness and responsibilities of life.

In this connection I propose to restrict myself to a consideration of the physiology and psychology of ovarian function.

I cannot claim any originality in what I am now going to say, but it is possible that some of the information culled from recent literature on the subject may be new to some of

my readers, and merit consideration from a scientific point of view.

We cannot discuss the subject of ovarian function without some passing reference to the phenomena of menstruation. The long accepted view that ovulation and menstruation were intimately related as cause and effect has, under pressure of the hard facts of later-day clinical experience, lost ground very considerably. On the one hand, ovulation has been known to take place outside the period of menstrual life. Several well authenticated cases are now on record of young women who have never menstruated becoming pregnant. On the other hand, menstruation has been repeatedly known to persist for months, and even years, after the removal by operation of the ovaries. Lawson Tait, in an attempt to adapt the theory to meet this difficulty, proposed the tubal theory of ovulation, in which he maintained that the menstrual impulse resides in the Fallopian tubes and not in the ovary; and, that in order to ensure cessation of the menstrual flux by operation, the thorough removal of the tubes is necessary. Yet Tait himself, according to Leith Napier, has recorded a case where, after the complete removal of ovaries, tubes, and a great part of the uterus, menstruation recurred regularly for years.

That the two processes are commonly correlated must be admitted; it is possible, as Leith Napier suggests, that they are influenced by common causes, though not by one another. The latest, and, as it seems to me, the most rational view, is that put forward by Christopher Martin, and subsequently elaborated by Leith Napier.

Arguing from analogy with numerous of the other pelvic functions which are known to be controlled by definite spinal centres, they believe that menstruation is dependent on the existence of a menstrual centre, probably situated in the lumbar enlargement of the cord. This view has much *a priori* evidence in its favour. The verification would serve to elucidate many of the anomalies of menstruation. Nerve centres, whether in brain or cord, it must be remembered, are merely areas of neural tissue, which, in the process of development and evolution, are set aside to meet the needs

of special tissues or functions as they come into play throughout life. This specialisation is, therefore, dependent upon some afferent impulse, and must proceed *pari passu* with that impulse, which in its turn must vary in intensity according to the temperament and constitution of the individual.

We find, for example, much diversity exists in infancy in the time necessary to evolve the centres which together control and produce speech, the requisite afferent impulse in this instance being an auditory one.

In like manner, provided the existence of a suitable afferent impulse can be established, might not the numerous cases now on record of precocious or delayed menstruation be explained. The very careful histological researches which have been made by many recent observers on the changes which the uterine mucosa undergoes at the time of puberty have resulted in the establishment of the presence, as a uniform accompaniment of the period, of a marked proliferation of the utricular glands. Moreover, each menstrual period is preceded by precisely the same changes in these utricular glands. Also, as we shall see when we come to discuss the phenomena of the menopause, the first indication of that change is to be found in these glands, which then begin to undergo degenerative changes. According to Leith Napier, this local change gives rise, probably by pressure on the uterine nerves, to afferent impulses, stimulates the menstrual centre and reflexly induces menstruation.

Returning from this digression, which may be pardoned on the ground that it deals with a constantly recurring, if less critical, phase in woman's life, I wish to refer briefly to some of the more important ailments liable to occur at puberty.

Of these, the various forms of anæmia met with deserve brief mention. True anæmia, *i.e.*, an actual deficiency of blood due to excessive loss, does occur, but by far the commoner form is chlorosis, associated usually with more or less amenorrhœa.

The dangers to which I wish specially to allude belong to quite a different sphere. Psychologists tell us that



puberty forms the first severe test of the mental stability of the individual. I have already referred to the group of functional derangements that for lack of more precise knowledge is designated as hysteria, which is frequently met with. Where the border line is between hysteria and insanity, it is often very difficult to say. In hysteria there is always some degree, however slight, of mental aberration, so that probably the distinction is one of quantity and not of kind. Insanity of a well-defined clinical type is of frequent occurrence at puberty.

Of it Clouston says :—

“ The immediate cause may be some irregularity in the coming on of the reproductive or menstrual function ; its real and predisposing cause is heredity, having for its object that higher physiological law, that the reproduction of the species is stopped when the inherited tendency to brain disease acquires a certain strength in any individual.”

I wish now to make a few remarks upon the attitude which we, as supervisors of the patients' bodily and mental health at this trying epoch, ought to adopt. We are not as often consulted as the seriousness of the condition would warrant, and when we are consulted we too often think only of the physical element of the case and leave out of account the mental.

The essential of treatment is rest, physical and mental. The condition of the Hindoo girl, who is for days together shut up in a dark room and fed on the simplest possible diet, is vastly more physiological and according to reason than that of very many of her more civilised sisters at this epoch. The social life of the patient should, for the time, be under our control. Late hours, extravagant indulgence in pleasures, especially of an exciting character, must be rigorously prohibited. Just as imperative, too, is the necessity for moderation in the pursuit of knowledge or of business. Already the heavy demand which the modern method of cramming makes on a girl's system has been noted as delaying the onset of menstruation, whilst in later life the many callings, literary and commercial, which the movement in favour of the “ New Woman ” has opened up,

have resulted in a very material reduction of her reproductive powers.

We come now to the last of the climacteric periods with which I purpose dealing. It is, judged by the number of ailments incident to its occurrence, also the most important. I refer to the menopause, or, as it is sometimes spoken of, the grand climacteric. This period is characterised "anatomically by the atrophic involution of the genital organs—ovaries more especially; physiologically by the cessation of the reproductive function, and pathologically by a vast number of nutritive and vaso-motor disturbances."

The period during which these phenomena occur extends, as a rule, over some two and a-half years. Before actual cessation of menstruation takes place, there is usually a longer or shorter spell of irregularity, constituting what gynæcologists term the premenopausal stage, which is spoken of in popular parlance as the "dodging" time.

The anatomical changes need not be referred to in detail; they are atrophic, constituting, in fact, the first evidences of senile decay. These anatomical changes do, however, sometimes give rise to pathological conditions, *e.g.*, where shrinkage of the cervical tissue takes place to such an extent as to produce closure of the cervical canal with subsequent production of pyo- or hydrometra.

The physiological and pathological changes are difficult to differentiate. The line of demarcation between them is a very narrow one. It is largely a question of the severity of the symptoms—a "normal" menopause being accompanied by less marked though practically the same symptoms as a pathological one.

The more important of these symptoms are, as you all know, flushings, shivers, cold clammy sweats, headaches, irritability, and great depression of spirits.

How comes it that the cessation of menstruation and ovulation should so uniformly be attended by such an ebullition of functional disorders of so pronounced a type?

The answer which first suggested itself and which constituted the natural complement of the "derivative" theory of menstruation, was what we may term the reten-

tion theory. This view may be discounted when we remember that the retention does take place under physiological conditions, *e.g.*, pregnancy, and without producing any such disorder.

Another solution which has been put forward is that the symptoms are due to the loss of the ovarian secretion normally produced; this view is based more upon analogy with other diseased conditions, known to result from extirpation or disease of certain glands, *e.g.*, myxoedema and thyroidectomy, than upon facts. I have been unable to find any account of the so-called ovarian secretion.

The latest view is that put forward by Leith Napier, and is based, in part at least, on the assumption of the presence of a menstrual centre already alluded to. He says:—

“ We are now prepared to solve the question of the definite determination of menstruation. We find that the periods cease owing to the degeneration and disappearance of the glandular tissues of the uterus, and secondarily to similar changes in the ovaries and other glands. In consequence of the removal of these factors of peripheral irritation the nerve centre—the menstrual centre above referred to—ceases to receive afferent stimulation, and after a given period, longer or shorter, ceases to functionate.” And again: “ In consequence of the loss of these nerve impulses, peripheral and central, changes which affect the vaso-motor and sympathetic nerves generally, and which determine alterations in the blood current, are brought about throughout the body.”

The vaso-motor group include such well-known symptoms as the hot flushes, the sudden alternations of heat and cold, of blush and pallor, the local and general sweatings, and probably also the headache.

That headache owns in some proportion of cases a vaso-motor origin, Lauder Brunton has determined in his own person. He was subject to attacks of megrim, and was thus led to study its etiology. He found that it was always accompanied by vaso-motor spasm of the temporal artery or of its branches, recognised by the firm whip-cord feeling which the vessel in that condition has, whilst at the same time he noticed that the opposite condition, *viz.*, dilatation

with violent pulsation, obtained in the external carotid artery from which the temporal artery has its source.

I mention this as it affords a typical example of mixed vaso-motor innervation of reflex origin, stimulation of the vaso-constrictor fibres controlling one portion of a vessel, along with stimulation of the vaso-dilator fibres in another portion—produced by one cause. In Brunton's case it was found to be a decayed tooth.

Mixed reflex neuroses of the vascular system originate then from very various and sometimes very trivial sources. That we should meet with such a variety at the menopause is scarcely to be wondered at when one remembers the number of nerve structures, peripheral and central, involved.

In conclusion, I have attempted to lay before you in a very general fashion the main outlines of the changes which occur at three of the chief mile-stones in the highway of life.

That the best of these has been treated with but scant courtesy and attention, I am well aware. Its adequate consideration would necessitate a separate paper, and is a task more suited to the veterans amongst us than to the recruit.

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 (ii.) CLOUSTON on "Mental Diseases;" (iii.) LEITH NAPIER on "The Menopause."

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Dr. MEEK expressed his regret that so little had been said in the paper on the subject of menstruation, and referred to the view in which its causation is put down to contraction of the non-stripped muscle fibres in the cervical region, which leads to engorgement of the blood-vessels with subsequent rupture and exfoliation.

Dr. HAWKES, after alluding to the importance of establishing accurate diagnoses at the period of dentition, went on to discuss some of the more important features of the grand climacteric, including premature and delayed menopause, and remarked that from comparison with his earlier experience, he thought that the menopause occurred later in life now than formerly.

Dr. CAPPEE, commenting on the gastro-intestinal derangements of infancy, said that no harm followed the sudden cessation of diarrhoea, provided that this was effected by means of the suitably indicated drug and not by astringents.

Dr. J. W. HAYWARD remarked on the frequency with which aural disease at the period of dentition occurs. He also emphasized the importance in treating irregularities of the menstrual function, of taking into consideration the mental impressions produced in a patient by her social habits and surroundings.

Dr. MOIR instanced several cases of early dentition. Referring to the time of the onset of puberty, he pointed out the need of reform in the prevailing educational system; whenever symptoms, such as breathlessness and lassitude, began to show themselves at that critical epoch, he found it wise to order the patient's removal from school, and to insist on her leading so far as possible an out-of-door life.

Dr. J. D. HAYWARD (from the chair), entered a protest against the view adopted in the paper of such purely physiological processes being regarded as in any sense "critical." He pointed out the liability which exists of women at the change of life acquiring the liquor habit and the consequent increased responsibility which the medical attendant who orders stimulants at that period thereby incurs.

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## MODERN ASPECTS OF PERITONITIS, MEDICAL AND SURGICAL.<sup>1</sup>

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AND

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MR. PRESIDENT AND GENTLEMEN,—You will remember how Carlyle, in his famous essay "Signs of The Times," delivers judgment on the leading characteristics of the age. He calls this a mechanical age. Much, however, has

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, January 5, 1899. This paper was illustrated by microscopic preparations, tube cultures, lantern slides and diagrams.

happened since then ; and were a review now taken of the century's progress, the warrant of the time to be styled the age of biological discovery would be very strong. Including the epoch-making hypothesis which filiates all animal organisms, present and past, and including the discovery of the invisible world of spores and germs, the advances have been such as to revolutionise modern industry and modern life. From the latter discovery, indeed, there directly springs what we have to say of peritonitis ; for as a working hypothesis, the germ theory inter-penetrates every division of peritonitis, making luminous its pathology, giving coherence to its clinical course, and, most important of all, conditioning our procedure in the daily effective fight against disease and death.

**Definition of Peritonitis.** For the purposes of this paper, the only definition with which we are concerned is the clinical one. We use the term Peritonitis to signify not a constant pathological process, but to denote that body of symptoms and signs which collectively constitute this clinical condition. These symptoms and signs are primary, as arising from the morbid condition of the peritoneum itself ; and secondary, as manifested in the constitutional disturbances evoked by the peritoneal *materies morbi*.

#### VARIETIES OF PERITONITIS.

Given, then, the occurrence of a well-marked clinical case of peritonitis, what is the pathological process evoking the symptoms and physical signs ?

Now, the view formerly taught, and still commonly held, is that peritonitis is due to an inflammation of the peritoneum, in the same way as pleurisy is due to inflammation of the pleura, or meningitis to inflammation of the cerebral meninges. But the exact pathological work of recent years disposes of this crude view ; it demonstrates that in many of the most severe cases of peritonitis there is very little inflammation of the peritoneal membrane to be made out, —sometimes, indeed, none at all.

Here we may cite cases in point :—

“ A woman of 62,” says a well known-authority, “ came into hospital with a femoral hernia which had been strangulated four days. Herniotomy was at once performed; the purple-coloured gut was reduced. . . The day after, the patient vomited with little cessation, her abdomen became swollen and painful, her pulse failed, and her strength reduced. On the morning of the third day she died. Throughout the temperature had never risen as high as 99°. The autopsy revealed an operation without a flaw and an abdominal cavity showing no morbid change other than a faint congestion and a fainter dulling of the lower districts of the peritoneum.”

Take another case.

Some time ago we met Dr. Dudgeon in consultation over a case of peritonitis which had eventuated from a condition of intestinal obstruction. It was desired to know the part the pelvic organs played in the morbid state. Operation being declined, the patient died, with the symptoms of septic peritonitis.

*Post-mortem* showed a peritoneum with *no signs of inflammation*, but with change in a limited part of the small intestine, this being purple in tint. A slight fæcal extravasation had occurred in one place.

Malcolm cites the following case :—

A woman, aged 44, after abdominal operation, commenced with vomiting and abdominal distension. There was a high temperature and pulse. The patient died in two days. *Post-mortem* : a coil of small intestine was found adherent to a very small raw surface of the broad ligament. The intestine was immensely distended above, and quite collapsed below. *No sign of peritonitis was found after death.*

**The Septic Type of Peritonitis.** What, then, is the interpretation of these cases of peritonitis, cases with little or no acute inflammatory changes in the peritoneum ? Briefly, that the state is that of acute and overwhelming septic poisoning, starting from the peritoneum in the first place, evoking the symptoms of peritoneal irritation, *but where the reaction of inflammation is absent*, this being inhibited by the general septic catastrophe that affects the whole body. This is the first clinical variety of peritonitis—the septic form.

Now in broad contradistinction to this there stands out another clinical type of peritonitis, where the clinical course and the pathological process are in marked contrast to the foregoing.

Again we will set forth the facts by the narration of cases.

A woman, aged 32, was admitted into hospital with obvious abdominal trouble. Abdominal section being performed, the evidences of peritonitis were considerable: intestines, omentum and mesentery were involved in a confused mass. The cause was pelvic suppuration, shut off from the general peritoneal cavity by the inflammatory reaction.

Again, in a case of acute peritonitis, there were present great abdominal distension, pyrexia, and pain. Operation being performed, a necrosing cyst was found and removed. The whole peritoneal cavity was a mass of inflammatory adhesions. The patient recovered.

**The  
Inflammatory  
Type of  
Peritonitis.**

These cases, equally well marked as instances of peritonitis from the clinical standpoint, differ in some important elements from those of the first category. These latter cases recovered; the former all died; the cases last cited, moreover, showed a well marked and sustained temperature curve of pyrexia as well as a parallel rise in pulse rate.

Further, the type is that which is usual in peritonitis originating in areas of the peritoneum not usually occupied by the small intestine. This is the second clinical variety of peritonitis—the *inflammatory form*.

Besides these well differentiated types, a *tertium quid* is sometimes seen, where the inflammatory form of peritonitis, after a lapse of time, definitely takes on the septic character with its strongly marked symptoms. Of such an issue the following is a specimen case:

A patient, the victim of recent abdominal traumatism, showed in twenty-four hours undoubted symptoms of sepsis, to which she soon succumbed. *Post-mortem* showed acute purulent peritonitis in the area of the injury; the contiguous gut was congested and distended, the duodenum had been ruptured, and its contents were leaking into the peritoneal cavity.



**The Common Factor in Types of Peritonitis.** Now under one of these two heads (a) mainly septic, (b) mainly inflammatory, every variety, every case of acute peritonitis comes; whether puerperal or tubercular, traumatic or malignant, or any other sort or kind. What is then the underlying element, the common factor, which is included in each and every case of peritonitis? We have seen that it is not necessarily inflammation, for many of the most furious, the foudroyant cases, occur with little inflammatory change, or none at all. What then is the common bond, present in every case, and to whose elimination the forces of nature and the art of man are directed? It is *the element of germ infection.*

*The Rôle of Bacteria and Micrococci in Peritonitis.*

**The Bacterium Coli Commune.** Only within the last twenty years has the causative part played in peritonitis by bacteria and micrococci been brought to the light of day. First and foremost of these invisible foes comes the *bacterium coli commune*. This is an organism normal to the human intestine, in which it flourishes in countless myriads.

In states of health its wanderings are limited by the barrier of a sound intestinal wall. But if the vitality of the intestine becomes impaired by strangulation, or traumatism in operation, or the irritation of abnormal fluids, such as urine or pus, &c., under such and similar circumstances two marked changes occur. The lowered vitality of the intestinal wall allows these bacteria to enter the tissues, and they then pour into the peritoneum literally in hordes and swarms. The other change is that the bacterium coli commune in thus migrating becomes enormously increased in virulence, and engenders secretions so acrid and poisonous that in a few hours or days the patient dies, a victim to the absorption into the circulation of the poisonous secretions from the escaped and now virulent bacterium coli commune.

**The Initial Factor in Sepsis.** It may be asked "How do we know that this is the true sequence of events? and that the escape of the bacteria really causes peritonitis?"

Is peritonitis actually present because of the bacilli, or do the bacteria merely follow, in a casual way, the peritonitis?" Now a recent authority supplies experimental proof.<sup>1</sup> The effect, says he, of injecting a culture of the virulent colon bacillus into the peritoneum varies, other things being equal, according to the dose. In the slightest cases, the animal, after an illness in which diarrhœa is a symptom, recovers. In another grade, a localised purulent peritonitis is produced which follows a chronic course. In a third degree, death is rapidly brought about by a diffuse fibro-purulent peritonitis. In instances where a large dose is employed, the animal dies of acute sepsis before any phenomena of peritonitis are produced.

"So far as the human subject is concerned it has been shown that the various forms of peritonitis which are assumed to be of intestinal origin, depend mainly, and in many instances solely on the bacterium coli commune."

**Streptococcus Pyogenes, &c.** In this kind of murderous work the colon bacillus finds several congeners. The *streptococcus pyogenes* is another micro-organism, which is responsible for puerperal peritonitis as well as for the peritonitis that follows operation. The streptococcus and the colon bacillus are, singly or together, the causes of nearly all the rapidly fatal forms of peritonitis.

The *staphylococcus*, the *pneumococcus*, the *gonococcus*, and the *tubercle bacillus*, each of these induces a special form of peritonitis marked by various combinations of clinical symptoms, and all these micro-organisms act in a similar manner in the engendering of the symptoms of peritonitis.

**The Course of Bacterial Sepsis.** When bacteria and pyogenic cocci obtain entrance into the peritoneal sac, the surrounding conditions are most favourable for their indefinite development; unless hindered, they increase and multiply with amazing rapidity, their poisonous secretions are caught up by the lymph stream, swept into the general circulation, and there kill by general paralysis of the sympathetic system, the cardiac ganglia suffering most considerably.

<sup>1</sup> Treves, "On Peritonitis."

This is how rapid peritonitis kills: by septicæmia or blood-poisoning. But as many cases of peritonitis recover, what are the measures which Nature employs to limit the wholesale reproduction of the extruded bacilli, and to head off the flow of their toxic secretions into the circulation? The measure which Nature employs is inflammation; the weapon with which she fights bacteria in the serous sac is the inflammatory process; the exudation and the adhesions are the contrivances for suppression which Nature uses in the conflict.

**The Protective Mechanism of Nature.** This view—a view warranted alike by clinical observation and pathological research—this view, we say, puts a new and a true interpretation on the appearance of the inflammatory process in peritonitis. Here is the view of one of the surgical leaders of the day:—"Peritoneal inflammation," says he, "is not a purposeless calamity; that which has caused it is the thing which is wholly ill. It is by the process of inflammation that the advance of certain deadly contents which have gained access to the body can be arrested. The purpose of inflammation in peritonitis is toward the saving of life, and not the destruction of it. What is seen within the abdomen, at autopsy, in a case of peritonitis, represents the results on the part of the organism to avert the cause of death."

**How Inflammation Limits Sepsis.** What, then, is the *modus operandi* of the inflammatory process in limiting the germ infection of the peritoneum, and preventing the absorption of the poisonous secretions into the body? When germ infection, to a limited degree and of a moderate virulence, invades the peritoneum it acts as an irritant to the peritoneal area at fault; and the inflammatory process ensues. By exudation the serous surface is coated, and septic absorption is thus hindered. By the adhesion of contiguous surfaces the area of septic irritation is hedged in, localised, circumscribed by an exudation barrier, and, by phagocytosis, the bacteria which have actually found their way into the serous cavity are disposed of.

This is a general sketch of the process ; various modifications clinically occur. If the bacterial infection be of a very virulent type, inflammatory reaction is paralysed : it does not occur ; and thus lacking the defence and the circumscription of the inflammatory process, the patient dies a swift death from sepsis. This is seen in those cases of peritonitis where a lethal issue occurs, with very little or no obvious change in the peritoneum. Or if the tissues are unhealthy, as in Bright's disease or rheumatism, the inflammatory reaction is out of all proportion to the infective cause ; it may overrun the mark, and become widespread, the unhealthy tissues offering no resistance ; and thus what should have been a protective and limited process becomes a widespread and substantive lesion, a dangerous condition in itself. Such cases are not uncommon, where, after an illness of days or weeks, universal inflammatory peritonitis is demonstrated *post mortem*. The cause has been infection, but the natural limit of the inflammatory process—healthy tissue resistance—has been wanting.

Or again, while the inflammatory process is efficient in circumscribing the lesion, it may reach so high a grade as to cause the formation of pus. Bacteria are prevented from overrunning the peritoneum by the limiting exudation barrier, but they are all active within this limit. Pus is formed, and adds its clinical symptoms to those of the peritonitis preceding. This issue is seen in many cases of appendicitis, in pelvic abscess, in tubercle, and elsewhere.

For a favourable issue in a case of peritonitis we require initial germ infection of only a moderate degree of virulence ; tissues that present a fair degree of resistance to the pathological processes in peritonitis ; an absence of severe shock, such as occurs in visceral rupture or perforation, or similar traumatism ; an effective hedging in by inflammatory exudation of the whole area of septic invasion ; and finally, the complete subsidence or elimination of the primary lesion that induced the peritonitis.

No issue short of this, if it leave damaged tissue ready to initiate the whole process over again, can be deemed wholly satisfactory.

*Peritonitis as a Complication of Constitutional Disease.*

**Peritonitis in Acute Specific Fevers.** As a concomitant of, or a sequel to the acute specific fevers, peritonitis has been actually if rarely observed. In measles, or small pox, or typhus, or relapsing fever, acute peritonitis rarely occurs. In scarlet fever it is only very occasionally seen. In enteric fever it is more common; and it is said to be one among the multiple evils which attend influenza.

Now the very exceptional occurrence of peritonitis, in the acute specific fevers, clearly indicates that it is not the virus of the disease alone—its specific infective germ—which evokes the peritonitis. What are the added conditions, then, in the abdominal viscera, which during any of these fevers actually evoke the peritonitic complication?

Sir W. Jenner records a case of typhus, complicated by peritonitis; we have verified the original account; the peritonitis was due to the rupture of a splenic infarct, secondary to endocarditis. In Clifford Allbutt's "System," peritonitis in relapsing fevers is attributed either to the same cause, or to dysentery. Still more definite are the statements in this authority on small pox: "Peritonitis, in this lesion, occurs in rare cases. I have seen extensive peritonitis in two cases after abortion; and in another, it was limited to the left hypochondrium and epigastrium where the spleen was studded with large emboli." "Again, in enteric fever the peritonitis may be due to perforation, or to rupture of a diseased gland, or to infection from an ulcerous patch."

These may be taken as types of the cause of peritonitis in the acute specific fevers. These latter have no direct impact on the peritoneum, but induce lesions which from their situation and character are fully competent to provoke peritonitis.

**Peritonitis as Complicating Nephritis.** Peritonitis is stated to occur in 10-12 per cent. of cases of Bright's disease. What is the cause of its appearance in this lesion?

There is no directly pathological proof that peritonitis is here induced by the toxæmia. Rather, considering the relative infrequency of peritonitis in chronic nephritis, is

the bulk of the facts against this view. The plain truth is that the immediate cause of the onset of peritonitis in Bright's disease has not been worked out. Three alternative courses are open to the imaginative but idle clinician. "The primary irritant," says the latest authority, "is *assumed* to be some toxic material derived from the products of tissue waste which the diseased kidneys fail to eliminate, and this may be *supposed* to cause a simple peritonitis in the first instance which in time, as organisms invade the serous cavity from the intestines, becomes purulent." Next, "since affection of the intestinal mucous membrane, even to the extent of ulceration, is known to occur in the course of Bright's disease, the peritonitis may be really infective from the first." Finally, "extension from the pleura and pericardium may explain some cases." And here we will leave the subject; merely noting that while certainty is here so uncertain, it is unwise, unscientific, to attribute to circulatory fluids an inflammatory irritability, which it is not proved they possess; and that the worked out observations which have made the pathology of other forms of peritonitis lucid, may yet cover the pathology of nephritic peritonitis.

**Peritonitis  
as Complicating  
Acute  
Rheumatism.** Acute rheumatism is of all constitutional diseases characterised by special stress on serous membrane. Yet peritonitis, as a complication of rheumatic fever, is of exceeding rarity. "No explanation," says the authority previously quoted, "at present is forthcoming for this remarkable freedom of the peritoneum."

Yet recorded cases have accumulated in literature, sufficient to indicate acute peritonitis as a possible complication of acute rheumatism. No genetic connection, however, has been pathologically worked out between one and the other. No bacteriological examination of the effusion has been recorded. But, says the same oracle, the obvious characters of the fluid suggest the presence of micro-organisms, the source of which remains for the present a matter of conjecture. Here then we will leave this inquiry awaiting further work; merely premising that as

the characters of the fluid suggest the presence of germs, the presence of germs connotes their entrance into the serous sac by some pathological route. The infrequent occurrence of the complication may well raise grave doubts whether acute rheumatism, unaided and alone, can induce acute peritonitis. The presence of germs in the serous sac being conceded, it remains to work out—not to guess—the antecedent morbid conditions which determined their translation.

The truest conception of "idiopathic peritonitis" is gained by applying the criterion of history, and history shows us the area of acute primary peritonitis as in continual shrinkage. Fifty years back idiopathic or acute primary peritonitis embraced the majority of cases of peritoneal inflammation, especially those which recovered; but year by year the circle of idiopathic peritonitis has been narrowed, until now it includes only a small group of cases, for which, in the present state of knowledge, no antecedent extra-peritoneal lesion has been found.

A comprehensive view of the problem is of more importance than an analysis of individual cases.

In these so-called idiopathic instances there is the fact that the organic lesion is that of peritonitis alone; no other part of the body being concurrently involved. There is the fact that usually the onset is definite, the symptoms acute, the clinical course that of the septic form. There is the fact that in contra-distinction to the limited area of the morbid process, and the definite character of the clinical course, the ascribed causes are vague, unusual, and apparently inadequate. A "chill" or a "fœtid smell," or the hurried swallowing of iced water, these are specimens of what is assigned as the causative factor.

Now if chill, or smell, or swallowing of iced water were competent to bring about uncomplicated septic peritonitis, the latter would be as common an issue as sore throat or gastralgia or pleurisy. The extreme rarity of peritonitis as a sole sequence after chill, &c., plainly indicates that in the vast majority of cases such causes are inadequate to produce

the result ; some unknown or unobserved factor really being the determining agent. The difficulty has arisen from the tendency to hastily ascribe causes without taking measures to verify the potency of these. All that can accurately be said is that a certain small number of cases occur where the primary pathological change in peritonitis has not been discovered ; or has been obscured, leaving no definite trace, in the inflammatory turmoil that accompanies an acute case.

Further, it is held by some authorities that many so-called idiopathic cases are really cases of early or localised tubercle. Here is a case in point :—

A short time ago we were asked by Dr. Madden to see with him a young lady, the subject of a recent attack of subacute peritonitis. The cause was difficult to find, and, mainly by a process of exclusion, we arrived at the opinion that tubercle was the most probable cause of the outbreak. Within the next few weeks a sharp attack of dry pleurisy, followed by marked symptoms of meningeal involvement, attested the accuracy of our conclusion.

We ally ourselves with the view expressed by that great clinician, Sir Wm. Gairdner, who insists that the primary cause of peritonitis, its precedent condition, must always be sought for.

Dr. Habershon is similarly emphatic : “ Although peritonitis,” says he, “ is spoken of and treated as an idiopathic disease, we do not find that it is so ; it is excited by injury to the serous membrane, or by the direct propagation of disease.”

Finally, as illustrating a favourite theorem of ours that problems are usually more complex than appears on the surface, we will cite the following :—“ Dr. Hawkins, in certain cases of so-called idiopathic peritonitis, made microscopic sections of the appendix, which to the naked eye appeared quite normal. The microscope, however, in the cases examined, revealed minute abscesses in its structure ; one of them, by bursting into the peritoneal cavity, might set up a peritonitis, apparently ‘ idiopathic.’ ”

**Peritonitis due to some prior lesion.** We hold, if not absolutely proven, at least as the only safe working hypothesis,



that peritonitis is the outcome of some prior lesion, for the most part local and abdominal. This view has a wide and far-reaching influence on practice, and directly explains the phenomena of recurrence. Many cases of peritonitis show a decided tendency to recur. An organ, say the appendix or the Fallopian tube, or a tissue, for instance a lymphatic gland, becomes inflamed. The peritoneum contiguous is tainted by the inflammation; the degree of the peritonitis is conditioned by the virulence of the inflaming cause. Local inflammatory peritonitis is set up; the bacterial irruption is ultimately neutralised; the peritonitis quiets down. What of the primary cause? If this also, in the inflammatory turmoil, has disappeared, if the ulcer has been healed, or the irritating fluid absorbed, or the abscess evacuated, well and good, there need be no recurrence. But (and this is usual) if the inflamed organ or tissue continues in a state of physiological damage, then the diseased Fallopian tube, or the catarrhal appendix, or the enlarged lymphatic gland, still remain a diseased nucleus, and further spoiled by the inflammatory storm they have excited. This diseased nucleus often persists, in a state of quiescence, after the inflammatory exudation has been absorbed. And now there may be made out, often for the first time, the organ or tissue which has evoked the peritoneal crisis. Such quiescence, however, is not stable, sooner or later there is a recrudescence of irritation, and peritonitis is again induced, which may again subside; or on the other hand, any of these recurring attacks may prove irreducible by therapeutics, or fatal from sepsis. It cannot be too strongly emphasized that recurring peritonitis means a persistence of the prime disease; that a patient walks as on a precipice who is the victim of repeated peritoneal seizures, for renewed attacks, however slight, do not bring any immunity from an ultimate fatal termination.

To sum up, in regarding peritonitis from the point of view of associated clinical conditions, the facts all indicate that primary acute peritonitis, inflammation of the peritoneal membrane alone, does not exist; that peritonitis is always secondary to some extra-peritoneal lesion of organ

or tissue; and that the primary cause of peritonitis, its inducing condition, must always be allowed for. It must be allowed for even though it often is not to be demonstrated until the subsidence of the exudation reveal the diseased nucleus, or the persistence of the symptoms, as in tubercle, indicate its character.

### *The Symptomatology of Peritonitis.*

**The Predominance of Sepsis, or of Inflammation.** In the introduction to this paper we drew attention to one factor—that of bacteriology—which had revolutionised our conception of peritonitis, and which was the underlying element in the new facts and new views now forcing their way to the front. Now, in the interpretation of the symptoms to-day, bacterial facts play a most important rôle; and as in the pathology, so also in the clinical symptoms we find the chief plane of cleavage to be between septic peritonitis and inflammatory peritonitis. In all cases, however induced, from whatever extra-peritoneal source arising, the first clinical question to be settled is—are septic symptoms or are inflammatory symptoms here predominant?

Now, as the signs and symptoms of peritonitis in general are distributed through both these sub-orders, we will place side by side the clinical features of each for contrast.

**Septic Symptoms in Peritonitis.** A patient in the throes of septic peritonitis has a *tout ensemble* that is unmistakable.

The temperature oscillates irregularly about the normal, and, as the disease progresses, often tends to fall rather than to rise. Not so the pulse: the characteristic, never-absent, invariable quality of the pulse is that of continuous increase in frequency. Combined with it is a continuous lessening in force; the pulse is soft, small, most easily compressed, and, finally, irregular. It is not wiry in any sense of the word.

Vomiting, occasional at first, is incessant as the case progresses, and the material ejected is green in tint and acid in character, finally becoming coffee-ground from

admixture with blood. The ejecta commonly possess no peculiar odour. The intestine usually is paralysed; neither flatus nor fæces pass; peristalsis is completely arrested. In some uncommon cases diarrhoea is present; there is then a constant discharge, almost involuntary, of intestinal fluid.

The abdomen is uniformly distended; the expansion sometimes becomes huge, and now and again a metallic tinkle may be heard over the colon—sure sign of paralysed bowel.

The pain is often inconsiderable; it is never a predominant factor; it is often localised as backache; there is no *very marked* tenderness of the parietes to contact or pressure.

Sleeplessness and restlessness are most marked, and persist to the end; and as the fatal termination approaches, the pupils become dilated, the tongue dry, the extremities icily cold, the face bedewed with perspiration. A fatal issue ensues usually in three or four days after the distinct accession of septic symptoms. We have known septic peritonitis to kill in thirty-six hours; it rarely continues for over a week.

This, then, is the form of peritonitis that kills in perforation of the appendix, or from septic infection during operation, or in strangulated hernia, or in the rapid forms of puerperal fever, &c

Now turn your attention to an instance  
**Inflammatory**  
**Symptoms in** where inflammatory peritonitis is in the  
**Peritonitis.** ascendant.

Rarely the attack commences with a rigor; but severe pain and a swift rise in temperature are the usual initial symptoms.

The pain is often agonising, is constant, and the parietes are sensitive to the slightest touch. In the early stage, the abdomen may be flat and boardlike, but very soon a certain degree of intestinal paralysis causes distension, which is seldom considerable.

The temperature goes up with a bound, and follows a definite curve, within fixed maxima and minima.

The pulse also rises, usually to 120 per minute, seldom

over; it is regular, and uniform; and throughout the illness a strict parallelism is maintained between this and the temperature. Constipation is present; usually amenable to enemata.

Vomiting may be present at first, but soon subsides; possibly recurring ever and again, but neither persistent nor progressive.

This is the type of peritonitis in appendicitis ending in recovery; or in pelvic peritonitis, or in the more protracted puerperal form, or in the earlier tubercular outbreaks.

These then are the differential character and course of septic and inflammatory peritonitis respectively. How shall we readily differentiate at the bedside, at any stage, between the septic form and the inflammatory form without loss of time?

**Criteria of Septic or of Inflammatory Predominance.** There are three criteria, which, taken together, allow an unerring judgement to be formed. The first is the pulse curve.

**The Pulse Curve.** Immediately on the onset of septic peritonitis, the pulse runs up to 120 per minute, mounting to 130 or 140 within thirty-six hours; and continues to rise to 150 or 160 within the next twenty-four hours, after becoming uncountable. Now this continuous rise in the pulse rate, from 120 per minute mounting up to an uncountable condition, is present in every case of septic peritonitis without exception; it normally reaches an uncountable state within three days. The pulse, therefore, offers an unailing test of the existence of septic peritonitis. It matters not how high the temperature, how acute the pain, how swollen the abdomen, or how troublesome the vomiting. If the patient does not possess this ceaseless and rapidly increasing heart hurry, the peritonitis is not septic.

In inflammatory peritonitis, on the other hand, the pulse rises also at the onset to about 120, but its course is not persistently upward. It oscillates about 120 per minute, now a little more, now a little less; but soon returns to this average.

This condition of pulse is a cardinal sign in distinguishing between the septic and the inflammatory conditions.

The next important sign is the lack of parallelism between the pulse curve and the temperature curve.

**Parallelism of Pulse and Temperature Curves.** Usually the time of onset of the septic poisoning is indicated, not only by a rise in the pulse, but by a very decided fall in the temperature. After this the curves of pulse and temperature are no longer parallel. In the most marked septic cases, indeed, the temperature oscillates about the normal, while the pulse is mounting by leaps and bounds.

Conversely, inflammatory peritonitis shows a remarkable and striking parallelism between the rise and fall of the temperature and the rise and fall of the pulse. There is no disparity in their movements, and complications, such as hæmorrhage or concurrent disease elsewhere, apart, this parallel movement is maintained all through.

**Vomiting as a Criterion.** The final criterion, almost though not quite as constant, is vomiting. Given the absence of sudden mechanical obstruction, such as strangulation or volvulus, vomiting marks the irritation of sepsis, becoming more constant and more frequent, until finally it is practically perpetual. The ejecta are green in tint and acid in character; as the lethal exit nears, the appearance becomes coffee coloured. Now vomiting is present sooner or later, in a well marked degree, in every case of sepsis; it may, with the pulse rise, herald the septic symptoms, or it may show itself when these are well under way, or it may be deferred until the end is within sight; but every case of septic infection has vomiting in its history, and once initiated, it never drops out, but persists to the bitter end. In inflammatory peritonitis the vomiting is infrequent, fitful, not progressive, often almost, or quite, wanting.

Now these three clinical points, the character of the pulse rise, the dissimilar pulse and temperature curves, and the presence of progressive vomiting, taken together and in combination, are pathognomonic of the septic form of peritonitis. This triad is in such cases invariably present; and in no other. But to base a positive diagnosis of septic peritonitis on any one or any two of these symptoms would be to court failure.

**The Paramount Importance of the Pulse Curve.** We lay down the canon definitely that in every case of peritonitis, the pulse curve is more necessary to study and register than the temperature curve. When, some twelve years ago, we began our original work in this subject, we started with the text-book notion that the temperature was the measure of peritonitis. After watching many cases go steadily to the bad, where the temperature was scarcely over 100, or 101 as a single occurrence, it became obvious that in the temperature we had no constant equivalent of what was transpiring within. Our next search was among the urinary constituents for an early constant sign of the occurrence of septic peritonitis. Many quantitative analyses were made, and much midnight oil expended, in the endeavour to obtain diagnostic indications of the occurrence and progress of the disease. Finally, in the pulse characters already set forth we found the earliest and most constant sign of the existence of the septic element in peritonitis.

#### *Prognosis.*

Acute peritonitis invariably gives cause for grave anxiety. Of one hundred consecutive cases of this lesion, at the London Hospital, no less than seventy died.

The immediate prognosis of peritonitis resolves itself into the prognosis respectively of the septic symptoms and of the inflammatory symptoms.

**Prognosis in the Septic Type.** Now when septic symptoms predominate the case nearly always terminates fatally. The recoveries are as rare as those from advanced cancer. Here is Lawson Tait's experience: "Septic peritonitis once completely established is a practically incurable disease, and almost uniformly fatal."

The cases which recover, then, are practically those where the immediate risk of sepsis has been effectively headed off by the inflammatory reaction. Where this neutralisation occurs it occurs early, for it is only sepsis in the localised and early stage that inflammatory reaction can subdue. Well marked septic symptoms usually kill in four days; they may, in special cases, drag on for a week or more.

Peritonitis where inflammatory symptoms predominate is characterised by numerous and definite risks. The inflammation may ruin the recuperative power of a feeble patient, and death thus ensue. Infancy and old age are thus especially liable to succumb to peritonitis. So also are those cases where collateral disease is present, *e.g.*, chronic Bright's disease or pleurisy. Here may be noticed the especial liability in acute peritonitis to lung complications. Of the hundred cases at the London Hospital seventeen had well marked pleurisy or pneumonia. Death may also ensue from the persistence of an acute state of suppuration, as in the later stages of peritoneal tubercle.

Having safely weathered the storm of the immediate onslaught of peritonitis, the remote issues are not without their lethal risks. Localised pus collections, unless properly treated, may readily leak into the unprotected peritoneum, and fatal sepsis be set up as a late issue; or, as in many cases of appendicitis, or suppurating Fallopian tube, the diseased nucleus persists, after the peritoneal storm has quieted down, and may any day induce another and a lethal seizure. We have seen a case of peritonitis, devoid of acute symptoms, suddenly become septic and die from the injudicious administration of a purgative. Once more, base your immediate prognosis of recent acute peritonitis on the state of the pulse.

A distinguished West-end colleague asked us to meet him over a case of peritonitis which had been existent only some two or three days. There was some sickness, some distension, a temperature of 102°, but more ominous than all combined, a rising pulse, already over 130 per minute. Our prognosis was of the gravest character, and, in fact, the patient died within forty-eight hours.

In the Later Stages of the Inflammatory Type. In the later stages, several factors have to be balanced: the recuperative powers of the organism, the presence of complications, the greater or less area of peritoneum involved, the persistence of a high temperature, &c. All these and other

factors must be duly balanced, and no special import attached to any single one.

Thus, in a case of puerperal peritonitis, seen with Dr. Johnstone, of Maidstone, various factors came for consideration. The inflammation was restricted to the pelvic area; no complication (suppuration, &c.) was known to exist; but the temperature maxima had been high for some time, and the illness prolonged. The pulse was not indicative of sepsis. A favourable prognosis was given, and entirely verified in the issue.

### *Treatment.*

The foregoing will have been written in vain unless it is obvious that the dividing line which separates septic from inflammatory in clinical type, in pathology, in symptomatology, and in prognosis, sweeps through treatment also. To this, indeed, all our previous considerations point, for the antecedent detail is useless unless it definitely culminates in treatment.

#### (1) *The Treatment of the Septic State.*

**Therapeutics of Septic Invasion.** Having determined that, in a given case, the symptoms are septic, what is the appropriate treatment? Among internal therapeutics there come  
Crotalus,  
Lachesis,  
Rhus.

These are addressed to the elimination of the septic symptoms. It is perfectly useless—the error has cost many a valuable life—it is quite useless to approach a case of septic peritonitis with the remedies that are specially adapted for states where inflammation is paramount. It is the septic element in these cases that kills; it kills by heart failure, the septic intoxication affecting the whole sympathetic system, but having its chief incidence on the vasomotor ganglia.

The serpent poisons are specifically homœopathic to this septic poisoning, crotalus and lachesis in particular; and



our firm belief is that the success of these remedies is bound up with their administration in low potencies, and preferably by hypodermic injection.

The ordinary heart-muscle tonics—arsenic, strophanthus, digitalis—appear to be quite useless in contending with the powerful depressant influence of these bacterial toxins on the cardiac ganglia.

Anti-streptococcus serum has been reported as of service in some cases of septic poisoning of puerperal origin.

**Accessory Treatment of Septic Invasion.** Accessory measures are of limited range. The free use of *alcohol* is commonly resorted to, with no direct ascribable benefit.

*Purgation* has been recommended, but this is apparently based on an entire mis-reading of the directions of Mr. Tait, who advises aperients for pseudo-ileus only, and energetically repudiates any responsibility for their use in sepsis.

*External applications* are useful in the inflammatory form, but find no vogue in the septic type.

*Washing out the stomach* by means of the stomach tube, for the mitigation of the constant vomiting, comes to us advocated by a German authority. We have tried this plan, and have been wholly dissatisfied with its result.

**Surgical Measures in Septic Invasion.** These, properly applied, have in some cases proved of paramount value. The old plan, of *merely* washing out the peritoneal cavity, is worse than useless; it is scarcely by itself even a half-measure. Lockwood, in 1894, first adopted the plan of making a small opening in the distended intestine and generally evacuating the flatus, as well as the unusually toxic intestinal fluids which supplied the bacteria now freely permeating the intestinal walls. His procedure, in some desperate cases, was successful; and it has been repeated, with similar success, by Treves. We strongly urge the adoption of this measure, by skilled hands, in cases obviously losing ground; and with this, peritoneal lavage may advantageously be combined. We record our opinion that no patient with septic peritonitis should be allowed to go down to the gates of death without an

earnest endeavour to neutralise, in this way, the *fons et origo mali*.

But before this surgical measure be carried out, it is highly desirable to instil into the venous circulation some quantity of normal saline solution, the "artificial serum" of French authors. Transfusion into the basilic or cephalic vein is easily carried out. Oxygen inhalation, freely administered, may be mentioned as an important accessory.

Before leaving this section we must clearly state that all measures, medical or surgical, are entirely nugatory if any gross lesion inducing septic symptoms still remains. Decomposing placenta, or strangulated hernia, or ovarian cyst, or twisted bowel, or ruptured viscus—these, when present, stand head and front among the conditions requiring urgent attention.

## (2) *The Treatment of Inflammatory Symptoms.*

**Therapeutics of the Inflammatory Lesion.** When it is determined that the symptoms are mainly inflammatory, there are various remedies that are in the very fore-front of efficacious measures:—

Belladonna.

Mercurius cor.

Bryonia.

Colocynth.

Terebinthina.

Veratrum viride.

These remedies, selected according to the special indications of the case, will admirably control in most instances the inflammatory process as affecting the peritoneum.

Few things in medical practice are more satisfactory than to watch the subsidence of the acute stage, and the neutralisation of the stress of the attack, under the action of such of these remedies as are germane to the symptom.

**Accessory Measures for Inflammatory Symptoms.** The bowels should be opened by enemata only. We have known the injudicious administration of a purgative to seriously endanger life.

### *External Applications.*

We can highly commend the external application of glycerole of belladonna to the abdomen, particularly where the peritonitis is localised. Our method is as follows: Over a wide surface of the abdomen paint the glycerole freely: upon this lay a single fold of lint, and well cover the lint with a layer of waterproof. This dressing remains *in situ*; and hot moist fomentations can be continuously applied, over the waterproof, to the abdomen, renewed as often as desirable. The belladonna application, with its protective coverings, is renewed every 24 hours.

### *The Ice-Bag.*

This is a form of local application much valued and frequently used on the Continent, both for the prevention of threatened peritonitis and for the control of the inflammatory symptoms when developed.

Fill a wide-mouthed ice-bag or bladder one-third full of ice broken into lumps not larger than a small walnut. After the ice is inserted, press the air out of the bag, and secure the neck firmly. Dry the exterior of the ice-bag; place over the skin a double fold of flannel, and on this rest the bag. One or two turns of a bandage will keep it in position.

Renew the ice when it is melted, taking care always to dry the exterior of the bag. In this way the ice-bag may be applied for several consecutive periods of six hours each; between each application an interval of one hour should elapse.

We have seen the ice-bag act admirably in suppurative peritonitis, limiting the area of affection and controlling the lesion very satisfactorily. And in imminent peritonitis during typhoid, we have employed it with signal success.

The sequelæ of peritonitis require as careful attention as the acute symptoms of the earlier stage.

Adhesions of parts contiguous to the site of inflammation often constitute permanent *remanets* of the plastic exudation. And not only does the irregular adhesion of parts

normally mobile cause various degrees of functional crippling of the parts involved; the strands of adhesion themselves, when drawn out and attenuated, become frequent sources of intestinal strangulation. Even after a successful abdominal section, the intestine, adherent to the linear scar, may cause trouble in this manner at some later date.

On the other hand, we have known a multitude of adhesions in the peritoneal cavity to entirely clear up in course of time, and leave no trace on the healthy serous membrane of their former presence.

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Dr. GALLEY BLACKLEY said he had been particularly interested in hearing of the gradual "shrinking," as Dr. Burford called it, in the number of cases which would be classed as idiopathic peritonitis. He had seen several which had been classed as "idiopathic" years ago, but would have been very glad of the chance of applying the crucial test of a bacteriological examination and seeing whether they were truly idiopathic or not. Cases of peritonitis following nephritis were by no means rare, and these, too, had been put down as bacterial in origin, but he (Dr. Blackley) was still somewhat sceptical as to this being the case. The natural feeling one had in hearing another extensive group of diseases attributed to bacteria and their elaborated toxins was that an anti-toxin might be discovered. The list of drugs used by the authors of the paper struck him as being somewhat scanty. One drug in particular he missed, from which he had had great help in several cases of peritonitis, namely colocynth. Bryonia was similar in its effects upon serous membranes, but personally he was inclined more and more to rely upon colocynth in peritonitis. He had found it more reliable, too, than belladonna or mercurius cor., although these were of undoubted value.

Dr. ROBERSON DAY said that among children peritonitis might be said to be decidedly rare, with two exceptions. One had been already alluded to, that arising from appendicitis, and the other form was tubercular peritonitis. With regard to tubercular peritonitis, he had found the greatest good follow from the administration of the iodide of arsenic. In one case, a little girl, aged 11, who came with the ascitic form, was treated with the iodide of arsenic 3 x, and very rapidly recovered. It was a very interesting case because after the disease was cured in the abdomen another

manifestation appeared in the inguinal gland, which suppurated. Then, later on, there were swellings of the knee and the elbow. The patient was eventually perfectly cured. Another patient, aged 13, exhibited the plastic form of peritonitis. This child came with gradual loss of strength, chronic diarrhoea and tenderness of the abdomen. The tenderness was localised to the region of the caecum, and for some time there was a doubt as to whether it might not have originated from appendicitis, but the subsequent course of the case showed it to be a large plastic mass of tubercular origin. Laparotomy was eventually performed, but unfortunately the case was discovered to be general tuberculosis, and ended fatally.

Dr. MADDEN said there were two points he wished to remark upon. The first was in regard to the treatment of septic cases; whether serpent poisons should be used or whether any sort of sepsin or pyrogen drugs could be used, such as the late Dr. Drysdale advocated. He suggested treatment by hypodermic injection, which, with these remedies, had never been carried out systematically. He did not think the full effects of any of this class of remedies could be obtained by giving them by the mouth. The other point occurred in connection with the case Dr. Burford saw at the hospital at Bromley. Tubercular disease began in a very insidious way, with peritonitis among its early symptoms. The patient had a large evacuation of the bowels after treatment in the hospital, and the conclusion at first was come to that her symptoms might have been caused by impaction; but it certainly was not so. On a later occasion—although abdominal symptoms had almost entirely subsided—when the bowels ceased acting for twenty-four hours the symptoms recurred again. She had definite symptoms of peritonitis and an increase of fever, and when the bowels could be moved again these symptoms subsided immediately. It was well known that in abdominal cases many operating surgeons made it a rule, on the first onset of peritoneal symptoms, to give calomel—and with remarkably good results. A very interesting side light was thrown upon this fact by the experiences of American surgeons in relation to soldiers who were wounded at the siege of Santiago. The soldiers were obliged to go into battle on empty stomachs, and the wonderful recoveries they made from abdominal wounds were most remarkable. Apparently there was no food or faeces mixed up with the wounds of peritoneum and the intestines closed up healthily; in fact, many cases were hardly in the hospital more than a few hours. They went out, and had no bad results. He thought it must be concluded from that, that

the stretching of the intestines, and thereby the stretching of the peritoneal covering, was a thing they should take very definite means to avoid.

Dr. GOLDSBROUGH considered the paper so thorough and elaborate that many remarks by way of criticism would be out of place. He wished however to emphasize more fully the distinction between the two classes of cases which had been described. If the hypothesis were accepted that inflammation in the first class was really a beneficial process, the question of peritonitis ought not to come into consideration at all in septic cases; the lesion to be dealt with was one of sepsis of the peritoneum. Therefore the types included in the paper under peritonitis should be still further clinically separated. They naturally separated themselves into two distinct varieties, the class sepsis of the peritoneum, and also the class peritonitis. In the first class, what they as practitioners had to deal with, was the fact of sepsis and not the fact of peritonitis. In this class they desired really to favour the production of peritonitis rather than to diminish it. Dr. Goldsbrough also referred to the most interesting rôle which the bacillus communis coli played. He had the honour of submitting a case of peritonitis, with resulting abscesses, to the Society about eight or nine years ago, for which he could not at that time find a sufficient cause, but now reading into it the rôle played by the bacillus communis coli he could see that the cause in that case was a direct infection of the peritoneum by this bacillus. At the time of its occurrence he was very dissatisfied with the result of the case. It had dragged on for about five months, and two abscesses formed in the peritoneum with many adhesions. But, after what they had heard that evening, the treatment by expectancy seemed to be still the best. With reference to puerperal peritonitis, out of three cases of fatal septicæmia, one of them he distinctly put down to peritonitis as a clinical variety. Was it a fact that a low temperature was ever seen in cases of puerperal peritonitis! Was not there invariably a rise of temperature even though there might not be evidence of inflammatory mischief? That point had not been referred to by the authors of the paper, but he (Dr. Goldsbrough), had never seen a case of rise of pulse in a puerperal condition and fall of temperature except in a purely neurotic condition. He thought that puerperal septicæmia involving the peritoneum was an exception to the general rule. He had seen a number of cases of slight inflammation of the peritoneum following the puerperal state, but only one genuine case of septicæmia of that form, and in that case the

temperature went up to 104°-105° along with the pulse to 120-140. He remembered distinctly his teacher of obstetrics (Prof. Stephenson of Aberdeen) telling the students to watch the pulse along with the temperature. He agreed with the authors of the paper that the pulse was the chief criterion of prognostic value, but in puerperal cases the temperature also had to be watched and considered.

Dr. STONHAM wished to know the proper time to administer purgatives in cases of operative abdominal surgery? Was it in the septic or in the inflammatory form that the practice was most useful, and at what stage ought it to be administered, and was it a routine treatment in every case on the first day or two of the operation? He had seen in a paper that it was more difficult to set up peritonitis in animals that had a short time before recovered from an attack of peritonitis, because the system had gained some resisting power. He believed that was clinically borne out by the fact that operations for appendicitis were never so successful as soon after a recovery from a previous attack of appendicitis which had not been operated on.

Mr. DUDLEY WRIGHT asked, in connection with the case of septic peritonitis which recovered (a chart of the temperature and pulse of which had been thrown on the screen), whether crotalus was the only means used for obtaining benefit, or whether an abdominal section was made afterwards in order to wash out the peritoneal cavity? He would also like to know whether Dr. Burford still used calomel. Dr. Burford first suggested it to him, and he had used it on and off ever since with considerable benefit. There were a few practical points to which he would like to refer. In the operation for appendicitis, it occasionally happened that the appendix had perforated and septic peritonitis was present before the operation took place. He operated on a case of this sort a short time ago. In opening the abdomen he discovered an enormous amount of pus; the abdominal cavity was one bag of pus. The pus was let out and he removed the appendix. The operation was done under gas, it being very convenient to do it in that way when the pulse was very poor, because it was not necessary in many cases to give very much in the way of anæsthetic except for the skin incision. The patient unfortunately died, and at the *post-mortem* he was very much impressed by the fact that on the right flank behind the colon a large pocket was found, full of pus, and that was the only collection of pus which he had not got rid of. Had he opened the cavity in this case, and let out the pus, the patient might have recovered. Unless a patient was absolutely dying he

should advise opening the abdominal cavity in cases of peritonitis to give a last chance. It was the same in the perforated stomach. A case occurred some time ago, and at the *post-mortem* it was seen that there was a large pocket of pus between the liver and the diaphragm. In such cases the stomach might be sewn up, the free pus in the abdominal cavity got rid of, but one pocket of pus left would spoil the whole operation.

Dr. VINCENT GREEN was rather astonished that arsenic was omitted from the list of drugs indicated in inflammatory peritonitis. In the few cases which he had seen he had not had the success with belladonna which Dr. Burford seemed to have had. Arsenic was his favourite remedy, alternated with mercurius cor. He did not think the pharmacology of belladonna suggested its use in acute peritonitis. He had seen several cases of belladonna poisoning in his hospital days and he did not remember any of the patients having symptoms at all resembling those of peritonitis, while it was well known that in arsenic poisoning acute pain in the abdomen and inflammation of the intestinal tract was a very common symptom. He had had wonderful results from arsenic in at least two cases of the kind. The clear way in which the two forms of peritonitis had been differentiated made the paper of the utmost value.

Mr. JAMES JOHNSTONE, in reply on behalf of Dr. Burford and himself, thanked the members for the very kind way in which the paper had been received and the very lenient way in which it had been criticised. The question had been asked, how do the bacilli get in from the bowel to the peritoneum? That question could not be answered with any decisiveness. No doubt there must first of all be some injury either to the nerve supply or to the blood supply of a portion of the bowel which lowered the vitality of the tissues and permitted the bacilli to pass through aided by their flagella or cilia. Also if the vitality of the individual cell was lowered, then it was unable to cope with the bacillus or act as a phagocyte. With regard to idiopathic peritonitis, so very much had been done in the last few years to narrow down the causes of peritonitis that he thought within the next ten years they might hope to find most of the cases of so-called idiopathic peritonitis cleared up and referred to a bacterial origin. Whether the peritonitis would be due to the same germ as caused a predisposing disease, such as rheumatism, was another question. There was no reason why two concurrent diseases should not go on together, and he thought it very likely that phenomenon would explain the existence of peritonitis along with rheumatism and certain other diseases.



Dr. Goldsbrough's division of peritonitis was logically correct. The "itis" following the word denoted inflammation, and inflammation meant heat, swelling, redness, pain, and so on. No doubt there was a condition of the peritoneum followed by a lethal result where there was absolutely no inflammation at all, or at most very little. In some cases which had died from peritonitis, the surface of the peritoneum had been found to be perfectly normal to all intents and purposes, but in some portion of the peritoneal cavity germs had been found, and toxins had no doubt been freely absorbed. Dr. Goldsbrough also raised the question of the rise of temperature in puerperal peritonitis. He (Mr. Johnstone) took it for granted that the puerperal peritonitis did not arise all at once, that there was a slight rise of temperature due to the initial lesion such as infected endometrium or lacerated perinaeum. There, in open wounds, the bacilli were working quietly for some little time before they ultimately reached the peritoneum, so that there was an extra-peritoneal inflammatory process in the uterus or pelvic tissues going on before the peritoneum was attacked. That would complicate the purely peritoneal pulse and temperature curves. The question of recurrent peritonitis was still in doubt. Theoretically, if they believed in the doctrine of immunity, the underlying basis of serum therapeutics, they ought to expect that one attack of peritonitis would make a person immune from a subsequent attack, but apparently in practice it was not so, because cases of recurrent peritonitis were found where the third, or fourth, or fifth attack proved fatal. It was probably the case in appendicitis that the dominant factor in determining the fatal issue was a greater inrush of germs in the one case than in the other. He commended Dr. MacNish's remarks about albumoses to the attention of the Society, and regretted that time would not permit him (Mr. Johnstone) to deal with all the interesting points raised during the discussion.

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## THE MEDICAL PROFESSION AND THE PRESENT HOSPITAL SYSTEM.<sup>1</sup>

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GENTLEMEN,—Though the wheels of fate move slowly, yet they are driven by a power which fails not; a power superior to strikes, lock-outs, Mabon's days, and other freaks of the labouring man. They move with a regularity which almost forces even the pessimists amongst us to doubt whether the motive power which drives this Juggernaut Car could be derived even from the "winds of adversity." Their advance is unfortunately not liable to interruption from failure of steam, resulting from shortness of fuel or breakdown of machinery; nor in the present untameable wildness of electricity can we imagine the unremitting force which causes them to revolve, carrying each of us, like a fly or particle of dust adhering to their circumference, now up to the top of their revolution where all is bright and sunny, and where we may see how bright is the prospect ahead if we can only reach it without receiving fatal crushing during the revolutions necessary to carry us so far forward.

Thus far, whenever it has been my turn to be on the under side of life's wheel, I have been fortunate enough to light upon a more or less soft place in the road upon which we are all travelling, with the result that although I have suffered from the pressure of the load above, even to having the breath temporarily squeezed out of my body, still the damage sustained has never been sufficiently severe to cause permanent injury. Yet who knows but that upon the next revolution I shall be nipped between the iron tyre of circumstances above, and some unyielding rocky position below, with the result that I am ground and annihilated, and left to mingle with the other cast-off dust and swept into life's rubbish-heap.

It is because I seem to see a cloud spreading over the medical quarter of the horizon, that I take this opportunity

<sup>1</sup> Liverpool Branch, January 12, 1899.

of remarking to my fellow-particles upon what I consider the causes which have led to the present clouding over of our prospects, and my opinion of the outlook for the future.

It seems to me that the present condition of the medical man is not satisfactory. He does not command the recognition or the remuneration to which his learning, skill, and labour fairly entitle him. The most popular explanation of this is that of "over-crowding of the profession," but I do not consider this a satisfactory explanation, and in my endeavour to give you my own ideas I shall consider the subject from three standpoints, viz. :—(1) Historical, or causes which have led up to the present state of things ; (2) The present, or the condition of things as we find them ; and (3) Prophetic, or the direction in which I consider improvement will follow.

#### (1) HISTORICAL.<sup>1</sup>

The historical survey may be indicated by stating that it traces the advance of the irresistible force which has gradually extended to the mass of the people many of the advantages which formerly belonged exclusively to the powerful classes ; and it shows that the altered conditions and increased competition of life between the different nations have caused it to be recognised that, even as a matter of self-defence, it is necessary for each nation to provide, at the public expense, those advantages which are either necessary or politic in order to ensure that the whole nation may compete successfully as a working machine with any other nation.

#### (2) THE PRESENT CONDITIONS.

As the movement has gone on, producing an altered and, in my opinion, greatly improved condition of life, it has been borne in upon men that all progress really means progress

<sup>1</sup> On account of the exigencies of space the historical survey originally forming part of this paper has been condensed into the sentence which appears above.

in education. You will obtain no improvement in conditions in any direction unless there has been, to some extent, a previous education in the minds of the people which creates a want or longing after some new condition to satisfy it. The improved condition of things at once confers new advantages and extends the field of knowledge wherein the development of education, theoretical or practical, may proceed. Increase of education and the resulting training of the mind has resulted in a more intelligent searching after the causes of the abuses and misfortunes which afflict the people, and it has gradually come to be recognised that the great and only true way to remove the misery, the misfortunes, and the vices of the people is through the medium of the school and education. The various governments, as representing the peoples, are recognising in an ever-increasing degree the important position of education as the essential thing, without which it is impossible to attain the general advancement in any people, and that if any improvement is to be made in the conditions of new colonies or fresh markets, they must at the earliest opportunity provide at their own expense full facilities for general education; all this is proved by recent signs of the times. No sooner does Russia colonise in China than she opens schools at Port Arthur and Talienwan. Before the smoke of victory at Omdurman has had time to clear away, the Sirdar rushes home, and, after consultation with his superiors, with feverish haste launches a scheme to provide schools at the remotest outpost attained, in order that the inhabitants around may develop a respect for, and a submission to, our guidance in trade and commerce and government, as at the first they will in the department of education.

Philanthropic movements which aim at alleviating the poverty, misery, and vice of the day would be of little use if the education of the people had not been thoroughly taken in hand. At the present time the truest workers after temperance know that the best and only satisfactory method of combating the drink and public-house is to educate the people to take intelligent interest in literature, art, or other pursuit, and then to provide them with some means of using

their improved intellect. For what other reason are the reading-rooms, the museums, the lectures without number, the secondary schools, and the innumerable intellectual entertainments and facilities which the entire community now recognise its duty and its own interest to provide? The whole people have, of course, recognised from all time that it is essential for their own preservation that they should provide, at the expense of the public purse, some effectual means of restraining the vicious members, and, by a further step, it has long acknowledged the duty to provide at any rate the absolute necessities of life. It has found that the most effectual way of relieving excessive expenditure upon prisons and workhouses is to undertake, as a people, the duty of improving the moral and physical condition of the whole community, so that they are lifted as a body above the temptations and poverty which tend to drag them into pauperism, disease, and vice. It is but a small and natural step from the performance of these absolutely necessary duties to the undertaking of others, which, while they may not be real necessities, are undoubtedly the very best policy. It is essential that all the members of the community should be able to take each his share in the daily work and production of the nation. For this it has been found that education must be carried beyond the elements of reading, writing, and arithmetic, and secondary and technical education are provided at the public expense for the general use, in order that, the power of production of the people being increased, the general wealth will be correspondingly augmented.

Education is now in a transition stage. We have recognised that it is the really best policy for all to be educated, and during the last generation all have been subject to compulsory education. By the Free Education Act we have gone a step further, and in school board and subsidised denominational schools provide free education for all. For the adequate preservation of the community as a working whole, it has long been recognised they must be guarded from dangers which threaten health and working capacity. For this reason the Government has taken up sanitary and

public health questions. At first sight it appears, perhaps, too socialistic that each man's sanitation and household cleanliness should, to a large extent, be done for him at the expense of the public purse, but on consideration no one will doubt the policy of this proceeding. Neglect on the part of one individual involves danger to those surrounding him, and this danger spreads in circles round the original point, as circles of disturbance spread round the place where a stone is dropped into a pond. To prevent neglect and obviate the attending danger, sanitary regulations are entrusted to one authority, and in this way they are performed in a far more satisfactory manner than if left to the individual. It is just as important that when any individual member of this machinery is temporarily laid aside by illness he should be refitted for his place in life as soon as possible, and for this end we are bound to have in the near future not only free medical attendance for all, but also compulsory use of the advantages to be provided.

The medical profession is now feeling, and will continue to feel in a greater and greater degree, the hardships which affected the teaching profession a short time ago, and from which it has now rallied. The struggles which the medical man of to-day has to make for a bare subsistence are due to two causes: firstly, that the actual amount of disease is being curtailed by hygienic and sanitary precautions and improvements, and secondly, that an enormous amount of the work for which he ought to be receiving fees, moderate in amount, may be, but in the aggregate constituting an enormous annual income, is taken from him by various philanthropic institutions. I quarrel with these philanthropic institutions as a whole, as I would quarrel with a so-called philanthropic series of schools, where all the teachers were persuaded by the managing committees to invite starvation upon their entire class by giving their services free, and so doing work for nothing for which they should be receiving pay.

If the people cannot pay for education and the State considers it absolutely necessary that everyone should have education, then it is the duty of the State to pay for education. In the same way, if the people cannot afford medical

attendance, and the State considers it politic that all should be compelled to have proper medical attendance in their own interests, and especially in the interest of the entire community, then it is the duty of the State to provide medical attendance and to pay those who are employed in carrying out the necessary work. We can be sure that anything which is imposed by the State as a necessity for its own welfare will have sooner or later to be provided free by the authorities. When vaccination was made compulsory it was essential to make it free to the people and paid for by the State. When education was made compulsory it had to be at once provided at a merely nominal fee, the teachers being paid partly by the State and partly by philanthropy. Even the nominal fee has had to be removed in quite recent times, and so it will be with all things that are done for the individual, the doing of which is a real though indirect benefit to the community at large. The recent exemption from vaccination legislation does not in any way weigh against this statement. Such exemption is the outcome of unwise agitation, and has been allowed because those in authority are uncertain how far great improvements in sanitation and disinfection have rendered unnecessary a precaution which in past times has been perhaps the greatest blessing to the race.

The State support or subsidy of all except private hospitals is bound to come, and come soon. At least 75 per cent. of the work done to-day by hospitals is done for people who cannot claim it, because they are able to pay for medical attendance themselves. We honorary medical officers who do the work know this perfectly well. Why do we continue to do the work then? Almost entirely from selfish motives. We desire for our own aggrandisement to be "on the staff" of some "public institution" and struggle for the positions on the lists of officers, although we know that three-quarters of the work we shall do will be done for people who could easily afford to pay moderate and graduated fees to some unattached member of the profession. Each hospital will without question allow attendance on almost any case which presents itself. Why? Out of pure "de-

nominal envy" and "jealousy of other establishments," each striving in numbers and calls for increased subscriptions to outdo other establishments. I myself do not blame the people who come to hospitals, although under the present so-called philanthropic management they are obtaining attendance under false pretences. I rather think that the increasing so-called "abuse of hospitals" is the natural result of real growth of popular opinion that medical attendance is as much a concern of the State as is education, and these people have, I believe, an undefined but a reasonable idea that they have as much natural right to free medical attendance as they have to free schooling, sanitation, &c. In my opinion they are right, and it is the present conditions under which we work which are wrong and are the cause for the great and increasing depression in the medical profession. We honorary medical officers of hospitals are in the ridiculous position of giving our services free when we have every right to insist upon the State paying the officers of hospitals out of the rates. Should we sympathise with the Board School teachers if they supplied the education which is compulsory without receiving pay? Should we call them philanthropists or idiots?

The teaching profession is only just emerging from a very severe crisis, a crisis in every way parallel to that in which the medical profession now struggles, and the salvation of the teaching profession has been worked out by the very process which I advocate in the case of the medical profession. The many private schools of small size, where the owner was the staff, were completely ruined by the philanthropic denominational schools, which provided a more complete course at a price which meant starvation if attempted in small private schools. Yet when compulsory education came in, and state schools were initiated, these teachers who had been ruined by the well-meant but ill-directed philanthropic efforts obtained positions far better than they had before, and although the board school teacher is poorly paid as yet, still he or she has a certain, if small, income, and is more secure than in the days when the sole dependence was upon the precarious fees from two or three pupils at their own houses.



The medical profession is at present ruined by well-meant but badly-managed philanthropic institutions. These hospitals were started, as charities no doubt, to attend upon the really poor, but they have come to be regarded, and I think rightly so, as provided for the people at large. They should be so, and paid by the State, the officers receiving pay for work done for the real benefit of the community. This would be a slight extension only of the principle now recognised in the payment of vaccination officers. When the government required special medical attendance, and made the attendance compulsory, it had to pay the officers who did the work, and even now when the attendance is not compulsory they still pay the officers. Why should they not also pay when the medical attendance required is of a general and more exacting character? The only reason why payment for hospital medical work has been so long delayed is that we in the profession provide an unlimited supply of misguided individuals, who, from blindness to the true state of affairs, and to their own interests, will supply at the cost of much unnecessary privation to the profession at large services which the State ought to pay for, and which the State would be quite ready to pay for were it not that we refuse to let the public see that by this neglect on the part of the State we are practically committing slow suicide. If we agreed that we would refuse in future to give our services free to hospitals, is there any one among us who thinks that the poor would in the slightest degree suffer? They most assuredly would not. It would only result in the hospitals being taken over by the State. The medical officers would be paid, and the work of the hospitals would be carried out more efficiently when backed by State facilities and supervision than they can ever be while they are dependent upon private charity. Let it once be brought home to the authorities that there is danger of failure of financial support to our hospitals from private charity, or failure of the self-destructive mistaken philanthropy on the part of the medical profession, and at once the State will recognise its duties, and place our medical institutions upon the same satisfactory basis as are now our schools.

To sum up, I may say that I think that there can be no doubt that the medical profession is not in a satisfactory condition. Work is neither as plentiful in private practice nor as remunerative as it used to be. There are two causes of this depression. One is that there is undoubtedly less sickness than there used to be, a fact due to the improved conditions of life, as produced by sanitation and the many other valuable means of preserving life; and not one amongst us could quarrel with this cause, but each gladly does all he can to advance it. The other cause is that a great and increasing proportion of the legitimate work of the doctor, for which he should receive proper remuneration, is done by him under the patronage of our hospitals for nothing. I do not quarrel with this cause either, but I consider that it is the worst kind of foolishness for the medical man to bankrupt himself by doing for nothing work for which he should receive pay. Whichever view of the question you take, this action of the doctor is wrong. People either have a right to the free attendance of our hospitals or they have not. If they have that right, then they certainly have no right to it at the entire expense of the medical profession, but the cost should be borne by all, which is State support. If they have no right to it, then the medical man is allowing himself to be imposed upon, when both he and the imposers know the nature of the transaction, a view which presupposes actual fraud on the part of the public, and just as decided imbecility on the part of the medical profession. Hospitals are, in my opinion, very proper institutions, and people have a right to attend if they desire to do so, but as they are at present managed they are at the entire expense of the medical profession. Private persons may partly defray the building expenses, &c., but the real cost comes out of the pockets of the medical profession, and it is slowly but surely bringing the profession to a state of bankruptcy. We must cast this burden upon the government; they will readily take it up when they are shown the necessity of doing so; they neither could nor dare allow the hospitals to suffer in any way, and in this manner the crushing weight would be lifted off our profession.

## (3) PROPHETICAL.

As regards the future, there will be little that I need say, after dealing at such length, perhaps ramblingly and without due clearness, with what I consider the present condition and its causes. The future depends upon efforts made to remove the influences which at present work our ill. We must at all costs and in all ways help on the formation of the inevitable decision that, so far as "medical attendance" is concerned, it is one of those necessities which it is the true policy of the State to provide for the nation at the public expense. We must, by concerted action in the profession, insist upon payment out of the public purse for any attendance which is given, *except* as a matter of private contract between doctor and patient. Such public payment is now made to teachers in board and technical schools, to vaccination officers, poor-law officers, and the like. This will not mean degradation of the profession any more than the institution of board schools has degraded the profession of teaching. The smaller and struggling class of private school may have died out, and their places been taken by the board schools, but there is still plenty of room for good private tutors, or well-appointed larger schools. The people must have the right and the compulsion to utilise proper medical advice, but just as it is not essential to send one's children to the board schools, so it will not be compulsory to have medical attendance at the State-supported hospitals. They are there, and give no excuse for neglect of medical attendance; but anyone is quite at liberty to select any qualified private medical attendant and make a contract as to payment. We should not all lose our identity and become so many dispensary doctors; each could have his ambition to obtain such a name that all who could afford would come to him, as they now can select any school to suit their principles and their purses. There would still be honourable leaders and general practitioners in the profession, but there would not be the struggling class of medical men who spend their miserable existences competing with the free dispensaries at prices which are as

insulting to any qualified man's intelligence as they are poverty-bearing to his physical condition.

How are we to help on this consummation? This is the chief difficulty. Public opinion will assuredly ripen itself in time, but it is weary work waiting until public opinion is so strong that it will force reward for services rendered upon a class of men who are so absolutely blind to their own interests that they have not as yet recognised that they are committing slow suicide by their present behaviour. Some short-sighted philosopher tried to comfort his friend by remarking that "everything comes to him who waits." But as this proverb applies with equal force to bankruptcy and hanging as to any other future event, I fail to see any real sagacity in the remark.

Of course there are many difficulties which would have to be arranged before State hospitals, and the right of everyone to medical attendance thereat, can be placed upon a perfectly satisfactory basis. As an example, we may mention the obvious abuse which might arise by people in good circumstances coming into a hospital for any and every trivial illness. It is true that such people would have a right to the advice of the staff of the hospital, but this must not be confused with the other questions involved in such a case. If they come into the hospital now, they not only obtain medical attendance free but also are supplied with board and lodging. No individual whose circumstances are not so straitened as to render this necessary has or can have any right to State support of this kind. Such would be an abuse which if not kept in strict check would be an enormous premium on laziness. Medical attendance must be placed on as nearly as possible the same lines as education. Everyone of us has a distinct right nowadays to send his children to the State-supported schools if he desire so to do, but we have no right to send them to a boarding-school at State expense, so as to relieve ourselves of all cost for their support. The two questions can be, and must be, kept quite distinct. The difficulty which their adjustment presents in no way affects the principle of the matter, it only adds to the care necessary in a consideration of the best means of carrying out the principle.

Some may think I am wrong in imagining that the day is coming when medical attendance will be either compulsory or State provided, but certain signs confirm my view. Two very interesting cases have occurred within the last month in connection with the sect known as Christian Scientists. The doctrine of this sect refuses to call in medical help in cases of illness ; and a recent case of a child in which this teaching was carried out was brought before the law courts. The case was considered with extraordinary care, even being referred to the Court of Crown Cases Reserved, and as a result the father responsible is now undergoing four months' hard labour. The punishment is light, but it confirms the principle, upon the highest judicial authority, that medical attendance is compulsory, at least, when there is any possibility of obtaining it. Another case was that of an adult who died through neglect to have medical attendance. The relatives were acquitted, as the patient being over age could presumably have had the medical attendance if he so desired. It will need very little to extend the responsibility for adults as well as children, as a certain danger to the community attaches to illness which is not attended to and regulated by skilled advice. Compulsory medical attendance is coming with certainty, although we cannot expect any aid in establishing it from the General Medical Council. Still we can do a great deal to instruct public opinion, and help forward the proper appreciation of the real issue. The movement lately established by the Prince of Wales is, in my opinion, essentially a wrong one. It seeks to perpetuate the present undoubtedly unjust methods by removing the portion of the difficulties in present hospital management which appeals more particularly to the general public. It thus hinders the development of the knowledge necessary to the proper recognition of the present injustice, while it seeks at the same time to extend the facilities to the public of obtaining at the expense of the medical profession free services to which 75 per cent. of them at least under the present *régime* have no claim whatever. Remember, the medical facilities provided at all our voluntarily-supported hospitals are luxuries, not absolute necessities. Were all such hospitals

shut up to-day, it would simply mean that the authorities would have to provide to-morrow sufficient hospitals of their own to adequately supply all really necessary medical attendance to those who could not obtain it for themselves at their own expense.

The ridiculousness of providing by means of a "national voluntary" subscription any facility which is regarded as a "necessity," does not seem to have struck the originators of the Prince of Wales' movement. It simply means that ninety-nine people are to be provided with something they have a right to, but for which they will not pay, by voluntary payments by the remaining one per cent. who subscribe; and that as the ninety-nine grow more exacting, or find necessity for further improvements, the one per cent. shall be called upon for further and still further contributions.

Yet even in this movement, wrong though it be, we can trace the definite advance of that opinion which will bring about the final remedying of our wrongs. The fund is essentially a "National" one in name, and it has been launched by a personage whose whole public acts are regarded as devoted to, and rightly claimed by, the nation. Here we have definitely recognised the opinion that hospitals are such necessities to the national welfare that it behoves the nation at large to support them in order to maintain itself in the best possible condition as a commercial and power-wielding entirety. It is Quixotic to hope or attempt, with such a growth of opinion, and with hospitals regarded as national necessities, to restrict the use of these institutions to only the absolutely destitute. The so-called "abuse" is growing and will continue to grow. This growth is a benefit to all—with the exception of the medical profession—and it would be a still greater benefit to the profession, were it not for the imbecility of the profession itself, which invites everyone to partake of these glorious benefits entirely at its own expense, and steadily refuses to claim the just share in the general national improvement, to which each member, even on the level of membership of the nation, has a right. When this voluntary national effort fails, as it most assuredly will, to keep

pace with the ever-increasing demands made upon our hospitals, I trust it will be a small step from national voluntary fund to national compulsory fund. The time is ripe for the change now, were a proper demand made by the profession, but even if it is found impossible to galvanise any show of life into ourselves which will rouse us to make such a demand, I trust that at that date the national conscience will have so far improved that it will insist upon paying some just reward to a profession which through its own stupidity has so long refused to request that its services should be recognised.

It is against all precedent when anything has come to be recognised as a necessity either to the individual existence or to the combined national existence as a work-producing mechanism, that such necessity can continue to be supplied by individual or philanthropic effort. To guarantee its being properly provided it must be supervised by the State, and paid for by the State; and this latest movement is only putting off the day, in the mean time perpetuating the injustice to the profession.

No medical man who appreciates this argument would grumble for a moment at a necessary hospital rate to take the place of present subscriptions and provide funds for the payment of the staff. Suppose the impossible theory that a sixpenny rate were necessary for this purpose, then taking the fair average rental of a doctor's house at fifty pounds, it would mean a payment of twenty-five shillings per annum for each medical man. This would total up to about six to ten thousand pounds from the whole profession in the United Kingdom, and would result in the distribution of more than as many hundreds of thousands of pounds amongst the profession. Which of us here would not be willing to pay a far larger sum than twenty-five shillings per annum in order to receive payment, however small in amount, upon all the cases we see which should pay fees but do not because of hospitals. Under the new arrangement all cases now seen at hospitals would be paid for whether they belonged to the class for whom the hospitals are nominally provided, and who have a true right to free

attendance, or to that enormous majority who, under the present conditions, have no such right, but who readily obtain our services through our jealousies, imbecility, and want of professional combination.

We must adopt the opinion that hospitals should be subsidised by the State, and din it into the ears of the public. In so doing we may perhaps develop a sufficiently intelligent conception of our own position to kindle some spark of proper dignity in the profession, and enable us to sink all our petty jealousies, and work together as a united whole for the remedying of our manifold wrongs, and the proper appreciation of our just rights.

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## DIARRHŒA IN CHILDREN.<sup>1</sup>

BY J. ROBERSON DAY, M.D.LOND.

*Physician for Diseases of Children, London Homœopathic Hospital.*

MR. PRESIDENT AND GENTLEMEN,—On my return to town last summer from my holiday, I found the juvenile population of this city suffering from a severe and widespread epidemic of diarrhœa. We had had an exceptionally warm summer, and at the time great heat was prevailing.

When the subjects for discussion at the forthcoming Session of this Society were being chosen, *Diarrhœa* naturally suggested itself as likely to be popular, for we have all probably had much to do with its treatment.

Before proceeding further with this subject, may I remind you of the physiological conditions which obtain in children.

The stomach is a somewhat rudimentary organ in early

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, Feb. 2, 1899.



life, and the salivary digestion imperfect until dentition is complete. The gastric juice and pancreatic juice are likewise feeble in activity, hence we find that relatively the intestines play a more important part in digestion than the stomach, as compared with the adult. Moreover, children are far more easily influenced by unsuitable food than adults are, and hence diarrhœa is such a common complaint.

There are two factors which constitute diarrhœa, viz., increased peristaltic action and increased secretion. In young children, moreover, two or even three motions daily are to be regarded as a normal condition, whereas the adult may be congratulated if he has his regular daily stool. When there are more than three motions a day, a child may be said to have diarrhœa.

It is obvious that it is only possible for me, in the brief time at my disposal, to deal with a portion of a complaint which is so wide-spread.

#### CLASSIFICATION.

Diarrhœa is not a disease but a symptom of some morbid process, but for the sake of convenience of description all diarrhœas may be divided into two classes:—

- (1) Idiopathic.
- (2) Symptomatic.

I shall confine my remarks to the former class. The symptomatic diarrhœas, such as are met with in enteric fever, or measles, would lead us too far astray.

The *idiopathic diarrhœas* are influenced by many and various causes, such as age, season of the year, constitutional state, diarrhœa being much more commonly met with in congenital syphilis, rickets, and phthisical children. Hygienic conditions also have an important bearing. Owing to the multitude of factors inducing diarrhœa a satisfactory basis for classification is hard to find. The pathological lesions are by no means constant or distinctive, nor are the symptoms always sufficiently distinctive for our purpose. Perhaps the simplest and best method is to

classify according to the portion of the alimentary canal which seems principally affected.

*Gastro-enteritis*.—When stomach and small intestine are chiefly involved.

*Enterocolitis*.—Where the small intestine and colon are the seat of the disease.

Each variety may be *acute* or *chronic*.

#### CAUSES.

Errors in diet are by far the most frequent cause of diarrhœa in children.

Breast fed children suffer far less frequently, but even they are not exempt, and depend on the careful living of the mother. Any unsuitable food taken by the mother affects her milk, and the child gets diarrhœa; but apart even from food, after excitement or exertion, or worst of all a fit of passion.

A nursing mother after a brisk game of tennis, I have known to upset her child by suckling directly after.

We see the same thing amongst the lower animals. A herd of cows with their calves, after a long drive are always milked first, and their milk thrown away, and then, after they have cooled down, the calves are allowed to suckle, otherwise the calves would be upset.

As the majority of infants at the present day have to be bottle-fed the milk they are fed on is largely the cause of diarrhœa.

In America and other tropical countries it is exceedingly difficult to rear a bottle-fed baby in the summer months. So prevalent is diarrhœa in some parts that I am told it has formed the subject of an epitaph:—

“ This little hero buried here  
Was conquered by the diarrhœa ! ”

Strictly speaking it is not the milk but the poison which the germs in the milk produce.

This leads us to the consideration of milk as an article of food, and so important is the subject that I trust I may be pardoned for somewhat digressing here.

Germs in milk may come *first* from the *fodder* of the cows, or from dirt off the udders. This *milk dirt*, as it is called, varies with the amount of care and cleanliness taken in tending and milking the cows. The chief germ from this source is the bacterium *coli commune*. It rapidly multiplies in the milk, which is a perfect culture medium.

*Secondly*.—Diseased cows yield milk which contains pathogenic germs, particularly the *B. tuberculosis*. It is said that one cow in every five in Germany suffers thus. In Denmark 17.17 per cent. of the cows suffer. One in every thirteen samples of milk sold in Paris contained the *B. tuberculosis*; in Washington one in nineteen.

The medical officer of health for Islington was recently instructed by the Public Health Committee of the local Vestry to submit 200 samples of the milk locally supplied to householders to bacteriological examination, with a view to ascertaining how far the milk was infected with tuberculosis. This shows our authorities are waking up to this danger. About 720 persons die annually in Islington from tuberculous disease, of whom 207 are children under five years old.

Thus milk may convey *tubercle*, also *anthrax* and any other disease common to cows and men. In addition to this there is a *third* source of danger, milk may be the carrier of germs of disease peculiar to man, *e.g.*, enteric fever, scarlet fever, diphtheria.

Now how can we obtain a milk free from these dangers?

By boiling milk all the pathogenic germs (with the exception of the spores of the *B. anthracis*) are got rid of in a very short time.

Bacteria which induce lactic acid fermentation are never absent from unboiled milk, but are destroyed at once by boiling. The housewife boils the milk in hot weather to keep it. Another group have their spores *liberated* by boiling, and these *spores* resist boiling, and germinate at moderate temperature, causing brisk fermentation. This is of great importance in infant feeding.

The Soxhlet method destroys pathogenic and lactic acid germs but not the hardy spores. These spores vary in

number according to the cleanliness employed in milking. They do not develop below 18° C., but do so when introduced into the child's stomach, causing flatulence and poisonous decomposition products.

It would appear also that this partially sterilised milk is more liable to ferment at the body temperature as there are no other germs which in unsterilised milk act inimically on these spores, as it were preventing them having it all their own way!

At the present time there is no practicable method of freeing milk from germs without at the same time injuring its flavour and nutritive value.

It is best to try and *exclude* these germs from the milk. This can only be done where the most perfect hygienic conditions prevail in the cow-sheds and dairy. The herds should be periodically inspected by veterinary surgeons, for to the farmer a cow may appear perfectly healthy, and yield a good quantity of what looks like rich milk, and yet it may be tuberculous. This can be ascertained by the hypodermic injection of Koch's fluid, when the cow, if diseased, will have a rise in temperature, &c. If not diseased, it will be unaffected.

Another serious drawback to the boiling of milk is the destruction at the same time of the *anti-scorbutic* element. This is essential for the well-being of growing children. Unless the source of the milk is unimpeachable I always advise that children's milk should be sterilised, and the anti-scorbutic element supplied in some other way, *e.g.*, raw meat juice, fresh fruits, &c.

The symptoms of diarrhœa are more than three motions in the twenty-four hours, often associated with vomiting of sudden or gradual onset, often abdominal pain and tenderness and flatulent distension. If the diarrhœa is severe or has lasted some time, there is rapid and marked wasting, showing itself in a flabby condition of the limbs, sunken eyes and depressed fontanelle. In severe cases and young children collapse may soon set in, with feeble pulse, cyanosis, and cold extremities. The secretion of urine is scanty, or may be suppressed.

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## DIAGNOSIS AND TREATMENT.

Before we can either diagnose or treat successfully any case of diarrhœa in a child, we must proceed in a systematic manner to make ourselves as thoroughly acquainted as possible with the entire case of our patient.

Here again practice amongst children and adults differs widely. The child is like a dumb animal (if I may be pardoned the comparison), whereas the adult is full of suggestions, and his loquacity can at times only be checked by an inspection of the lingual organ. On the whole, perhaps we gain here rather than lose, for the astute physician learns to discount largely the subjective signs and to rely chiefly on his own observations.

However, in the matter of treatment, the homœopathic physician is deprived of all subjective symptoms, which are so often a help in choosing between closely indicated remedies.

In examining a child always have it stripped and laid on a couch in a blanket, and then proceed to watch the child leisurely. Note the size, colour, state of nutrition, observe the abdomen, particularly if distended, the costal border if everted. Next proceed with the warm hand to palpate the child from head to foot: *the head*, for the shape of the skull and condition of the fontanelle—a very important point; *the mouth*, to see if the number of teeth correspond with the child's age, the mucous membrane for thrush or stomatitis, the gums if spongy, and the tongue if mapped or furred; *the chest*, for beaded ribs and the transverse groove; *the abdomen*, if tense or flaccid, distended or retracted, or if the viscera are of abnormal size; *the limbs*, for the state of muscular development, whether firm or flabby; *the skin*, if loose and in folds, or covering a healthy deposit of subcutaneous fat. Particular attention should be paid to the condition of the nates, which may be reddened and excoriated by the alvine discharges, or there may be mucous tubercles about the anus.

Nor should we stop our examination here; the character of the motions should be enquired into, and if possible seen.

Never neglect to personally inspect the napkins if possible. We can thus gain information of the greatest value, which can be got in no other way, for the mother or nurse will use terms in *their* description which are valueless. Of what use is it to be told a child's motions are "like corruption"? This is not nearly so helpful to the physician from a diagnostic point of view as being told a child is afflicted with the "viper's dance."

Observe the colour of the motions; if green, or watery, or streaked with blood, if there are portions of undigested curd or food, if there is the gelatinous mucus; further, if the motion is frothy and passed with much wind.

In examining a child with diarrhœa, we must always be on our guard lest we overlook an intussusception. An acute attack of diarrhœa with vomiting has many of the symptoms of intussusception, and mistakes have been made, and cases are recorded where an operation has been performed where no intussusception existed; but probably far more often the opposite mistake is made, and a case of intussusception treated for acute diarrhœa.

#### TREATMENT.

Is best considered under two heads: (1) Dietetic; (2) Medicinal; and they are of equal importance.

*Dietetic.*—If the child is taking the breast it is best to diet the mother before proceeding to so radical a measure as weaning the child. If the child is bottle-fed and the case severe, it is best at once to stop all milk and give either *whey* made with rennet or *wine whey*. The white of a new-laid egg beaten up in half a pint of water with a teaspoonful of sugar of milk and strained answers very well in other cases; or again, a few drops of Valentine's meat juice in water at frequent intervals will help to tide over the time until milk diet can be resumed. It is then best to give either barley-water and milk or peptonised milk. The humanised milk does well in many cases, and can be easily prepared by abstracting half the curd from milk with rennet and adding cream and milk sugar.

*Medicinal.*—Tooker says “there is no specific for this affection and rarely a single remedy that will cover the totality of the symptoms.”

Fisher says “almost every medicine in the *Materia Medica*, especially those which have an affinity for the gastro-intestinal canal, may be needed in special cases.”

Gentlemen, it is not my intention to weary you with such a list as this, which can be obtained from the various books on the subject. I shall simply mention those remedies which I have found useful, with their chief indications.

*Mercurius sol.* or *corrosivus* 3x is perhaps the medicine I use most often, the *green* motions being the indication, and when mixed with slimy mucus and blood *M. corrosivus* is specific.

*Ipec.* 1x, where vomiting and diarrhœa co-exist, and especially if cough and bronchitis are present.

*Arsen. alb.* 3x for profuse watery diarrhœa, especially in the morning, with thirst and restlessness.

*Colocynth* 3, where there is much griping.

*Croton* 3x and 3, for sudden expulsion of motion and tenesmus.

*Podoph.* 3, when associated with prolapsus ani. If the prolapsus ani is of recent origin with an acute attack of diarrhœa, podophyllum is specific; but if the prolapse is of long standing, associated with a chronic diarrhœa, its effects are disappointing and other remedies will be needed, like aloes or china. It is most important to improve the general state of nutrition in these cases, and the prolapsed bowel should be promptly returned, using as a lubricant hamamelis ointment.

*Aloes* 3x, where there is much tenesmus, the lower part of bowel being the chief seat.

*Rheum* 3x for the very sour smelling motions.

*Calcarea Carb.* 6 for diarrhœa in rickety children, than which there is no finer medicine.

*Chamomilla* 3x when associated with teething and great restlessness and fretfulness.

*Ars. iod.* 3 and 3x for very fetid motions in tubercular subjects.

TABLE SHOWING RESULTS OF TREATMENT OF TWENTY-SEVEN CASES OF DIARRHŒA.

No.	Age.	Description.	Drug Treatment.	Mode of Feeding.	Treatment begun.	Treatment ended.	Result.
1	3 m.	Motions like putty, green, loose, 5 or 6 a day. Firm, well-nourished.	Cham. 3x, pil. i. 2h.	Breast and bottle.	Aug. 25	Sep. 26	Cured
2	4½ m.	Duration 7 d. M. watery, green, slimy, sour; 12 a day; much pain and wind.	Rheum 3x, pil. i. 2h.	Bottle.	Sep. 8	Sep. 22	Cured
3	8 m.	Duration since previous n. 8-12 p.m. M. constant, yellow-green, offensive, with vomiting.	Ipec. 1x, pil. i. 2h.	Bottle and bread, biscuit, condensed milk.	Sep. 19	Sep. 29	Cured
4	8 m.	M. 11 in 24 h.; dirty water, offensive, with vomiting; congenital sp.	Ipec. 1x, pil. i. 2h.	Bottle and Allen and Hanbury's Food.	Sep. 1	Sep. 3	Cured
5	2 m.	D. 3 d. M. green; 6 in night.	Merc. s. 3x, gr. i. 3h.	Breast and Nestle's Milk.	Sep. 15	Sep. 17	Cured
6	1 yr. 1 m.	D. 14 d. M. green, slimy, offensive; during sleep, 9 to 10 in 24 h. Tg. furred. Fat, flabby, only 8 teeth.	Merc. s. 3x, gr. i. 3 h.	Bottle.	Sep. 12	Sep. 26	Cured
7	1 yr. 4 m.	M. with pain, green; 8 in 24 h.	Merc. s. 3x, gr. i. 3h., cham. 3x pil. i. n., china 1x, m. iii. t. d.	Bottle since 6 weeks.	Sep. 19	Oct. 3	Cured
8	10 w.	M. green, slimy, sour, with griping after bottle, 5-6 in 24 hrs.	Merc. s. 3x, ars. alb. 3x, coloc. 3x, rheum 3x, china 3x	Breast 3 wks., Allen and Hanbury's Food.	Sep. 8	Oct. 6	Cured
9	2 yr. 6 m.	M. dark, blood, offensive, prolapus ani. Tg. furred, feverish.	Merc. s. 3x, podoph. 3.	Breast 10 m.	Aug. 29	Sep. 19	Cured
10	10 m.	D. 2 wks. M. blood, slime, with vomiting.	Merc. c. 3x, m.ii. 2h., calc. c. 6 gr. i. t. d.	Bottle, cow's milk, and barley water.	Aug. 25	Sep. 1	Cured
11	7 m.	D. 5 d. M. yellow, watery, 4 in morning. Rickets. Congen. S.	Ars. a. 3x, m.iii. 2h.	Bottle, Nestle's Milk.	Sep. 15	Sep. 23	Cured
12	2 yr. 8 m.	M. green with blood, 12 in night.	Merc. c. 3x, merc. s. 3 x, ipec. 1x	Breast 11 m.	Sep. 1	Sep. 22	Cured



13	1 yr. 1 m.	D. 3 wks. M. dark, offensive with vomiting at night.	Ipec. 1x, pil. i. 2h.	Breast 11 m.	Sep. 26	Oct. 9	Cured
14	8 yrs.	D. 4 wks. M. v. offensive. Ap. poor.	China 1x, merc. s. 3x, ars. i. 3x.	—	Sep. 26	Nov. 7	Cured
15	2 yr. 6 m.	D. 2 weeks. M. 5-6 in 24 h. Tonsils and cervical glands enlarged.	Calc. phos. 1x, gr. ii. t. d.	Breast 1 yr. 4 m.	Sep. 5	Sep. 29	Cured
16	2 yrs.	D. 6-7 wks. M. slimy, curdled, offensive. Tg. furred; sick at times.	Merc. s. 3x, gr. i. 3 h.	Breast, Mellin's.	Oct. 3	Oct. 10	Cured
17	1 yr. 1 m.	D. since previous d. M. almost constant since 4 p.m.; vomiting.	Ipec. 1x, cham. 3x.	Breast.	Oct. 10	Oct. 17	Cured
18	1 yr. 3 m.	D. 5 wks. M. green, offensive; large, flabby abdomen; cough, bronchitis.	Ipec. 1x, pil. i. 2h., ars. i. 3x, gr. i. 3h.	Breast 1 yr. 2 m.	Sep. 22	Oct. 18	Cured
19	1 yr. 5 m.	D. for weeks. M. green, slimy; 5-6 in 24 h.	Merc. s. 3x, gr. i. 3h.	Breast 10 m.	Oct. 20	Oct. 27	Cured
20	11 m.	D. 7-8 wks. M. green, slimy, offensive. 13-14 in 24 h.; no vomiting. Rickety.	Calc. c. 6, gr. ii. 3h.	Breast 3 wks., then Mellin's	Sep. 12	Sep. 26	Cured
21	11 m.	Collapsed on admission. D. 24 h. M. light yellow, very frequent.	Ars. a. 3x, brandy, m. x. p. r. n.	Breast.	Sep. 1	Sep. 13	Cured
22	1 yr. 9 m.	Rickets. D. 4 d. M. frequent, bright green; extremities cold.	Ars. a. 3x, merc. dulcis 3x, sq. calcia.	Breast.	Sep. 22	Oct. 1	Cured
23	2 yrs.	Very collapsed. Thirsty; vomiting. M. fluid, green.	Ars. a. 3x.	—	Sep. 27	Oct. 1	Cured
24	1 yr. 4 m.	M. every 10-15 min. for 3 d. Yellow and varied colours, offensive.	Ars. a. 3x.	Breast.	Sep. 19	Sep. 26	Cured
25	8 m.	Collapsed. Vomiting and d. v. frequent.	Ars. a. 3x, ipec. 3x.	Breast.	Sep. 20	Sep. 24	Cured
26	2 yr. 6 m.	D. 2 wks. on and off; offensive.	Ars. alb. 3x, merc. s. 3x.	—	Sep. 23	Sep. 26	Cured
27	1 yr. 6 m.	D. and vomiting, latter ceased in 2 d.	Ipec. 1x.	—	Sep. 3	Sep. 10	Cured

*China* 1x where there is great debility; often it follows well one of the foregoing.

*Acid phosph.* 1x used in the same way, especially in neurotic subjects passing phosphates in the urine.

*Alcohol* is necessary in many of these cases, and should be given in drop doses, and its effect closely watched, from three to fifteen drops at a time, according to the age of the patient. Whisky is to be preferred to brandy, as it is more readily obtained pure.

*Lavage* of the intestines I have employed, and in cases of acute vomiting and diarrhœa it is recommended to wash out the stomach as well. I have used a weak solution of boro-glyceride which is slowly allowed to irrigate through a large catheter by hydrostatic pressure.

I should like to say something about hygienic treatment and prophylaxis, and though I place them last it is not because I consider them least in importance. Children, even more than adults, need plenty of fresh air, and nothing is more likely to lower their vitality than crowding too many in the same nursery.

Amongst the poor it is impossible to prevent this, and hence the high mortality in their families.

The effect of sea air is often marvellous, and lately a little patient of mine with diarrhœa and commencing mesenteric disease has returned quite well from Eastbourne.

*Prophylaxis* is all important, and until we recognise the part which bacteria play in poisoning milk, we shall continue to see milk infection one of the commonest causes of diarrhœa.

It has been suggested that the milk supply of large towns should be under municipal control, and no doubt this would be a wise piece of legislation. Until this is done we should deal only with dairies where the health of the herds and employes is attended to and every care observed to obtain a pure milk.

There are several forms of sterilisers for home use, *e.g.*, Cathcart's, Aymard's, and Soxhlet's; the last two I have here to show you.

DIARRHŒA IN THE ADULT.<sup>1</sup>

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ALTHOUGH the title of this paper is Diarrhœa in the Adult, it must not be supposed to exclude those who have not quite arrived at that period of life to which the term adult is applied, but, it being the intention to deal with the disease in the form peculiar to young children in another paper, it is left for me to consider its occurrence generally, and at any age other than that of infancy or early childhood.

## DEFINITION.

By diarrhœa we understand a frequent action of the bowels, the evacuations being more or less liquid and different in other particulars from the normal condition. The disease may be a purely functional derangement; or it may be an accompaniment of some inflammatory process, either of the bowels themselves or of some other organ; or it may be due to some constitutional disease, such as typhoid fever, cancer, or tuberculosis.

## ÆTIOLOGY.

Diarrhœa is the result of some irritation of the mucous coat of the intestinal canal. The agents which produce this are indigestible food, unripe fruit, impure water or other irritating drinks, certain medicines which are known as purgatives, and also irritant poisons. These, acting directly upon the mucous membrane, are the chief ætiological factors. In addition there are other conditions (such as exposure to extreme heat or extreme cold, or sudden changes from the one to the other, extreme fatigue, and mental emotion),

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, Feb. 2, 1899.

which will often produce diarrhœa. It also occurs in association with, and as a symptom of, some morbid processes, as tuberculosis, pyæmia, cancer, or enteric fever. Then we have it produced sometimes in a mechanical way, as in portal obstructions with ascites; the dropsical fluid may be rapidly absorbed, and the system be considerably relieved by the consequent diarrhœa.

#### PATHOLOGY.

Diarrhœa is a symptom rather than a disease, a functional disturbance, and not due to any change of structure. Those pathological conditions which in an indirect way produce diarrhœa, or in connection with which diarrhœa occurs, do not come within the scope of this paper. It is, however, a very difficult question to decide, whether any given manifestation of the disease is purely due to functional disturbance, or whether it is due to some real change of structure in the bowel itself or some other organ.

It is, however, perfectly clear that irritating causes producing functional diarrhœa, if not removed, would soon give rise to inflammatory and other changes. The pathological elements which may be regarded as constant—which always accompany diarrhœa, whether functional or dependent upon actual structural changes, are:—

- (a) Increased peristaltic action of the bowels;
- (b) Increased transudation;
- (c) Increased secretion from the mucous follicles;
- (d) More or less congestion of the parts involved.

#### VARIETIES AND SYMPTOMS.

Diarrhœas have been divided into many varieties, the divisions being chiefly founded upon the appearance and character of the discharges. Thus we have:—

- (1) The feculent or fecal;
- (2) The bilious;
- (3) The serous;
- (4) The lienteric;
- (5) The colliquative.

(1) *The feculent* is chiefly characterised by the stools being abnormally soft or almost liquid, and this liquid condition may be entirely due to increased peristalsis; the contents of the bowels are hurried along so rapidly that there is no time for absorption, the odour and colour being quite normal; there may be little or no pain, or if there be, it is always relieved by evacuation.

(2) *The bilious*. The motions in this variety are not only liquid, but the colour also is changed either to a deep yellow or to green; there is more constitutional disturbance, there is generally nausea, the tongue is furred, there is loss of taste, almost complete anorexia and headache; the abdominal pains are much greater, but there is more or less relief experienced when the bowels move. This form is, no doubt, due to some irregularity in the flow of bile into the bowel, as, for instance, after the passage of a gall stone, or when the bile has passed into a comparatively empty bowel during the night and the patient receives an early and urgent call, either before his usual time for getting up, or so soon as he gets upon his feet.

(3) *Serous diarrhœa*. The fluidity of the stool in this variety is much greater, and can best be described as "watery"; the bowels move more frequently; there is considerable abdominal tenderness; in addition to the loss of appetite, nausea, furred tongue, the water is scanty and high coloured, and there may even be some rise of temperature. The pain is very severe, of a griping, gnawing, or grinding nature.

(4) *Lienteric diarrhœa*. The stools in this variety contain undigested food, giving rise to the name by which it is known. It chiefly occurs in those who have become, from some cause, weak and out of health; the process of digestion and assimilation seems at a standstill. The appetite in this form, unlike the others, is increased or perverted, but in spite of food taken into the system the patient rapidly wastes, loses strength, becomes anæmic, and, unless the disease is checked, dies of exhaustion.

(5) *Colliquative*.—Any form of diarrhœa is called colliquative when rapid exhaustion follows. It occurs in those

whose vicissitudes of life are very great, in women who have large families and who have hoped in vain to limit the number by over-lactation ; or in those who have been the subject of some prolonged chronic disease, and whose health has got undermined and enfeebled, although there may be no intestinal lesion.

These varied forms may appear either as an acute or as a chronic manifestation, but in addition to them there is a form of chronic diarrhœa peculiar to those who have lived abroad, and who have been exposed to malarial poisoning. This is very common in India, where it is known as diarrhœa alba, or white flux. It is also met with amongst both European and American soldiers, and has obtained for itself the name of camp diarrhœa. It is very insidious in its approach, giving but little trouble at first. The stools are pale or drab in colour, becoming more so as the disease progresses. They also become more fluid, sometimes lienteric or even dysenteric in quite the latest stages, and the patient dies after the usual manner in chronic diarrhœas, from either exhaustion or convulsions.

#### DIAGNOSIS.

An ordinary case of feculent diarrhœa presents no difficulty in the matter of diagnosis, but the difficulty of distinguishing between the various forms of this disease is very great. If, however, there be an absence of much abdominal tenderness, or if pain is relieved to some extent by the movement of the bowels, it may be concluded that there is little or no inflammatory condition, such as accompanies enteritis, or ulceration. There is also considerable difficulty in distinguishing between a bilious diarrhœa and the early stage of dysentery, but the greater amount of tenesmus, together with the appearance of the discharges when mixed with water, is sufficiently characteristic. In simple bilious diarrhœa the addition of water simply dilutes the whole, whereas in dysentery the water removes much of the colouring and soluble matter and leaves shreddy mucus, and flocculent stringy masses, adhering to the vessel.

## PROGNOSIS.

If the case be recent and uncomplicated, the prognosis is always favourable, even in inflammatory diarrhoea. If, however, diarrhoea comes on in a patient suffering from long-standing constitutional disease, such as cancer or tuberculosis, or where there is a distinct history of hepatic or splenic trouble, the prognosis must be regarded as distinctly unfavourable.

## TREATMENT.

The treatment divides itself into two, dietetic and medicinal; for the sake of brevity we will only deal with the latter, the medicinal:—

Medicines suitable for the treatment of diarrhoea, either acute or chronic, are simply appalling from their number. Dr. Hughes well says in his work on therapeutics, with reference to this very question: "No pathogenetic effect of drugs is more common than purging; and it is probable that every substance in nature, which, by specific affinity, and not merely by local irritation, causes diarrhoea, has some corresponding variety of the idiopathic disorder for which it is a remedy better than any other." Allen's symptom-register gives 425 drugs which have diarrhoea in their provings; whilst Dr. James Bell, of Boston, in his admirable work entitled, "The Homœopathic Therapeutics of Diarrhoea," has in the most masterly manner dealt with 141 of our medicines, and has thus placed within our reach a manual, indispensable to any one who frequently has this disease to treat; and who of us has not? I conceive, however, that this work will be found most useful in treating chronic and intractable diarrhoeas, which come to us after they have been tired and wearied out under ordinary treatment. Fortunately for our patients, and for the reputation of homœopathy, we have from eight to ten well known and tried drugs, whose indications are to all of us so familiar that it is an almost daily experience to prescribe them with the very best results. I will not therefore make any attempt

to deal with the very wide field above referred to ; this, indeed would be a task neither agreeable to your convenience nor yet to my ability ; but will content myself with naming our old friends, with some of the indications for their use.

*Arsenicum* is not a medicine for purely functional diarrhœa, and very seldom is it called for in the acute variety ; but in cases of malarial origin, or in connection with deeply rooted structural disease, it is certainly one of the best remedies. The stools are of a slimy green character, watery, and at times mixed with blood, not preceded by much pain, but generally followed by a burning in the anus and rectum. The patient is restless and thirsty, but does not drink much at a time, and shows many indications of prostration and considerable emaciation.

*Baptisia* is suitable to those cases which have been produced either by inhaling noxious gases or by drinking contaminated water, and in all cases of diarrhœa occurring during a typhoid epidemic. It is suitable in those cases where the stools are small and frequent, and horribly offensive, but accompanied by little or no pain.

*China* is most suitable for cases of diarrhœa coming on in patients who are the subjects of chronic disease, or in those who have suffered from loss of fluids, as in hæmorrhage or over-lactation. It has been a great favourite for summer diarrhœa, and if one had to make a choice of one remedy for this complaint, without much hesitation the choice would be china, and with the assurance that but a few cases would not benefit by it. The stools are painless, watery and undigested, worse after meals and at nights ; there is considerable colic before stool, and a feeling of great exhaustion afterwards.

*Colocynth.*—This is a medicine which occupies a very limited range, but within that range its action is always most satisfactory ; the pain calling for it is described as griping, twisting, cutting, bending the patient double ; stools are copious, very fluid, accompanied with considerable flatus, generally rendered worse by food or drink.

*Iris versicolor.*—This medicine also holds a very good



place in the treatment of summer diarrhœa, and is most useful in those cases whose character is so severe as to be called British cholera. There is generally considerable vomiting of an extremely sour fluid in the cases calling for iris versic.

*Mercurius* is suitable for cases which occur during damp or cool weather, or when the day and night temperature varies very greatly; the stools are green, slimy, brownish, rather scanty and often mixed with blood; there is much colic, burning and tenesmus, before, during and after stool.

*Podophyllum* is one of the most useful of remedies, and the indications for its use are generally very well marked in that form of diarrhœa which shows itself by an urgent call in the early morning, either before the patient's usual hour for rising, or so soon as he begins to move about; the same urgent feeling is experienced during a meal, so that he has difficulty in finishing it. *Podophyllum* is then clearly indicated. If, in addition, there is prolapsus ani, or a great deal of sacral pain, further confirmation of its suitability is afforded. The stools may either be yellow and liquid, or green, watery and undigested, or they may be of a clay or chalk-like appearance, generally frequent, profuse and gushing.

*Veratrum album* is a remedy of great value in those cases characterised by violent, painful and copious stools of a greenish watery character, mixed with flakes; the patient experiences severe pinching colic, before and during stool, with considerable nausea and vomiting.

I regret that I am unable to give any cases illustrative of the effects of these remedies: diarrhœa is so common that but few cases of it find a permanent record in our literature. This is a matter that is to be regretted, and let us also hope to be remedied.

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Dr. MADDEN expressed his thanks to Dr. Day and Dr. Murray for their papers, and said he was pleased to notice that a special point had been made regarding the use of raw meat juice for feeding babies subject to diarrhœa. It produced admir-

able results, and there was usually no difficulty in getting children to take it. He was also glad that Dr. Murray had recommended Bell's book on diarrhœa; it was one of the best hand-books they had. He did not notice, in Dr. Murray's paper, a reference to the necessity, in every case of chronic diarrhœa in adults, of examining the rectum.

Dr. GOLDSBROUGH extolled Bell's book as being a reliable guide to remedies according to their indications. In very young babies he had sometimes found meat juice perpetuate the trouble, and had then been obliged to fall back on simple rice water for a short time. A child could live for a few days on that, with a chance of getting over the diarrhœa meanwhile, and then a more suitable diet could be ordered. He had found cream and water (1 in 10) very serviceable when other things had disagreed, especially if there had been vomiting. He wished to re-inforce the well-known homœopathic practice, that a dose of medicine should be given after each stool; only after a stool, and not in regular doses. He often found it necessary to go from lower to higher dilutions. Sometimes, as for example with mercurius and arsenicum, the higher dilution did more good than the lower. He would also emphasize the value of mercuris dulcis or calomel, also gummi guttæ or gamboge.

Dr. GALLEY BLACKLEY said, with regard to Dr. Day's paper, that the feeling he had had during the last few years, since the sterilization of milk had come so much to the front, was one of disappointment that it should be necessary. There must be some other way out of the difficulty. By boiling, the anti-scorbutic principle was eliminated, and when, as Dr. Goldsbrough had pointed out, children would not take the raw meat juice, they were in a difficulty. He had been in hopes that some form of centrifugal machine would be devised, which would send all the bacteria and cocci to one end of the vessel, and leave the pure milk and cream at the other. With regard to Dr. Murray's paper, Bell's book on "Diarrhœa" had given him (Dr. Blackley) very great help at times for twenty-five years past, both in England and in the Tropics. He bought the book at the homœopathic chemist's shop in Cape Town, and it was one of the best investments he had ever made. He did not agree with Dr. Murray in thinking that arsenic was not a medicine to be employed so much in acute diarrhœa as in chronic cases accompanied by grave organic changes; he (Dr. Blackley) thought it was equally useful in both classes of disease.

Dr. ROBERSON DAY, in reply, said he expected the discussion

would chiefly turn on the question of feeding children suffering from diarrhœa, and the sterilization of milk, and that was why he gave it prominence. In the question of feeding with milk they were on the horns of a dilemma. If they bought milk from the ordinary dairy they ran a great risk of communicating several diseases; but by sterilizing it they defended themselves from many accidents, and yet at the same time robbed the milk of its so-called antiscorbutic properties. He would emphasize the need of bringing the milk supply under some municipal control, so that the herds of cows would be healthy and of such a character that they would produce a *safe* milk. It was possible, and was done in some countries on the continent. Again, in England the tuberculin test was more the exception than the rule. They had not yet reached the stage of sanitation which he had mentioned, and it was therefore better to run a known risk (*e.g.*, of producing scurvy-rickets) than to incur an unknown one, where tuberculosis, scarlatina, diphtheria, enteric fever, and other diseases might be contracted.

It rests with, and is the duty of, the public to demand a pure milk, obtained only from healthy herds which have been subjected to the tuberculin test.

Dr. MURRAY, in reply, said he was very much obliged for the way in which his paper had been received.

With reference to the question of the supply of milk to the community, dealt with in Dr. Day's paper, he thought it of prime importance that the milk should be so handled, that sterilization should not be required. If they tried to obtain an Act of Parliament they would have to wait for some time. In the meantime they ought to try and move local authorities to adopt a voluntary inspection. Those who supplied milk to the community might submit the herds, and conditions of keeping the milk, to an inspector or medical officer of health, who could give a certificate, which the cow-keeper or milk vendor could show to the community.

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ON HEART DISEASE<sup>1</sup>

BY BYRES MOIR, M.D.

*Physician to the London Homœopathic Hospital.*

MR. PRESIDENT AND GENTLEMEN,—I have first of all to thank you for the honour you have done me in asking me to read a paper before you this evening. I have accepted your invitation with much pleasure, but at the same time with a certain amount of trepidation, for Liverpool to me is always associated with one of the best, if not the best worker and philosophic thinker the homœopathic body has produced—the late Dr. Drysdale. Knowing his careful work, I can only ask from those who have been trained by him to have mercy on my shortcomings.

Your Secretary gave me a free hand with regard to the subject of a paper this evening, and in taking up Heart Disease, there is a wide field of subjects which may give rise to a practical discussion. From birth to the final exit we find functional and organic changes of the heart and circulatory system, and at no period of life, unless there is complete degeneration of tissue, do we meet with any conditions that do not well repay careful treatment. Even in congenital malformations, which we are too apt to look upon as medical curiosities, something may be done. When visiting the Central Gymnastic Institute at Stockholm last year, I was very much struck with the case of a boy of 10, the subject of congenital malformation, who by careful and persistent exercise was able to run about and enjoy life, while without such treatment he would have been condemned to a life spent between bed and an armchair. I said that from birth we find these cases, but we have to go further back than that, as several cases are now on record where a murmur has been detected in the fœtus *in utero*, and a *post-mortem* has revealed later, that the valves showed

<sup>1</sup> Presented to the Liverpool Branch, February 9, 1899.

all the signs of rheumatic endocarditis, though the mother had been quite free from symptoms of rheumatism.

### RHEUMATIC HEART DISEASE.

If we leave out cases of heart disease which result from chronic degenerative changes in age, we find that the majority of cases met with are caused by rheumatic fever. Under the age of 15 few cases of acute rheumatism escape cardiac complications; if the first attack occur after 25 it is rare to find the heart implicated.

We are all too well aware of the insidious way in which the heart trouble often commences, and it ought to be a routine practice to examine the heart among children out-patients, as any joint trouble may be quite absent; but I think there is nearly always more or less rise of temperature. Until recently implication of the valves was looked upon as the most serious possible danger, but of late much more attention has been paid to peri- and myocarditis, for there has been found in most cases what Dr. Sturges called "carditis," that is, both exo- and endocarditis. Pericarditis is nearly always present, and probably contributes largely to the fatal results. Dr. Lees, in a paper read before the British Medical Association last year, gave as a definite statement from the result of 150 *post-mortems* in rheumatic heart disease of children, "that in only nine was the pericardium found healthy. It was found to be more or less adherent in 113 cases (75 per cent.) and in 77 of these, or one half of the entire number, the adhesion was complete over the whole surface of the heart. In only 38 cases of the 150, or 25 per cent., was it noted that any fluid at all was present in the pericardial cavity, and in many of these the amount was small, in only six more than 3 ozs. The highest estimates were five and six ounces, and each of these in one case only."

One of the most marked features in these cases of rheumatic heart disease is the increased area of dulness which is found on percussion. I must say that formerly I used to think that the increased area of dulness was due to effusion

of fluid, but I do not do so now. As a typical case I will give a few notes of one I have watched for some years.

F. H., a boy of 12, was admitted to the wards of the London Homœopathic Hospital October 14, 1896. He had previously been in the hospital three times with rheumatic fever and heart trouble, the first attack being when 8 years old. His pulse was 80; temperature 99.6°; respiration 32. Apex beat was in the sixth space, one inch outside nipple line, with visible impulse in the fifth and sixth spaces. No thrill felt. Cardiac dulness—upper limit second intercostal space, left limit a curved line from second space, 2 inches from sternum, passing outside nipple to apex beat. Right limit  $\frac{1}{2}$  inch to right of sternum at second space and  $1\frac{1}{4}$  inches to right of sternum at fifth space. At the apex there was a blowing systolic murmur conducted into the axilla, the second sound being much accentuated in the pulmonary area. In the middle of the præcordial area, *i.e.*, over the inner ends of third and fourth spaces and corresponding part of sternum, there was a rough superficial pericardial friction sound having the usual to and fro character and increased by pressure.

The diagnosis was old mitral disease with pericarditis; no appreciable effusion, but partly adherent pericardium. We have here evidence of very great dilatation of the heart, and an interesting point is upon what does this dilatation depend. Many observers seem to think that it may be explained by the toxæmic effect of the rheumatic poison upon the muscles of the heart, as simple adhesion of the two walls of the pericardium does not account for it, and it cannot depend upon the mitral regurgitation.

Only last week, in talking to Dr. Edward Blake, he told me of some experiments made by Dr. Leonard Hill and others which throw great light upon it. It has been found that when the pericardium is healthy it is very difficult to obtain any dilatation of the heart, but when a slit is made in the pericardium, or the walls are softened by disease, it is quite easy to obtain extensive dilatation. The pericardium may thus be compared to a continuation of the walls of the arteries, the two layers separating to allow of the movements of the heart. This would explain the dilatation, the pericarditis, which I think is always present in these cases,

leading to a softening of the pericardium, and so allowing of the dilatations. In slight cases the heart may regain tone, but in many the dilatation becomes permanent.

*The causation of acute rheumatism* is at present receiving much attention. The old chemical theory is not now in favour. Instead, the view that it is due to a specific micro-organism is steadily gaining ground. Many points contribute to the formation of this opinion, although the "cocculus" has not yet been separated. The frequent occurrence of tonsillitis before an attack would lead one to think that the tonsils may in some cases be the origin of infection, and accepting the infective theory, it would give an explanation of chorea, which in children is of undoubtedly rheumatic origin, assuming that the chorea results from the action of a toxin on the nervous system. But even if a specific microbe of rheumatism is separated, the field of causation is not completely surveyed, for we have to find what is the soil which allows of the microbe being developed. In the children with acute rheumatism which come before us in London, one is struck with want of development and marked anæmia. Want of fresh air, improper diet—meat being allowed from early months, and exposure to wet and cold, would account for a state of the blood which renders it a suitable medium for the development of micro-organisms.

*In treatment* there is not much help to be derived from the therapeutics of the old school. The salicylates, which give such decided relief to the joint troubles in adults, have little room for benefit in children where the arthritis is so slight; they have no influence in preventing the heart complications and are more likely to do harm by lowering the system.

Dr. Sansom, in a paper reported in the *Lancet* of December 10, 1898, gives a much-needed warning against the use of digitalis in these cases; he refers to an investigation by Drs. Lauder Brunton and Theodore Cash on the use of digitalis, and drugs which act like it, in febrile conditions, and expresses the opinion "that not only during periods of rheumatic pyrexia but also when the heart structures are actively infiltrated during rheumatism, though it may be in

the apparently chronic stages, digitalis is often inert or harmful." He recommends rest in bed, the ice-bag over the heart, hypodermic injection of morphia,  $\frac{1}{10}$  to  $\frac{1}{4}$  grain, and small doses of calomel,  $\frac{1}{2}$  grain three times a day for three or four days together. We may turn with much more confidence to our own remedies.

*Aconite* is, as Dr. Hughes says, truly homœopathic to the rheumatic poison, and especially to the cardiac condition. Dr. Jousset found that the introduction of increasing doses of the extract into the circulation had the invariable result of producing lesions of the mitral valve; and I think that if its administration is begun early in a case, it has a decided action as a protection from cardiac complications. I do not think we need fear any depressing effects. I have frequently given 2 drops of the mother tincture every hour for four or five doses in endocarditis, when the pulse has been very frequent and feeble, with great relief to the symptoms. I do not wish to advocate these doses in ordinary cases, as they are not necessary, but I think that aconite is not often persevered with steadily enough.

On the alternation of aconite and bryonia, which now seems a routine practice with many homœopaths, I need not dwell; bryonia certainly has a specific action on the pericarditis of rheumatism.

Some years ago there was a letter from an Australian *confrère* recommending *lycopodium* in rheumatic fever, and I have since had some very satisfactory results from its use in controlling the febrile condition. Before that I had, in my ignorance, always associated lycopodium with chronic conditions; but I found on turning to Hughes, that the tincture had produced inflammatory rheumatism of arm, wrists and forefingers, and that Dr. Hughes himself had found it of benefit in a case of aneurism.

To *spigelia*, which gives such relief in acute cardiac pain, and to several other remedies, I should like to refer, but will only take up your time with one other drug, which I do not think has yet been given the position which it deserves in these cases, and that is *cactus grandiflorus*.



Cactus was first used by our school, although of late it has been generally taken up and recommended as "a valuable cardiac nervine and tonic in five minim doses" and there is also a large sale of the extract in the form of "cactina pillets." It was introduced to practice by Dr. Rubini, of Naples, who proved it upon himself and his wife, and in his pamphlet, which was translated by Dr. Dudgeon in 1864, he states that "my wife and I, on perceiving how powerfully it acted on the heart and circulatory system, causing the shedding of tears and feelings of terror, had not the courage to go further in experiments, which might endanger our lives." He expressed his hope that others with more fortitude and less timidity would be able to complete and correct whatever symptoms had not been accurately described. Gentlemen, these heroic provers have not yet appeared; and we are sadly in need of provings of this and other drugs, with the results tested by the modern instruments of precision.

In the meantime I would place the action of cactus as midway between that of aconite and digitalis. It certainly seems to control the inflammatory condition and at the same time to strengthen the heart contractions. In its provings it seems to have the power of producing peri- and myocarditis, and to give a better picture of the rheumatic carditis than any other drug. I have been using it lately with good results, and hope soon to have definite statistics to lay before you.

So far it has had a better reputation with us for functional diseases of the heart; but that is I think because we have not attended to the directions of Dr. Rubini, who advised that in organic diseases of the heart it should be given in doses of from 1 to 10 drops of the tincture, and in nervous diseases of the heart in the 6th, 30th, and 100th dilutions. For the rheumatic heart I would advise two to five drops of the  $\phi$  tincture according to the age of the patient.  $\phi$

The frequent relapses we see in acute rheumatism ought to receive more attention than is given to them. I think they would be preventable by our keeping sight of our cases till we see them in really good health. In hospitals

there is always the desire to get out cases as soon as possible, and relapse is frequently the consequence. The anæmia after an attack is most marked. By careful after-treatment much might be done in the way of prevention, for the most serious cases of heart trouble are in those who have had repeated attacks.

It is in these cases we so frequently see the most fatal form of heart disease, viz., infective or ulcerative endocarditis. The damaged valves seem to be particularly liable to the development of micro-organisms, the three most common in ulcerative endocarditis being the "staphylococcus pyogenes aureus," the "streptococcus pyogenes," and the "diplococcus pneumoniæ." So far neither school can boast of much success in its treatment.

I have not time to dwell upon it to-night, but have brought down some charts which may interest you. Nothing can be more painful than to watch a long case of marked fever, in which one is in doubt of any certain means of treatment.

*Chart No. I.* is from a case which lasted over nine months and derived no appreciable benefit from the treatment of many physicians.

*Chart No. II.* ran a more rapid case and illustrates well a point which we owe to the observations of Dr. Burford, and was well shown in his paper on peritonitis, viz., that in septic cases the pulse must be taken as a danger signal, and that when the temperature falls and pulse rises the end as a rule is near.

*Charts Nos. III. and IV.* are two which I am glad to say show a satisfactory termination in our hospital, and both a boy and a girl are now leading an active life. No. III. was not of such a malignant type, but as to the septic state there could be no doubt, and No. IV., which was under the care of Dr. Epps, proves the exception to Dr. Burford's law, the temperature falling to 95° and the pulse rising to 240, the patient being in a complete state of collapse, yet recovery took place. In these two cases the medicines which seemed to be of benefit were strophanthus and naja.

## MITRAL INCOMPETENCE.

Turning to mitral incompetence and want of compensation, I will begin with short notes of a case, which on admission to the hospital seemed almost hopeless, but left with compensation well established.

A. L., aged 26, female, admitted to the hospital June 5, 1896. Discharged August 1, 1896.

*History.*—Had rheumatic fever at the age of 12 and a second attack when 20. Was married at 21, when she was apparently in good health, but at the birth of her only boy two years afterwards became very weak and has not been well since. Suffers from palpitation and dyspnœa, with swelling of the feet and legs. During the last few days the abdomen has begun to swell, and her general state was so much worse that she sought admission to the hospital.

*Condition on admission.*—Was suffering from marked dyspnœa. Mucous membranes were pale. Conjunctivæ tinged yellow. Complains of severe pain in left side of chest and behind shoulder blade, there is also palpitation and orthopnœa on the slightest exertion. Pulse rapid; very irregular both in time and force. The præcordia is distinctly bulged. Apex beat is felt as low down as the eighth left interspace and as far out as the mid-axillary line. The whole præcordia is seen to heave with the pulsations, and there is also pulsation in the epigastrium and vessels of the neck. Auscultation reveals a blowing systolic murmur in the mitral area well conducted round to axilla and the angle of the left scapula. It is less marked towards the tricuspid area. No murmurs at the base. The heart's action is very rapid and irregular.

*Respiratory system.*—There is dulness on percussion at both bases posteriorly with diminished breath sounds, and vocal resonance is also diminished. Moist crepitus can be heard at the right base. *Alimentary system.*—Appetite is very bad and patient suffers from constant vomiting. *Abdomen.*—There is marked abdominal distension (measurement  $39\frac{1}{4}$  inches) with prominence of the umbilicus. The walls of the abdomen pit on deep pressure. Dulness to percussion in both flanks, which shifts in position on lateral decubitus. Well-marked fluctuation thrill. The edge of the liver can be felt about two inches from the umbilicus; it is tender to pressure but quite smooth. There is general anasarca

of the loins, abdomen and lower extremities. *Urine* scanty in quantity; copious deposit of urates with trace of albumen.

Infusion of apocynum ʒ i. every three hours was ordered.

The urine passed in the first twenty-four hours was 10 ounces, the next day 24, then 32. It fell again to 8 ounces, and infusion of digitalis ʒ i. every three hours was ordered. With this it rose again to 32 ounces, but fell again to 14 ounces. So on June 15 strophanthus m̄ v. was given, and under this steady improvement took place. The quantity passed rose to 70 ounces and the dropsy passed gradually away, and she was able to leave the hospital with compensation well established.

The tracings will show the improvement in the pulse, and the abdomen, which on admission measured 39½ inches, was reduced to 29½ inches.

#### ACTION OF MEDICINES IN DROPSY.

It is now generally allowed by homœopathists that to obtain good results in cardiac dropsy, tangible doses of the medicines have to be used. At a meeting of the British Homœopathic Society in July, 1896, there was an interesting discussion on the question whether medicines like digitalis and strophanthus given in large doses could be considered to be homœopathic in their action when used in cases of cardiac failure.

Drs. Hughes, Dudgeon and others considered their action was antipathic, while Dr. Dyce Brown was very strong on the opposite side and quoted Professor Hale, of Chicago, in support of his views. Dr. Hale 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 similars should oblige us to take cognizance of this dual action and select the dose in accordance with such action."

The essential question in homœopathy is, I maintain,

not the actual amount of medicine given, but that the action of the medicine should be similar and the amount given not sufficient to aggravate.

In the provings of digitalis the action of small doses is seen to cause at first increased frequency of the pulse, which afterwards becomes feeble and irregular, while in poisonous doses the heart's action is at once slowed and soon paralysed. No medicine is more used in heart disease than digitalis, and in properly selected cases no remedy could act better. There can be no question, however, that the use of the drug is abused. To quote from an allopathic source: "There is probably no one drug in the Pharmacopœia the promiscuous use of which has done so much harm to the human race." The indications for its use are therefore of the greatest importance. The cardinal symptom indicating it is irregularity of the heart and pulse with low tension. A condition like the case I have read you, hypertrophy and dilatation of the ventricles with mitral regurgitant murmur and quick, feeble, irregular pulse, is one typical of the class where digitalis acts most beneficially, but in that patient, for some reason which I cannot explain, it did not act so well as strophanthus. In a similar condition, where there may be also aortic disease, digitalis may be of great service, but must be used with more caution; the reason for this I will refer to later.

Its diuretic action is hardly to be relied upon apart from heart disease, but when heart disease is present its diuretic effect as a rule is beneficial. I have said "as a rule," for in certain cases digitalis gives no relief and is apt to be a great danger. At first, perhaps, you get a diuretic effect but very soon the opposite result takes place and the urine is diminished. This is probably due to the action digitalis has in causing contraction of the arterio-capillaries and great tension, and a feeble heart is then being whipped up against greater obstruction than it can overcome, and fatal syncope is very often the result. It has often been noticed that digitalis does not act until the patient has been well purged, a good purge being a most effectual way of lowering the general tension of the circulatory system.

In the discussion which I have referred to before on the

heart remedies, Dr. Neild, of Tunbridge Wells, was most emphatic on the brilliant results he had obtained by prescribing nitro-glycerine in alternation with digitalis. Nitro-glycerine was in his opinion the complement of digitalis. It acted antipathically, and corrected the main difficulty with digitalis, viz., extreme tension and contraction of the smaller blood-vessels.

By preventing tension with these two remedies we obtain a diuretic effect, and thus have all the good of digitalis without its evil results.

Dr. Neild believed with Dr. Dyce Brown that the action of digitalis was frequently homœopathic. In one of his cases the patient had a rapid, irregular and very feeble pulse, symptoms like a typical case of poisoning by digitalis as shown in the "Cyclopædia." There was a certain amount of tension, the kidneys were scarcely acting, and there was albumen in the urine.

He gave Burggraevæ's granules of digitalin, eight or ten daily. The curious thing was that he had to give very minute doses of nitro-glycerine. He usually began with one drop of one in a hundred, but in that case he had to halve and halve again and again this dose on account of its physiological action, headache and flushing being so extreme. The sixteenth of one drop of one in a hundred was the antipathic dose that allowed the digitalis to act homœopathically and cured the patient when apparently hopelessly ill.

nitro-glycerine  
2<sup>x</sup> m.  
3<sup>x</sup>

The preparations of digitalis used are of great importance. For myself I prefer the fresh infusion to the tincture, giving a drachm every three or four hours, but directly the pulse becomes regular and the flow of urine is established, the frequency of the dose is to be much lessened.

Strophanthus acts in heart disease by increasing the force of the systole, at the same time that it diminishes the rapidity of the heart's action.

It has little or no effect upon the blood-vessels and therefore causes less tension than digitalis, it also causes less gastro-intestinal disturbance. It is not cumulative in

its effect and can be used in smaller doses than digitalis. It is indicated in all cases of valvular disease where compensation has broken down. In mitral regurgitation where œdema and dropsy have supervened, its action is often most marked, the heart being strengthened and slowed, the respiration relieved and free diuresis set up. In the case I have narrated the quantity of urine secreted rose from 10 to 70 ounces, but in some cases the flow may be as much as 150 ounces in the twenty-four hours. In aortic stenosis and incompetence where there is want of compensation, and where, as is often the case, there is marked atheroma of the vessels, strophanthus is much preferable to digitalis. In chronic conditions like the irregular heart of old people and where, a rapid action is not necessary, one or two drops three times a day continued steadily give the best results; but in more acute cases five or ten drops are necessary.

Apocynum Cannabinum—This drug was first brought to our notice in "Hale's New Remedies," where it is mentioned that in America it has received the title of a "veritable vegetable trocar." About its powerful diuretic effect there can be no doubt, but precise indications are still wanting as to the exact conditions in which it proves useful. It belongs to the same class as strophanthus, and its diuretic action appears to be similar, viz., through the heart and not as a local renal diuretic. I have found it a very disappointing remedy, although sometimes it gives splendid results. Failures are probably due to a want of knowledge of the precise indications for its use.

Strychnine is of great value in cases where there is a slow, feeble, and irregular pulse. In cases of sudden failure where there is not time to obtain the action of a medicine by absorption from the stomach, strychnine given hypodermically may generally be relied upon.

With the benefit to be derived from *arsenic* in relieving pain, palpitation, and dyspnoea, as well as its marked influence over anasarca, we are all well acquainted.

The homœopathic use of drugs is steadily and quietly permeating the old school, without acknowledgment though it may be. I must say that I am glad to see such a careful

observer as Prof. George Balfour, of Edinburgh, in speaking of arsenic say, in his book on "The Senile Heart":—

"Most excellent results indeed occasionally follow the prolonged use of almost infinitesimal doses. I well remember one old gentleman, exceedingly sensitive to the action of drugs, to whom the  $\frac{1}{80}$  grain of arsenious acid was quite poisonous, but who could tolerate the  $\frac{1}{160}$  of a grain without difficulty. After taking this minute dose daily for two or three weeks, and nothing else, for a dilated and hypertrophied heart beginning to fail, he said to me, 'I don't know what benefit you expected from the treatment, but I know what I have received. I can go upstairs much easier than I used to do.'"

"Arsenic," he also says, "may be given alone, and in anæmic and very sensitive persons who can only tolerate a very minute dose, this is often the best way of employing it."

We find here, in Balfour's recommendation, the similar relations, the small dose and one medicine at a time.

There are many other medicines that I should like to refer to, but time forbids. I can only mention that we have in the Nauheim method of baths and exercise a most valuable adjunct in many cases of failing heart; we frequently make use of it in our hospital, and it can be easily carried out in a private house.

I am afraid of wearying you, gentlemen, but there are a few points of interest that I should like to bring before your notice before concluding.

In the class of cases we have been so far considering, viz., inflammation in young people, and chronic failure in middle life, much may be done by medicines; but in cases where degenerative changes have proceeded to a certain point, especially if occurring at a period which ought to be the prime of life, little can be done by medicines, and our efforts ought to be directed to prevention before they reach such a stage.

By degenerative changes I mean the atheromatous and fatty changes found in the blood-vessels as well as the heart itself. If for a moment we look upon the heart as a pump connected with a series of elastic tubes, we can see how



these changes are brought about. To represent the capillaries we should need a network of fine tubes to complete the flow of fluid to and from our pump. We can easily see then how any interference with the calibre of these fine tubes would alter the work which falls upon the propulsive power, the least contraction of the tubes would mean increased work for the heart to overcome, and if such force is applied, there must be increased tension in the vessels leading to the capillary network. This is what actually takes place. In gout, Bright's disease and allied conditions, we have foreign matters retained in the blood which either by irritation cause a contraction of the capillaries and small vessels, or by altered constitution of the blood interfere with its free passage. In either case we have interference with the peripheral circulation, and as a result hypertrophy of the walls of the heart, and a general arterio-sclerosis is developed, and from this, atheroma.

On the other hand, with a weak propulsive power and low tension in the vessels, we get interference with the return of the blood to the heart, and a general condition of venous stasis; this, from the want of proper oxidation of the tissues, leads to fatty deposit and degeneration.

From this we can see the need of an accurate means for measuring the blood pressure. For my own part, I find it most difficult to decide in many cases, from the touch of the fingers on the pulse, the exact condition with regard to tension. The sphygmograph gives some help, which these tracings illustrate. I have here Dr. Leonard Hill's sphygmograph, and shall be glad to demonstrate its use after the discussion. It is the best means we have at present for determining the blood pressure, and already some good work has been done with it, especially by Dr. Maurice Craig, of Bethlehem Hospital, who, in a paper published recently by him on the blood pressure in lunatics, shows clearly that melancholia and delirium are associated with high and low tension, and he gives the result of treatment in these conditions.

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Dr. HAWKES referred more particularly to acute infective endocarditis, and recounted two cases which had lately been under his care. In regard to the treatment of pericarditis, a patient at present in the wards, who at the end of a long attack of subacute joint trouble had suddenly developed well-marked pericarditis, had recovered rapidly and completely under the use of *colchicum 1x*.

Dr. MURRAY MOORE said he had for thirty years used *cactus grandiflorus* with marked benefit. He considered that the exhibition of *digitalis* called for very careful consideration, as it sometimes gave rise to an aggravation. In the treatment of a certain class of heart disease, where it was required to produce more efficient cardiac action without at the same time increasing the peripheral resistance to be overcome, he used *iberis amara*.

Dr. GORDON pointed out that the "cactina pillets" which had been referred to in the paper contained not only *cactus*, but also small quantities of *convallaria* and *strophanthus*. In cases of rheumatism where there were rapidly shifting pains, he considered there was greater liability to rheumatic heart trouble, and in such cases he relied chiefly on *aconite*, given generally in the 6th dil.

Dr. GREEN gave particulars of a case in which two-drop doses of *digitalis*  $\phi$  had produced distinct aggravation, but which was speedily relieved by *cactus grand*. He used *apis* in cases of pericarditis with effusion, and considered that drug was of use in limiting the amount of fluid effused as well as aiding in its absorption.

Dr. ELLIS announced himself as sceptical of the good to be derived from the use of homœopathic medicines in mitral incompetence and allied heart diseases. He did not believe that *digitalis* ever did or ever could act homœopathically. He had been accustomed to use *cactus grand*. in functional heart cases only.

Dr. J. W. HAYWARD referred to the value as a prophylactic of all rheumatic affections of correct hygiene, especially of sufficient physical exercise and bathing. As regards medicinal treatment, he advocated more thorough study of and appreciation of the salient indications of individual drugs.

Dr. MEEK said his chief difficulties in the management of heart cases generally, were in regard to (1) diet; (2) action of the bowels; and on these points he would like further information.

Dr. J. D. HAYWARD (in the chair) tendered to Dr. Byres Moir the sincere thanks of the Society for his presence there that evening, as well as for the extremely interesting and instructive paper.

SPECIMENS SHOWN : SESSION, 1897-98.<sup>1</sup>*Ovarian Cyst removed on account of Pain.*<sup>2</sup>

THE patient was a well-developed girl of 22 years, who had been for some time past suffering from persistent backache. Examination disclosed a pelvic growth contiguous to the uterus. The pain continuing in spite of prolonged rest and local treatment, abdominal section was performed, and a small dermoid cyst of the ovary removed. Result : Recovery from the operation and entire loss of the previous pain.

*Ovarian Cyst removed on account of Hæmorrhage.*<sup>3</sup>

In this case the patient was 27 years of age, married, and had had three children. The catamenia were profuse, recurring every two or three weeks. Examination indicated the existence of a pelvic cyst. Ovariectomy was performed, an ovarian cyst removed, and the patient made a good recovery. The menorrhagia showed marked abatement for several months ; a year afterward, local uterine conditions repeated the same symptom.

*Four large Gall Stones removed by Cholecystotomy.*<sup>4</sup>

A lady, past the menopause, had been for some months suffering with symptoms indicative of subacute toxæmia. The liver was much hypertrophied, and the symptoms pointed to this organ as the *fons et origo mali*. On exploration, the gall bladder was found quite devoid of fluid, but containing instead four large gall stones. These were removed, the gall bladder stitched to the abdominal wall, and drained ; the toxic symptoms soon subsided, and the patient made a satisfactory ultimate recovery.

CLINICAL EVENING.<sup>5</sup>*Carcinoma of Uterus.*

A patient on whom vaginal hysterectomy had recently been performed for uterine carcinoma. She was 53 years of age, had

<sup>1</sup> These specimens were omitted from the JOURNAL of the Society for October, 1898.

<sup>2</sup> Exhibited by Dr. BURFORD, Jan. 6, 1898.

<sup>3</sup> Exhibited by Dr. BURFORD, Jan. 6, 1898.

<sup>4</sup> Exhibited by Dr. BURFORD, Jan. 6, 1898.

<sup>5</sup> The cases included under this head were exhibited by Dr. BURFORD at the Clinical Evening held on June 2, 1898, but omitted from the JOURNAL in October.

had eight children, the last nineteen years ago. Slight daily hæmorrhage had occurred for six weeks before admission; the menopause had been instituted for a twelvemonth. Intra-cervical carcinoma was diagnosed, and vaginal hysterectomy advised and performed. The operation was completely successful, the patient, when seen some months after, being entirely free from local lesion.

The uterus, as removed by vaginal hysterectomy, was exhibited at the same time.

*Carcinoma of Breast, Fibroid of Uterus, and Floating Kidney.*

A patient showing the unusual concurrence of cancer of the breast, fibroid of the uterus, and floating kidney. She was 53 years of age; the breast condition (scirrhus) had been noticed for some three years; the fibroid was of moderate dimensions, and caused no obvious trouble, nor was the kidney any source of marked discomfort. The breast condition was best controlled by hydrastis, given as mother tincture.

*Ovariectomy.*

A patient was shown who had recently undergone ovariectomy for ovarian tumour. She was 28 years of age, and had one child. The tumour was of considerable dimensions. The patient made a good recovery.

CASES, PATHOLOGICAL SPECIMENS, &c., EXHIBITED  
AT VARIOUS MEETINGS. SESSION 1898-99.

*Hydronephrotic Kidney.<sup>1</sup>*

Hydronephrotic kidney removed from a young man. There were symptoms of colic for two years, which came on regularly every Monday and which were attributed to over-eating on Sunday. Operation disclosed advanced hydronephrosis of left kidney due to complete closure of the ureter about two-and-a-half inches from the pelvis of the kidney. Recovery followed.

*Calculus weighing 404 grains.<sup>2</sup>*

This calculus was removed by supra-pubic operation with

<sup>1</sup> Exhibited by Mr. DUDLEY WRIGHT, October 6, 1898.

<sup>2</sup> Exhibited by Mr. DUDLEY WRIGHT, October 6, 1898.

successful result from a boy who had presented symptoms for only three months previously.

*Calculus weighing 522 grains.*<sup>1</sup>

This calculus was removed from a man aged 72 years, the subject of advanced hypertrophy of the prostate. The stone was lodged in a large post-prostatic pouch, and was removed by supra-pubic operation. Recovery from operation took place, and later the vas deferens on both sides was divided in order to reduce the size of the prostate, but this did not appear to have the desired effect.

*Sarcoma of Thigh.*<sup>2</sup>

This specimen was of the round-celled variety of sarcoma occurring in a girl. It was removed by successful amputation at the hip-joint.

*Calculus weighing 1,686 grains.*<sup>3</sup>

This was a vesical calculus, removed by supra-pubic cystotomy from a young man.

*A Needle.*<sup>4</sup>

This was a needle removed from the periosteum of the phalanx of the thumb by the aid of a radiograph (also shown).

*Post-Menopausal Carcinoma of Fundus Uteri removed by Vaginal Hysterectomy.*<sup>5</sup>

The patient was a lady a year and a-half past the menopause. Of late coloured uterine discharge had occurred; curetting showed cancerous elements in the tissue removed. On operation the cancerous area was clearly to be seen at the fundus uteri. The recovery was complete and uncomplicated.

*Post-Menopausal Polycystoma of the Ovary removed by Ovariectomy.*<sup>6</sup>

This case was one of marked loss of flesh and vigour in recent years, with rheumatoid symptoms in various joints. There was

<sup>1</sup> Exhibited by Mr. DUDLEY WRIGHT, October 6, 1898.

<sup>2</sup> Exhibited by Mr. JAMES JOHNSTONE, Oct. 6, 1898.

<sup>3</sup> Exhibited by Mr. JAMES JOHNSTONE, Oct. 6, 1898.

<sup>4</sup> Exhibited by Mr. JAMES JOHNSTONE, Oct. 6, 1898.

<sup>5</sup> Exhibited by Dr. BURFORD, November 3, 1898.

<sup>6</sup> Exhibited by Dr. BURFORD, November 3, 1898.

a large abdominal tumour closely applied to the uterus. Diagnosis, multilocular ovarian cyst. Ovariectomy was performed, and the cyst removed with some difficulty. The patient made a good recovery.

### *Lead Poisoning.*<sup>1</sup>

Dr. James Watson exhibited a patient giving the following clinical history:—Wm. C., aged 24, painter by trade for past twelve years; during the last three months has had three attacks of abdominal pain of a colicky, drawing character, bowels costive, and no sickness during the attacks.

When first seen he showed very marked tremulousness of muscles of face, hands, &c. He complained of pain in left shoulder and left upper arm, and weakness of middle and ring fingers of right hand. There was no "lead" line present, and no headache. There was no wrist-drop.

The chief interest centred in the condition of the middle and ring fingers of right hand; they were in a state of semiflexion; they could at will be completely flexed, but patient was quite unable to straighten them, and when forcibly straightened, they always returned to the semiflexed position on being liberated.

In some of its features the case resembled one of plumbism, whilst in others it was suggestive of a simple trades' spasm.

### *A Uterus and Myo-Fibroma, which reached, during life, to the umbilicus,<sup>2</sup> with temperature chart.*

H. H., aged 42, married. Admitted to Ebury ward, London Homœopathic Hospital, September 27, 1898. Had attended out-patient department for some months.

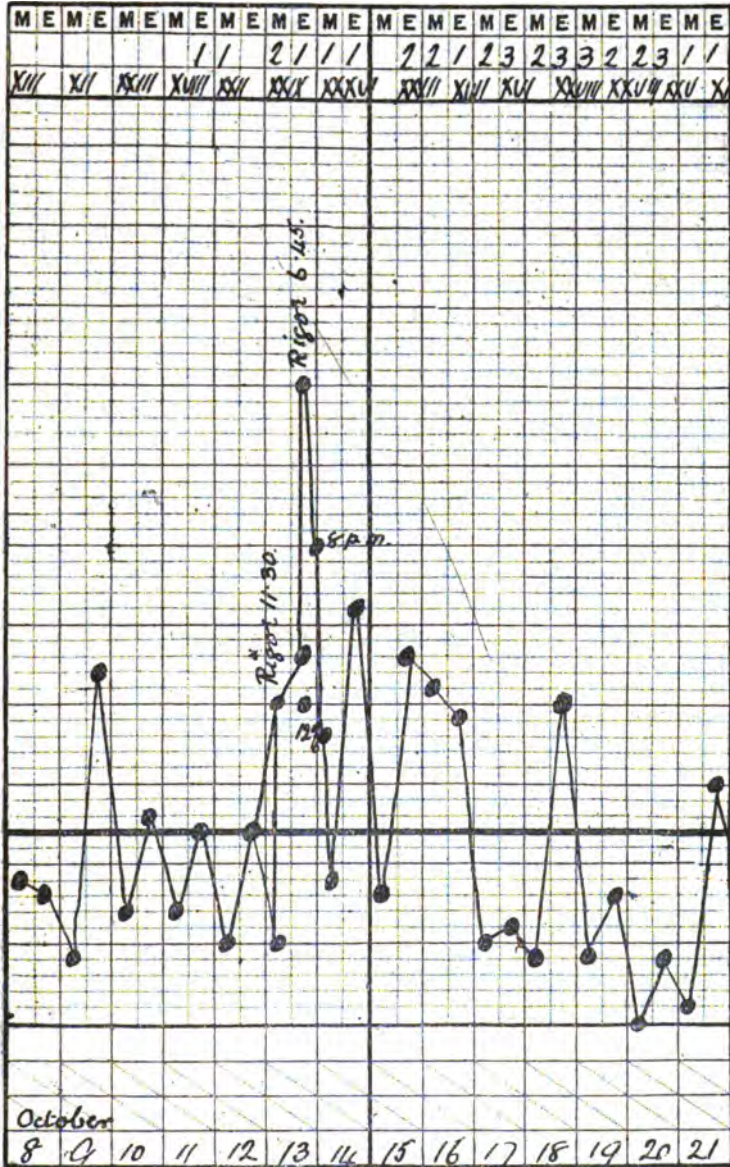
*History.*—Menorrhagia, metrorrhagia, dysmenorrhœa and abdominal tumour, which now reached the umbilicus. Very anæmic. Urine contained some albumen.

*Operation, October 1.*—Abdominal hysterectomy, by the retro-peritoneal method, the right ovary being also removed. Patient had some shock after the operation, but, save for a rather rapid pulse (108-120), did well till October 13, there being no albumen after the 4th. On the 13th she had two rigors. The temperature rose to 104° and the pulse to 140, and she had some pain in the left iliac region. Nothing abnormal was found on examination but a slight swelling to the right of the cervical stump. The temperature continued rather irregular, but after the 15th did not

<sup>1</sup> Liverpool Branch, November, 1898.

<sup>2</sup> Exhibited by Dr. EDWIN A. NEATBY, December, 1898.

rise above 100-2°. There was some diarrhoea from the 7th, lasting till about the 21st. She was discharged pretty well, though still very weak and anæmic, on the 31st.



*Uterine Appendages from a case of Salpingo-öophoritis,<sup>1</sup>  
with temperature chart.*

E. M., aged 31, married, admitted to the Durning ward, London Homœopathic Hospital, September 12, 1898. Had attended out-patient department since February, 1896.

*History.*—Had had repeated attacks of "inflammation." From that time till admission had had almost constant pelvic pain, worse at menstrual period. She was getting weaker and thinner.

*On vaginal examination.*—Fundus uteri drawn to the right, both ovaries tender, the right prolapsed and right tube dilated and thick.

*Operation, September 17.*—Both ovaries and tubes removed with difficulty, owing to firm adhesions. Patient had much shock for a day or two, but rallied and went on well till September 28, when she complained of pain in left groin, and temperature rose to 102·2°. In left groin an area was found, dull on percussion, hard, but fluctuating and tender, extending two and a-half inches upwards from Poupart's ligament. This did not improve till October 8, when it was opened and a large quantity of dark thick blood let out. The temperature, which had varied from 101° to 103·8°, now began to fall, and the patient recovered without further interruption.

A period of nearly normal temperature and pulse from September 22 to 26 inclusive is omitted from the accompanying chart.

*Small Ovarian Multilocular Cyst.<sup>2</sup>*

M. B., aged 25, single. Admitted to Durning ward, London Homœopathic Hospital, October 3, 1898. Had attended out-patient department since October, 1897.

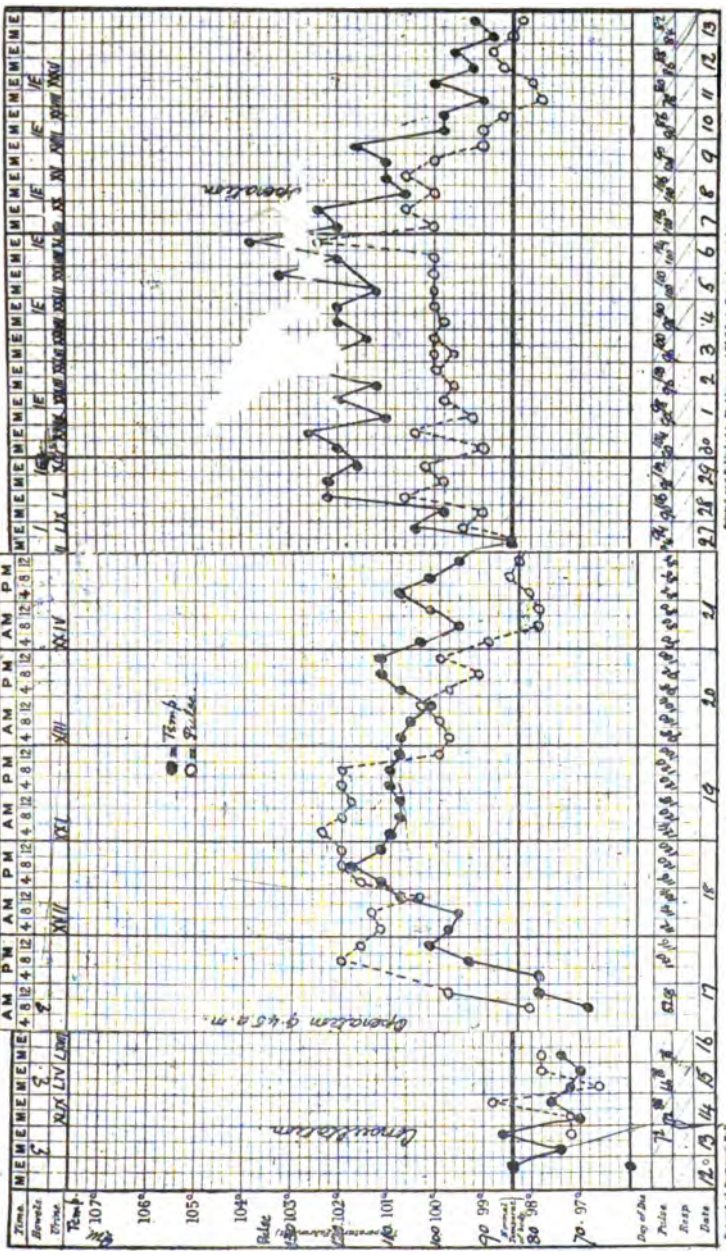
*History.*—Prolapsus uteri for fifteen months, some urging to micturate, shooting pains in the legs for a fortnight.

*On vaginal examination.*—Uterus prolapsed and retroflexed. To the right of, and below the fundus, was a large cystic swelling, tender, not very movable. It was thought that this might be a hydro-salpinx (it had diminished somewhat in size under apis, taken for two months).

<sup>1</sup> Exhibited by Dr. EDWIN A. NEATBY, December, 1898.

<sup>2</sup> Exhibited by Dr. EDWIN A. NEATBY, December, 1898.





Record of Encephalogram  
 Printed and Published by *Waldrop & Co. 2100 Street - Toronto Ont.*  
 Supply Order # 744

*Operation, October 8.*—Right ovary found to be cystic, about the size of an orange. It was removed with the right tube. Left ovary was exposed and some small cysts incised, emptied and obliterated by stitches. Uterus stitched to anterior abdominal wall. No drainage tube was used ; stitches removed October 17. Patient made a good recovery without drawbacks.

#### *Tuberculous Liver.*<sup>1</sup>

The liver from a girl, A. T., aged 10, who had suffered from tubercular peritonitis and general tuberculosis. On admission she had a hectic temperature with breaking down of the left lung. Under phos. 3 and bell. 3x this condition much improved. There was then much fluid in the peritoneal cavity, and as ars. i. 3 x and medicinal treatment failed to relieve, laparotomy was performed. No benefit, however, followed from this, and it was repeated, but still without any good. Finally, patient died from the general peritonitis, and at the autopsy the lungs were found very extensively diseased and the liver presented a very remarkable appearance, the surface being studded with hard nodules of tuberculous material. It was also enlarged. The peritoneal fluid was examined on two occasions for the bacillus tuberculosis but with negative results.

#### *Large Parenchymatous Bronchocele successfully removed by Thyroidectomy.*<sup>2</sup>

Arthur M., aged 19, was admitted to the hospital, November 5, 1898, with a large bilateral bronchocele. He had suffered from fits till he was 14. Had always been rather breathless on exertion. The swelling in the neck was first noticed about three years ago, and its increase had been steady and persistent. Lately his respiration had become so difficult that he was unable to follow his occupation. There was uniform large, soft enlargement of both lobes of the thyroid, extending laterally beneath the sterno-mastoids, and downwards beneath the clavicle and sternum. Just above the clavicle on each side were enormously dilated veins. The voice was altered, and respiration was laboured.

On November 22, under chloroform the left lobe of the thyroid was removed by a vertical incision in the middle line, and a transverse one from the upper extremity of this across the

<sup>1</sup> Exhibited by Dr. ROBERSON DAY, January, 1899.

<sup>2</sup> Exhibited by Mr. C. KNOX SHAW, January, 1899.

sterno-mastoid, which was divided. In removing the tumour the pleura was opened. The isthmus was too broad to be ligatured, and so was torn through. A portion of the tumour which extended beneath the sternum was left *in situ*. The patient made a rapid recovery, getting up ten days after the operation. The right lobe of the thyroid began at once to decrease.

#### *Cystic Dilatation of the Vermiform Appendix.*<sup>1</sup>

The patient from whom this specimen was removed, a young lady, aged 21, had a severe attack of typhlitis in 1894. Six months later another, and every few months since then attacks recurred with greater and greater frequency. Operation, November 28, 1898. Complete and rapid aseptic recovery.

The appendix was firmly adherent to the cæcum, being buried in adhesions; its distal half was bent at right angles to the cæcal end, and was greatly dilated. At two spots there were smaller cystic protrusions, with extreme thinning of the cyst wall. The cystic dilatation was caused by a stricture half way down the appendix; it contained mucus.

#### *Gall Stones removed by Cholecystostomy.*<sup>2</sup>

Three small gall stones removed by cholecystostomy from Mrs. P., aged 24, who began to suffer from severe biliary colic during her second pregnancy, which occurred fifteen months before her admission to the hospital on November 15, 1898. The attacks were very severe, occurred so frequently as to make life unbearable, and for them she was frequently given morphia. They were always attended by vomiting, but she had only once been jaundiced. The gall-bladder, whilst she was under observation, was always tender, and at times was palpable, at others not. She was in hospital a fortnight, during which time she had three attacks, one followed by jaundice. On November 29 the gall-bladder was opened, and the calculi removed. There was no trouble at any time with the wound, which was quite closed by December 19. During convalescence she had a mild attack of apical pneumonia. She left the hospital December 27.

It is interesting to compare these calculi with another shown to the Society last year. In that case the gall-bladder was greatly distended, but the calculus was too large to give rise to much colic.

<sup>1</sup> Exhibited by Mr. C. KNOX SHAW, January, 1899.

<sup>2</sup> Exhibited by Mr. C. KNOX SHAW, January, 1899.

*Myoma Uteri.*<sup>1</sup>

This tumour was removed by hysterectomy, retro-peritoneal method. Tumour reached umbilicus; chief symptom, hæmorrhage. A single lady, aged 39. She was very anæmic, the pulse showed by the sphygmograph signs of failing tension. Operation was advised and performed on October 18. Patient complained the first night, at intervals, of abdominal pain, especially with the sickness (four times), but she slept two hours, in short spells; next day, "not much pain." Second night, three and a-half hours of sleep, "a good night until 6 a.m., then vomited, which caused abdominal pain." Third day, "not complained of abdominal pain." Urine was passed naturally once on the third day, but the catheter was used again for two days. Bowels opened early on fifth day.

The pulse reached 110 for a few hours the day after operation but soon descended to 100; after the fourth day it was under 90.

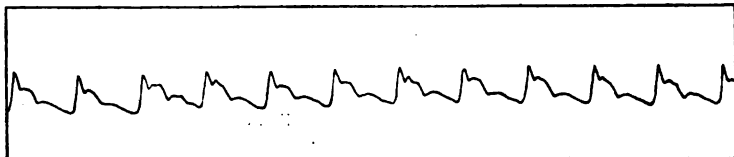
Stitches removed at two sittings, seventh and tenth days.

Patient was lifted out of bed at the end of a fortnight and tried her feet a week later; left the nursing home four weeks after operation. There were no drawbacks.

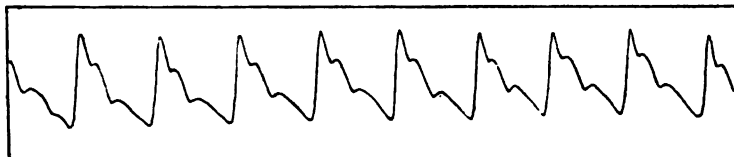
*Sphygmogram taken before Operation.*

A tracing which shows some increased tension, which is probably due to hypertrophy of the walls of the heart, but is similar to what may be seen where there has been long-continued high tension; but the walls of the heart are beginning to fail.

("Dr. MOIR.")



After Operation.



<sup>1</sup> Exhibited by Drs. BENNETT and E. A. NEATBY, January 5, 1893.

*Carcinoma and Myoma in the same Uterus.*<sup>1</sup>

Caroline S., aged 59, single, admitted Nov. 30, 1898. Menopause ten years ago. Had had vaginal discharge, sometimes hæmorrhagic, for eight years. This had been constant and profuse for four months. Severe abdominal pain, paroxysmal, first attack four months ago. *Per vaginam*, uterus enlarged and nodular. Vaginal hæmorrhagic discharge, no fœtor. Uterus removed by retro-peritoneal method. Multiple fibroids were found, and a malignant growth in the body. Patient has made a good recovery, but is still rather weak.

*Myoma Uteri with great Fœtor.*<sup>2</sup>

C., aged 41. The tumour was removed by hysterectomy—combined method. Result: death. These two cases were brought forward to show an important clinical contrast.

*Fibroid Tumour of Uterus removed by Hysterectomy.  
Uterus and Appendages left intact.*<sup>3</sup>

The patient was a single woman of 34 years of age, a patient of Dr. Madden. She had a large solid abdominal tumour, which was detected by Dr. Madden, who concurred with Dr. Burford as to the desirability of its removal. Abdominal section was performed, the tumour found to be a large myoma, connected to the uterus by a thick pedicle; this was divided, the tumour removed, the uterus being left intact. Weight of tumour on removal, eleven pounds. Result: recovery.

*Large Ovarian Cyst containing over Three Hundred Ounces of Fluid.*<sup>4</sup>

The patient, a single girl, aged 26, came under the care of Dr. Goldsbrough, who diagnosed the presence of a large ovarian cyst. Ovariectomy being performed, a large unilocular cyst, containing over 300 ounces of fluid, was removed. The cyst fluid contained an abundance of cholesterine. The recovery was easy and uneventful.

<sup>1</sup> Exhibited by Dr. EDWIN A. NEATBY, January 5, 1889.

<sup>2</sup> Exhibited by Dr. EDWIN A. NEATBY, January 5, 1899.

<sup>3</sup> Exhibited by Dr. BURFORD, January 5, 1899.

<sup>4</sup> Exhibited by Dr. BURFORD, January 5, 1899.

*Ovarian Cyst with Twisted Pedicle, but not Strangulated.*<sup>1</sup>

This patient was a girl of 18 years, who came under the supervision of Dr. Percy Capper, of Tunbridge Wells. He transferred her to Dr. Burford for operation. The cyst was found to be ovarian, of moderate size, with the pedicle rotated on itself, not acutely enough to arrest the circulation. There were no further complications. The recovery was complete.

*Dermoid Cyst of the Ovary.*<sup>2</sup>

(See the accompanying illustration.)

The cyst weighed thirteen pounds on removal. It contained a large quantity of fluid fat, masses of hair, irregular bosses of bone, and one or two structures resembling mamillæ. The patient was a young woman, aged 25, in whom the cyst was accidentally discovered by her physician, she being entirely unconscious of its existence. Operation: recovery.

*Two much-hypertrophied and Cystic Ovaries without Tubal Disease.*<sup>3</sup>

The patient was a woman of 35, who had led a life of chronic invalidism for eight or ten years. Various forms of treatment had been systematically carried out, but without success. Operation: recovery.

*Mixed Uric Acid and Phosphatic Vesical Calculus.*<sup>4</sup>

This stone, weighing 94 grains, was removed by litholapaxy from a patient aged 87. He had an enlarged prostate, and had to use a catheter daily. Dr. Galley Blackley, whose patient he was, considered him able to bear a rapid operation. To minimise risk a preliminary careful dilatation of the prostate was instituted. The actual crushing took seven minutes. The patient was up and downstairs forty-eight hours after the operation, and has remained well.

*Thirteen Gall Stones of medium size and several smaller ones.*<sup>5</sup>

These were removed from a female aged 65 years. She had suffered pain for two years, swelling for several months. A large

<sup>1</sup> Exhibited by Dr. BURFORD, January 5, 1899.

<sup>2</sup> Exhibited by Dr. BURFORD, February, 1899.

<sup>3</sup> Exhibited by Dr. BURFORD, February, 1899.

<sup>4</sup> Exhibited by Mr. C. KNOX SHAW, February 2, 1899.

<sup>5</sup> Exhibited by Mr. DUDLEY WRIGHT, March, 1899.

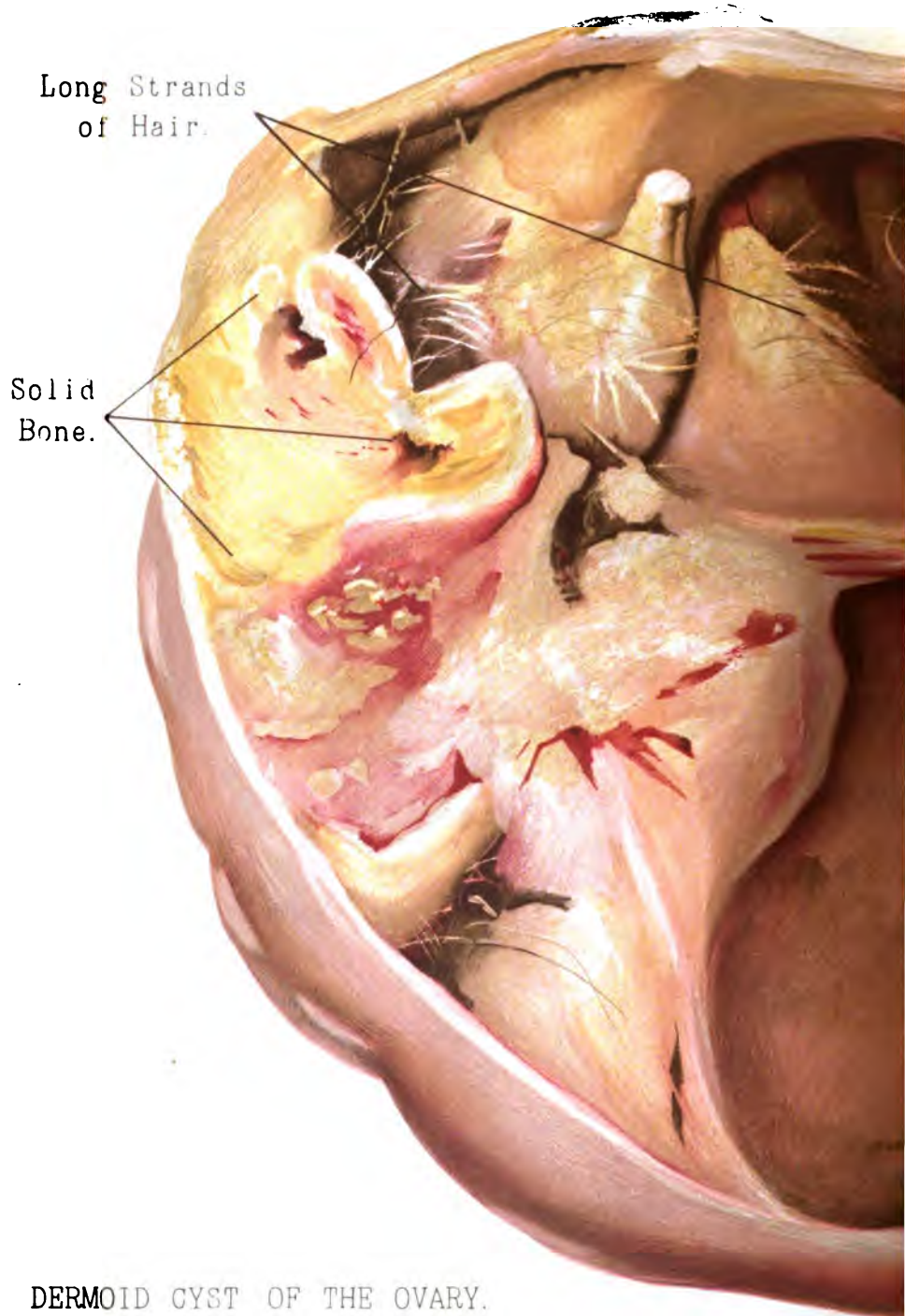
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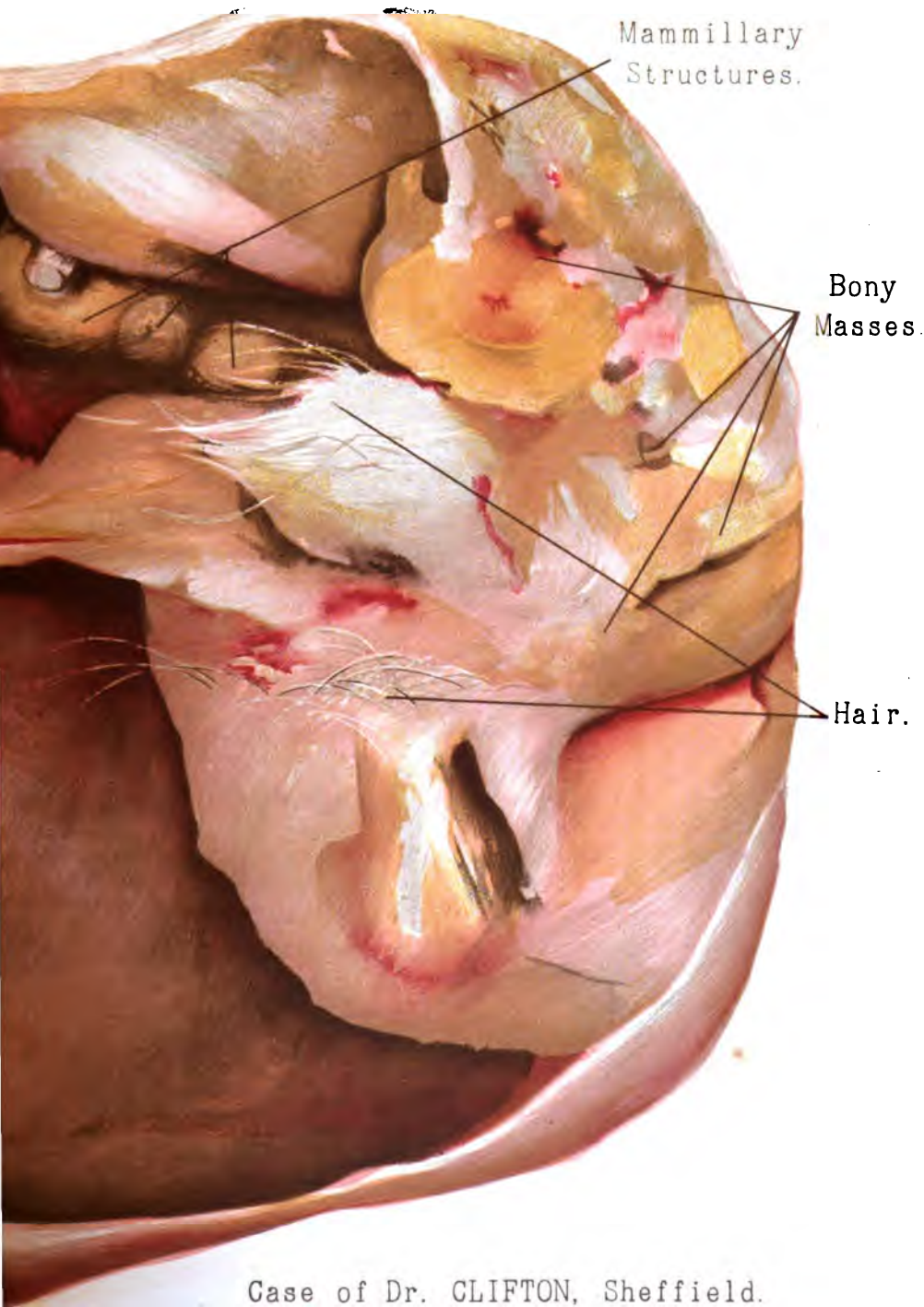
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DERMOID CYST OF THE OVARY.  
— Weighing 13-lbs. on removal.





Mammillary  
Structures.

Bony  
Masses.

Hair.

Case of Dr. CLIFTON, Sheffield.

Operation by Dr. BURFORD. See page 212.



tumour was present on the right side close to the cæcum and to the side of the ascending colon. At the operation the tumour was found to be a distended gall-bladder to which omentum and bowel were adherent. After separating these, needling of the gall-bladder showed the presence of stones, which were removed in the usual way. Several were found in the cystic duct, which was so distended as to easily admit the little finger. Uneventful recovery.

#### *Gall Stone.*<sup>1</sup>

This stone was removed from a woman aged 46, a patient of Dr. Wheeler. She had suffered pain in the gall-bladder region for some years. Had passed some small gall stones. No tumour to be felt by palpation. Uneventful recovery after operation.

#### *Hydatid of the Liver.*<sup>2</sup>

This hydatid of the liver, containing several daughter cysts, was removed from a patient of Dr. March, of Reading. The cyst formed a large tumour projecting from the left lobe of the liver which had become partially adherent to the abdominal wall. Uneventful recovery.

#### *A Cycle Seat.*<sup>3</sup>

A new cycle seat in the shape of a hammock fixed crossways on the machine, rather far back and low down. The handles must be brought back low and long to the level of the knee at the top of the pedal. In this way this seat is extremely good.

<sup>1</sup> Exhibited by Mr. DUDLEY WRIGHT, March, 1899.

<sup>2</sup> Exhibited by Mr. DUDLEY WRIGHT, March, 1899.

<sup>3</sup> Exhibited by Mr. GERARD SMITH, March, 1899.

**SOCIETY NEWS.***The New Materia Medica.*

At the meeting in February, Dr. Ord brought forward the new specimen drug, *Kali Bichromicum*, which had been printed and distributed to members before the meeting.

On a motion that the specimen be adopted as a model for proceeding with the work,

Dr. HUGHES said the specimen medicine had given him very great satisfaction. Whatever criticism be passed on details, the general lines of the work came out well, and the actual working and filling-in of the outlines seemed to him to have been very well and thoroughly done. The whole therapeutics presented in that way would give them a book of the utmost value in practice. Passing to criticism, he was not quite sure that Dr. Ord made a happy choice in selecting kali bichromicum as the specimen medicine. It was almost too easy a drug to handle. Its pathogenesis they had in the most intelligible form, and in the recorded experiments, both English and Austrian, there were no difficult questions of authenticity. It was easy in that it had been worked up by their late lamented Drysdale in a most thorough manner. The compiler of the present work had therefore simply to condense and to supplement what had previously been done. That it had, however, been done so well augured happily for more difficult tasks. He also would say a few words on what he conceived the character of the work should be. Homœopathy, in its ideal, was the application of drug symptoms produced on the healthy body to the phenomena of disease, according to the rule, *similia similibus curentur*. For the working of this rule they required a genuine and intelligible record of the effects of drugs as observed in provings, poisonings, and in experiments on animals. He thought they had all this material provided in the "Cyclopædia of Drug Pathogenesis," and it was sufficient for ideal practice. But in everyday practice they required helps or props in the record of such clinical experience as had been already gained with drugs. They also needed studies of the drugs, general views of their working and physiological action, explanations and refer-

ences to the anatomical seats. The materia medica they were now considering was intended to supply to the working practitioner the material for his actual practice of homœopathy. He hoped all the work would be done as well as Dr. Ord had done his part.

Dr. DUCE BROWN expressed admiration for the manner in which the work had been carried on. He thought the choice of drug was a good one, for the reason it had been worked up so well by Drysdale; he considered the Society owed Dr. Ord a great debt of thanks.

Dr. DUDGEON considered the work very good, but was afraid the young practitioner might rely on the therapeutic part and neglect the pathogenesis. He thought a good addition would be a section on contrasts in unusual symptoms in various medicines.

Dr. ORD thanked the members for the very kindly appreciative way in which they had received his little effort. He was very grateful indeed for the praise of Dr. Hughes, whose opinion in these matters he valued above everybody else's.

Mr. KNOX SHAW discussed the specimen from the side of a practical homœopathist, not as an idealist. He feared that the future study of homœopathy would diverge more and more from the ideal and come more and more to the practical, and, therefore, such a study of materia medica as presented that evening would be more likely to suit future homœopathists than one compelling them to dig and dive among crowds of symptoms to find out exactly what was wanted. He thought the new work would be extremely valuable to busy men. He had looked through the specimen of the new work several times and each time was more delighted with it.

Dr. GALLEY BLACKLEY made some remarks on the financial aspect of the proposed work.

Mr. LESTOCK REID hoped the work would be carried through. He did not think the clinical cases would be of very much use; naturally they had to be condensed a good deal, and in that process he thought they lost much of their point.

Mr. DUDLEY WRIGHT, after making one or two criticisms, expressed his opinion that the work was excellent, and Dr. Ord was to be congratulated upon it. He agreed with others that the clinical cases might be simply summarised at the end. By turning up the cures in the Index to Literature in course of preparation by Dr. Burford, plenty of clinical material would be forthcoming.

Dr. McNISH thought this presentation of the drug too complicated for practical purposes. He suggested that the symptoms

should be given in the order in which the drug acted on them in disease.

Dr. BYRES MOIR said that Dr. Hughes had shown them the way previously, but to put Dr. Hughes' work on Pathogenesis before the beginner would not do. If the student read through the clinical summary given in the specimen, which would be best at the beginning, he would at once get a picture of the drug disease. Many men would not be satisfied with the clinical summary, but would then turn to more finished work in the pathogenesis of clinical cases.

Dr. BURFORD (in the chair), in concluding the discussion, said they had now gathered for the first time between two covers a very fair clinical picture of not what cases *kali bichromicum* *might* be useful in, but *had* actually been useful in. The work was monumental.

The resolution was then put, and carried unanimously.

Letters had been received from the following Fellows or Members unable to be present, giving opinions on the proposed work:—Dr. A. C. Clifton (President), Drs. Ashley Bird, Black Bodman, Hervey Bodman, Midgley Cash, Hayle, Harper, McKechnie, Nicholson, Pope, Proctor, Cash Reed, Staley, Percy Wilde, Wills and Wingfield. These were, with the exception of Dr. Proctor, unanimous in their approval of the specimen which had been distributed.

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At the meeting in January, H. G. T. Dawson, L.R.C.P.I., L.R.C.S.I., L.M., Sandridge House, Shewsbury Road, Birkenhead, was elected a member of the Society.

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At the meeting in February of the Liverpool Branch, Alfred Johnston, 18, Walmer Road, Waterloo, Liverpool, and George Herbert Drury, M.B., C.M. (Edin.), 2, Mewsham Drive, Liverpool, were elected members of the Society.

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## SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

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

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DECEMBER, 1898—FEBRUARY, 1899.

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### PHARMACODYNAMICS.

**Acidum carbolicum.**—Dr. Proctor calls attention to the remarkable homœopathicity of carbolic acid to pneumonia, and relates a case, in a lady of 68, where prune-juice expectoration was present, and the usual remedies inoperative, while rapid recovery set in on resorting to drop doses of the liquor acidi carbolici of the B. P.—*Monthly Hom. Review*, Feb.

**Acidum lacticum.**—The power of lactic acid to inflame the joints has not hitherto been used homœopathically, as in acute articular rheumatism—whose arthritis most resembles that caused by the drug—the *materies morbi* is probably that very acid itself. A Dr. Zolatorin, however, is reported in the *American Homœopathist* of Jan. 15 as having obtained great benefit from it in arthritis deformans. In the case specified, which was of ten years' standing, the patient, who had become bedridden for a twelvemonth, got up and walked after three weeks' treatment, and so improved thereafter that no further care was required, and ordinary duties could be resumed.

**Acidum picricum.**—Dr. Halbert records a severe case of writer's palsy, in which, with static electricity, picric acid 3x was administered. (Electricity in all forms had been vainly tried before.) Complete recovery, with great improvement in general health, occurred in three months; though the patient did not relinquish the type-writing which was her vocation.—*Hahn. Monthly*, Jan., p. 76.

**Apocynum.**—In the *Therapeutic Gazette* of December, Dr. Turner records his experience of apocynum in dropsy, which has been very favourable. It is in anasarca rather than local dropsy that he esteems it, and when the origin is cardiac rather than renal. He gives it in doses just short of those causing emesis.—*Hom. Recorder*, Feb.

**Antitoxin.**—The following is another<sup>1</sup> case of speedy death following upon the injection of diphtheria-antitoxin:—"Dr. Combe, of Lausanne, in a girl of 12 years, who for a long time had suffered from bronchial asthma, and whose heart was slightly irregular, injected 10 c.cm.'s of anti-diphtheritic serum (Roux's). She was dead in five minutes. The necropsy revealed a very large thymus gland compressing the trachea, a synechia of both lungs and an intense congestion of the bronchi."—*Hahn. Monthly*, Dec.

Another case is extracted in the *Homœopathic Physician* of January. Here the symptoms—collapse, coldness, cyanosis, dyspnoea—did not set in till about seven and a half hours after the administration of the antitoxin, but they ended in death after three hours more.

In the *Medical Era* for February the Health Department of Chicago report on "Twenty-Six Months of Antitoxin Treatment," and from an experience embracing 5,739 cases of diphtheria claim a mortality rate of only 6.77 per cent. Before the introduction of antitoxin the rate averaged about 35 per cent. On the other hand, in the *American Homœopathist* for the same month (1st) we find Hennig, of Königsberg, taking a strong stand at a Congress held at Wiesbaden against the antitoxin treatment, and reporting 1,927 cases treated with limewater gargling and continuous application of the ice-cravat, with a mortality of 3.06 per cent. only.

**Arsenic.**—Two cases of arsenical pigmentation are recorded by Dr. Hardaway, in both of which the discoloration was preceded by hyperæmia of the skin, and only occurred on such spots as presented this prevenient condition.—*Amer. Homœopathist*, Dec. 1.

Three interesting cases of medicinal arsenical poisoning are extracted in the *Homœopathic Recorder* for February. In the first two there were palpitation, insomnia and severe laryngeal catarrh; the third had most of the features of locomotor ataxy.

<sup>1</sup> See p. 82 of this volume.



**Arsenicum iodatum.**—Dr. Stäger relates two cases in which recurring hæmoptysis was rapidly checked by arsenicum iodatum, fourth trit., in one consolidation of the apices also clearing away under its use.—*Hom. Recorder*, Dec.

An old-school physician—Dr. Rousseau Saint Philippe—has come forward to sing the praises of this medicine, which he uses in a 1 per cent. aqueous solution (the anhydrous iodide being employed to make it). Speaking from an experience with it embracing some 200 cases, he cannot speak too highly of it for the eczemas, ophthalmiæ and chronic catarrhs of scrofulous children—the last-named including recurring bronchitis and persistent diarrhœa.—*L'Art Médical*, Dec.

Dr. Bonino records the case of a woman of 53, childless, but who had aborted twice after being infected syphilitically in her 37th year. After a series of morbid manifestations, now in her bones and now on her skin, there appeared a collar of enlarged cervical glands, which suppurated and corroded away the skin so that the muscles of the neck were exposed. They gave rise to intolerable burning pains and discharged an extremely stinking pus. Under the internal use of the iodide of arsenic for five months this morbid condition disappeared wholly, the skin healed over the excavations, and they filled up entirely.—*Hahn. Monthly*, Feb.

**Atropine.**—A Dr. von Noorden praises the steady use of atropine in keeping off attacks of asthma in young subjects without chronic complications. He begins with half-milligramme doses, and gradually increases them.—*L'Art Médical*, Dec.

**Baryta.**—Amongst the late Dr. E. M. Hale's contributions to materia medica is an article on "The Action of the Barium Salts on the Heart," which is summarised from the *Medical Visitor* in the February number of the *Hahnemannian Monthly*. He finds that baryta is one of the best remedies in senile heart, where the other cardiac remedies seem to have little effect. "There is one symptom," he adds, "not to be found in the pathogenesis of barium—a sensation of sinking emptiness or faintness in the pit of the stomach. This symptom belongs to several cardiac remedies, viz., digitalis, ignatia, veratrum album, convallaria, and cactus. It is also found in hydrastis, lachesis, and caladium. But wherever this symptom is found in old people, baryta is almost specific."

**Bromoform.**—A case of poisoning by this substance, in which eighteen drops were taken by a child of 4½ years, is given in the

*American Homœopathist* of December 1. Sopor came on in about twelve minutes; the body became limp, involuntary evacuation of bowels and bladder occurred, and the doctor summoned found the child collapsed, cyanotic, and apparently dead. Artificial respiration, removal of large quantities of mucus from the mouth, antidotes and stimulants, restored the case.

**Caulophyllum.**—Dr. M. E. Douglass relates a case in which caulophyllum (3x), given for chloasma, not only removed the spots, but rendered the periods painless, whereas hitherto the patient had suffered much at every recurrence of them.—*Amer. Med. Monthly*, Feb.

**Cocaine.**—The sensation as of foreign bodies under the skin, noted in our fifth volume (p. 286), is now known as "Magnan's symptom" of chronic intoxication by cocaine. Dr. R. T. Cooper relates an instance of its idiopathic occurrence in a sufferer from chronic rheumatism. He gave gr.  $\frac{1}{4}$  in a single dose, with (at least temporary) decided benefit.—*Hom. Recorder*, Feb.

**Curare.**—Claude Bernard's observation as to the power of curare to induce glycosuria and diuresis in animals, noted by Clotar Müller, has been utilised by Dr. Burckhardt, of Berlin. He has had excellent results in many cases of diabetes from the 4th dil., given three times a day.—*L'Art Médical*, Jan., p. 67.

**Duboisin.**—The demonstrated power of duboisin to cause hyperæmia of the optic nerve and retina was well turned to account in a case of amblyopia coming before Dr. Helfrich. The optic nerve was found red, and its outlines indistinct; the retinal veins were tortuous and enlarged. The patient saw a red object in the field of vision, which moved with every movement of the eye. Duboisin 3 was prescribed, and at the next visit the patient was completely cured.—*Amer. Homœopathist*, Dec. 15, p. 408.

**Ergotin.**—A sufferer from chronic diarrhœa became afflicted with incontinence of the fæces; he had not even the sensation of an approaching passage. He had been under old-school treatment for some time, but without result, and was meditating suicide. Secale 3x and 2x caused only slight improvement, but four days after beginning ergotin 2x the doctor was agreeably surprised to see the patient walk into his office and report himself able to control his sphincter.

[It is not said how long the improvement had lasted when the report was made.—ED.]—*Hahn. Monthly*, Feb..

**Ferrum phosphoricum.**—Dr. Parenteau, acting on the suggestion of Dr. Nimier, has used ferrum phosphoricum in infra-orbital neuralgia of the right side, with morning exacerbations, with occasional striking success, but as frequent complete failure. He has come to the conclusion that it is only to be depended on when the patient is a youngish woman with imperfect uterine health and tendency to menorrhagia. He gives the 6th dilution. —*Revue Hom. Française*, Dec.

**Helonias.**—Dr. R. Chancerel reports to the Société Française d'Homœopathie two cases of diabetes in which at least temporary cure seems to have been effected by the use of helonias 6, re-inforced sometimes by uranium nitricum of the same strength. —*Ibid.*, Feb.

**Hyoscyamus.**—Dr. W. E. Taylor, who is superintendent of the Illinois Western Hospital for the Insane, gives his experience of hyoscyamus as a remedy for mania, in which condition he thinks it more frequently indicated than belladonna or stramonium. Its delirium has certain fixed peculiarities. The patient "is quarrelsome, will attempt to argue, wants to fight, and invariably uses profane and indecent language. He may attempt to trip or kick you one moment and laugh at you the next; his conversation is disconnected, and he wanders from one subject to another, or chatters away incoherently. He will not remain in bed, and as a usual thing is determined to be nude." Dr. Taylor begins with low dilutions and then goes up higher.—*The Clinique*, Jan.

**Iodine.**—Dr. H. K. Leonard relates a striking instance of the value of iodine in pneumonia—the exudation under old-school treatment remaining unresolved, and the case presenting all the appearances of acute phthisis. Forty drops of the ordinary tincture were put into a gobletful of water, and a teaspoonful given every two hours. "The patient simply raced his way to recovery."—*Med. Century*, Feb.

"Iodine as a Gynæcological Remedy" is the title of an interesting paper by Dr. E. J. Burch in the February number of the *Clinique*. The remedy is beginning to acquire "characteristics," of which emaciation and bulimia, melancholia and restlessness are duly marked.

**Jaborandi.**—"The two remedies which have served me best in exophthalmic goitre are iodine and jaborandi. . . . Strangely

enough, I have not found *jaborandi* anywhere recommended as a remedy for Graves' disease. Its pathogenesis contains a larger number of the more prominent symptoms of the disease than any remedy with which I am familiar. It gives rise, in full doses, to increased heart's action with pulsation of the arteries, to tremor and nervousness, to sweating and the subjective symptoms of heat, to redness of the skin, to diarrhœa and dysuria, to disturbance of vision, and to bronchial irritation with expectoration. In fact, the drug covers the symptomatology of the disease so clearly that it must not be given below the 3x dilution, or aggravations will ensue."—Dr. James Wood, in *North Amer. Journ. of Hom.*, Feb.

**Kali Iodatum.**—A patient suspected of being syphilitic had taken for about two months 3 to 4 grammes of iodide of potassium daily, when he found his mental condition becoming affected. He lost his memory, could not produce the words he wanted, or report occurrences, his musical accomplishments failed him, there was fornication in his hand and notable weakness of the lower extremities. The suspension of the iodide caused speedy improvement, and a subsequent attempt to take it again brought about as rapid a renewal of the troubles.—*Journ. Belge d'Homœopathie*, Nov.-Dec.

Two more cases of medicinal poisoning with this salt are given in *L'Art Médical* for December. The symptoms of the first consisted of what is called "mumps limited to the glands of Wharton;" of the second they were an erythematobullous eruption, with intense itching, and slight albuminuria.

"It is not always necessary to use iodide of potash in appreciable doses. The 2x trit. has decided therapeutic action. Often you will have under treatment a chronic case of some kind, but your usual remedies—sulphur, calcarea, or other medicines—fail to affect it. In this event give to your patients a course of kali hyd. 2x. Often it will act as an 'alterative,' as our friends the enemy would call it, and a most remarkable and gratifying change will come over your patient's condition. It is undoubtedly true that there is a luetic taint in many people, and, as in the use of quinine in malaria, the kali hyd. not only bears a therapeutic relation to the case, but at the same time acts as a diagnostic agent."—Dr. Ch. Gatchell, in *Med. Era*, Feb.

A syphilitic, after taking iodide of potassium in half-gramme doses daily for three days, was seized with coryza, lachrymation, and deafness of the left ear. On examination, a catarrhal otitis of the middle ear, with serous effusion, was discovered. All the

symptoms disappeared on the suspension of the medicine, but the deafness returned on its resumption. The sodium salt, which was then substituted, had no such effect, even when pushed to 4 grammes daily.—*L'Art Médical*, Feb., p. 152.

**Kali phosphoricum.**—Dr. W. T. Laird praises kali phosphoricum in nervous dyspepsia, its cases being analagous to those for which we give anacardium, but presenting more marked aggravation from emotional causes. Its indications are “a neurasthenic patient; all-gone feeling in stomach, temporarily relieved by eating; aggravation of the gastric symptoms by excitement or worry; diminished urine, with excess of phosphates.”—*N. Am. Journ. of Hom.*, Dec.

**Lolium temulentum.**—Dr. Boner observed a carpenter, of 39 years, who, from his eighteenth year, had trembling of his hands, which was especially pronounced mornings; latterly his legs had begun to become tremulous. Curiously enough, his father and one brother were subject to the same disease, without any cause being known. He received at first mercurius, and then agaricus, which latter relieved partially, but only transitorily. Finally, lolium temulentum was administered, which, in a short time, led to restoration to a normal state.—*Hahn. Monthly*, Feb.

**Magnesia phosphorica.**—In view of the extensive use made of magnesia phosphorica in neuralgic and other pains, it may be well to note that the original provings and a (mixed) symptom-list of the drug are given (from the *Medical Advance* of 1889) in the *Calcutta Journal of Medicine* for July-Aug., 1897.

**Melilotus.**—Dr. Bowen comes forward again<sup>1</sup> to testify his confidence in melilotus. He has found no difference between the action of the *M. alba* and the *M. officinalis*; but of late has always used the former, making his tincture from the whole plant. Congestions (especially cerebral) and hemorrhages are still the main sphere of its action, which has the advantage of being rapid. He still gives the 1st cent. dil. in every case.—*Amer. Recorder*, Jan.

**Mercurius corrosivus.**—Dr. Mayer, of New York, has conceived the desirableness of putting diabetics on a course of perchloride of mercury, even when there is no syphilitic history

<sup>1</sup> See this Journal for 1894, p. 360.

to call for it—thinking it may act as a bactericide. He has obtained unexpectedly favourable results, both as to the glycosuria and the general health. He begins with .005 milligr. three times a day, ascending to .01 centigr., and then falling to .015 milligr. once more.—*L'Art Médical*, Feb., p. 154.

**Naphthalin.**—The genesis of the opacity of lens (and also of cornea) induced by naphthalin has been studied by Klingmann. He finds it secondary to inflammatory change (mainly iridocyclitis), which occurs not in the eye alone, but also in the kidneys, liver, spleen, and heart.—*Hahn. Monthly*, Jan., p. 74.

**Oleum animale.**—This substance—"Dippel's oil"—is an old homeopathic medicine which has fallen into disuse. The *Calcutta Journal of Medicine* for July-August, 1897 (a belated number which has only just reached us), extracts from the *Hahnemannian Advocate* of April in that year an article upon it, in which an account is given of a new proving, and of some clinical experience, with it. It seems to deserve trial in neuralgic drawing-pain of testicles and cord.

**Palladium.**—Dr. W. D. Young contributes to the *North American Journal of Homœopathy* of February a study of this drug, which, without containing anything exactly new, well presents what is known of it pathogenetically and clinically.

**Quebracho.**—Dr. E. M. Hale (since lost to us) has contributed to the February number of the *Hahnemannian Monthly* a full account of quebracho, the power of which over the symptom dyspnoea, however occurring, seems well-established. It is best given, he says, in a preparation known as "aspido-spermine," which consists of all the six alkaloids of the bark.

**Quinine.**—A woman was heavily dosed with quinine in an attack of influenza. For two years thereafter she had two or three times a month severe congestive headaches like that which had resulted from taking the drug. Nothing availed to help them till Dr. W. James, of Philadelphia, gave her belladonna with much relief, and then pulsatilla with complete cure.—*Amer. Homœopathist*, Feb. 1.

The persistent administration of this drug, in gramme doses daily, has been found singularly beneficial in exophthalmic goitre.—*L'Art Médical*, Feb., p. 157.

**Rhus.**—Dr. Taylor reports a case of typhoid which on the

fourteenth day, after two intestinal hæmorrhages, passed into a state of collapse. The patient (a girl of 16) lay motionless, flat on her back, with eyes wide open and glaring; any attempt to move her seemed to cause great distress. It was then found that from the occiput to the lower end of the spine she was perfectly rigid. She had dry tongue and involuntary diarrhœa. At 9 p.m. rhus 6 was given hypodermically. At 11 it was repeated, and at 12 she closed her eyes for the first time and slept peacefully for several hours. In the morning the rigidity had disappeared. Her bowels did not move during the night, nor for ten days thereafter, when she had a free and natural evacuation. The rhus was continued (it is not said how often) till recovery.—*The Clinique*, Dec.

**Salicylica.**—*L'Art Médical* for December gives two cases brought before the Société Médicale des Hôpitaux of Paris, in which severe and persistent delirium was induced in sufferers from acute rheumatism by full doses of salicylate of soda.

**Stramonium.**—In the *Clinique* of February, Dr. Taylor follows up his study of hyoscyamus (*q.v.*) in insanity with one of stramonium. Dulness of intellect, hallucinations, emotional disturbance and instability, loquacity, but without violence or obscenity, are his main indications for it. It is, he thinks, specially adapted to puerperal mania.

A case of poisoning by stramonium is extracted in the *Calcutta Journal of Medicine* for December, which presents some unusual features, viz., sensation of swelling in eyes; everything lifted seemed to patient exceedingly heavy; inco-ordination of lower extremities; pale face.

**Thuja.**—Dr. Orrin Smith gives a case, and refers to another and to his general experience, in confirmation of the power of thuja taken internally to cause the disappearance of warts; but with this novel feature about the treatment, that he gives the remedy in drop doses of the mother tincture.—*The Clinique*, Nov.

**Thyroidin.**—A case is recorded in which feeding with thyroid extract—3 to 15 grains a day—seems to have dispersed a number of carcinomatous nodules recurring in the neighbourhood of the cicatrix left after extirpation of the breast for the same disease.—*Med. Century*, Dec.

Dr. Malcolm Macfarlane has proved thyroidin, in the 15th dil. It was "given often, and for several days, to a great number of

persons slightly ailing, but not aware of being provers. The prime symptoms were sighing, disturbed and unequal respiration, anxiety about the chest as if constricted or as if the movements were obstructed by tight clothing. This constriction lasted but a short time, varying from a few moments to an hour or longer, and showed a disposition to recur several times during the day. With the sighing was rapid heart-action, fear, nervousness and anxiety, indisposition to exercise. The majority of the provers were women."—*Hahn. Monthly*, Feb.

Yet another employment for this product, which is fast becoming a polychrest! Drs. Quéan and Reclus report to the Société de Chirurgie five cases of ununited fracture, in three of which formation of callus set in speedily after the administration of capsules of thyroid extract, and good consolidation resulted.—*L'Art Médical*, Feb.

Dr. Bailey's report of his success with thyroidin in uterine fibroids<sup>1</sup> has led to a large testing of the remedy, the results of which may be read in the *Clinique* of February. They are too numerous to be summarised here, but they show an undoubted power on the part of this substance (generally in the 1x trit.) to relieve the symptoms and often to reduce the size of fibroids, while goitres rarely fail to yield to its influence.

"Bauman has been able to extract the active principle of the thyroid gland, and finds it to be identical with iodine."—*N. Am. Jour. of Hom.*, Feb.

**Yespa.**—"About two months ago I had an urgent summons to go and see Miss S., who had been stung by a wasp in the throat. When I arrived she was just recovering from a fainting fit. Soon afterwards she was seized with pain in the stomach and violent vomiting. Under treatment she soon recovered from this first attack. A few days ago, however, she had the misfortune to be stung by a wasp the second time, on this occasion in the hand. She expired a few minutes after my arrival at the house. On making enquiries I elicited that a few minutes after being stung her mother noticed that her face was very red. She next complained of feeling numb all over, and losing her sight, after which she fainted away. (These symptoms of numbness and blindness also occurred in her first attack.) Her face from red turned suddenly pallid, and she expired in about twenty-five minutes from the time she was stung."—*Calcutta Jour. of Med.*, Dec.

<sup>1</sup> See our fifth volume, p. 226.



## THERAPEUTICS.

**Ascites.**—Dr. Mattoli reports “a grave case of ascites,” but which reads more like one of tuberculous peritonitis. The curious tendency to recovery shown by this form of tuberculosis, generally when the abdomen has been opened, appeared here as a result of medication. Apis and sulphur, in high dilutions, after some relapses achieved a definitive cure.—*Revue Hom. Belge*, Oct.

**Cancer of tongue.**—Dr. Jousset reports a case of indubitable cancer of the tongue in which complete cure has been effected by hydrastis. Compresses of an aqueous solution of one in ten were kept continually applied to the organ, and three or four drops of the mother-tincture were taken daily internally. The cure required only three to four months. Dr. Boyer followed this with another case, in which the same medicine, but in the 6th dil., was given with success only less striking.—*Revue Hom. Française*, Jan.

**Cataract.**—Dr. A. B. Norton, from his experience at the New York Ophthalmic Hospital, maintains that opacity of the lens cannot be removed by homœopathic medication, but that it can be checked in its progress. In 100 cases he had checked the process in 50, mainly with causticum. Naphthalin had proved a failure in his hands.—*Amer. Med. Monthly*, January.

**Cystitis.**—Dr. de Nobili relates a case of muco-purulent catarrh of the bladder, with much constitutional disturbance, following maltreated gonorrhœa, in which a very satisfactory cure followed upon the alternate use of terebinthina and cannabis indica (both in the 3x). The latter variety of hemp has hardly received employment in such cases.—*Revue Hom. Belge*, Dec.

**Enlarged tonsils.**—Dr. G. H. Rice, who is a throat specialist, has an interesting article in the *New England Medical Gazette* for January on “The Curative Action of certain Remedies in Diseases of the Upper Respiratory Tract.” When the tonsils (including Luschka’s) are chronically enlarged, he gives calcarea carbonica, phosphorica, or iodata: the first where the organs are large, soft and readily bleeding; the second where they are not so large and more resistant; the third where they are large and firm, and also ragged from the numerous crypts which indent their surface. The first two are given in the 3x or 6x trit., the last in the 2x or 3x. They must be persisted in daily for several months.

**Gynæcology.**—In a paper on “Medical Gynæcology,” in the *Homœopathic Journal of Obstetrics, &c.*, Dr. Henry E. Beebe well summarises the characteristics and practical adaptability of twenty leading remedies in diseases of women. He does so with the view of promoting their larger use in preference to a too ready and exclusive employment of surgical measures, and his remarks are well calculated to serve this end.

**Hyperchlorhydria.**—Dr. E. O. Adams has an article on this affection (which, however, he calls “hyperchlorrhidia”) in the *Medical Century* of December. His account of its dietetic and chemical treatment is good, but he has no information to give as to dynamic remedies.

**Influenza.**—Dr. Fisher publishes an exhaustive article on this disease in the February number of his journal, the *Medical Century*. Its symptomatic indications for remedies are very full, and the confidence of the writer in the middle and higher potencies is stimulating.

**Leucorrhœa.**—Dr. A. M. Cushing finds from his long experience that leucorrhœa is nearly always curable by internal medication, without local treatment or even examinations. In recent cases low attenuations will suffice, but for those of longer standing the higher must be used. He gives illustrative cases.—*Hom. Recorder*, Feb.

**Lupus erythematosus.**—A case of this disease, invading the whole face, was treated tentatively by the Roentgen rays, allowing them to fall on the left side only. The patient was presented to the Vienna Medical Society with that side almost in a normal state, while the other retained its morbid condition. The reporter in *L'Art Medical* (December) aptly recalls the severe erythema often induced by exposure to these rays.

**Nervous syphilis.**—In a thoughtful paper, Dr. E. Colby calls in question the assumption of the syphilitic origin of chronic nerve-degenerations like locomotor ataxy, because the patient has, in the past, incurred specific infection. He points to the admitted uselessness of anti-syphilitic treatment of such cases as pointing to other directions—sometimes to the absence of such taint in the system, sometimes to the existence already of some mercurial or iodic poisoning, due to too active or prolonged treatment of the primary disease. On such suppositions he would base homœopathic treatment of the nervous affections in

question, and not without hope of success.—*N. Eng. Med. Gazette*, Feb.

**Otalgia.**—Dr. Copeland, of Ann Arbor, contributes a practical paper on ear-ache to the *American Homœopathist* of February 1. The indications for remedies are very full and plain.

**Pertussis.**—Dr. Cartier gives an extract from a post-graduate lecture of his on the homœopathic treatment of whooping-cough, with which he is well satisfied. He warns against giving too soon the medicines suitable for the spasmodic stage, *i. e.*, corallium and drosera (which he esteems in this order). He finds it useful to give a few drops of *passiflora incarnata*  $\phi$  in divided doses during the night. Ambra he finds effective when there is much eructation with the cough; cina when there is "clucking" and when the paroxysm returns at regular intervals; mer. corr. when the latter is duplicated; coccus cacti when the patient awakes with a terrible attack of coughing, and when this is excited on brushing the teeth.—*Revue Hom. Française*, Feb.

**Phthisis.**—Dr. Marc Jousset communicates a case of phthisis in the second stage, where really brilliant results were obtained from Dr. Martiny's treatment of alternate days of arsenicum iodatum and calcarea phosphorica, both in the 6th dil.—*Ibid.*, Jan.

**Pityriasis rubra.**—Dr. C. D. Collins relates a striking case of this kind, in which all the cutaneous appendages, even to the lanugo, fell away. Under arsenicum iodatum 3x every three hours, and cosmolin locally, improvement began in ten days, and complete recovery ensued in three months.—*The Clinique*, Jan.

**Sea-sickness.**—The editor of the *Medical Century*, who has recently paid us a welcome visit, records (in the December number) his experience, while crossing the Atlantic, in the treatment of *mal de mer*. "My experience," he writes, "covered fifteen cases. *Cocculus* was most helpful when the patient was 'oh! so sick,' and could not move; vertigo, faintness, extreme nausea, and deadly paleness completed the picture. A single tablet of the sixth decimal gave prompt relief in nearly all such cases. Only three times was it necessary once to repeat the dose (save, of course, on subsequent recurrence of the symptoms). *Ipecac.* was helpful in those in whom emesis occurred easily. *Glonoin*, 6th, did excellent service for two patients with whom violent headache took the place of gastric disturbance; and *apomorphia*,

3rd, one tablet, made a homœopath of a lady who had failed to obtain relief from old-school treatment and from *cocculus* previously administered."

**Tetanus.**—A discussion on the homœopathic treatment of this malady at the King's County Medical Society is reported in the *North American Journal of Homœopathy* for January. Dr. Simmons had had ten cases, all of which had died. Dr. Bayliss had had four—two traumatic, recovering under *angustura* (he does not say whether *a. spuria* or *a. vera*); two idiopathic, where the general symptoms led to *calcareæ* and *chamomilla*, with success. Dr. C. W. Smith had had one case, traumatic, which *nux vomica* and *hyoscyamus* brought to a happy issue.

**Tinnitus aurium.**—Dr. W. Spencer thinks that this disorder, especially in old people, is due to fibrous bands and adhesions, confining the ossicles, and making pressure on the labyrinthine fluid. Seeking for means whereby to melt these down, he has come upon thiosinamine, an allyl sulphocarbamide derived from the oil of mustard-seed. It has been shown to exert a solvent influence on lupus and enlarged glands, when injected locally; and Dr. Spencer has such "satisfactory and gratifying results" with it in tinnitus that he urges further trial of it. He does not say how he administers it.—*Hahn. Monthly*, Jan.

**Veins, affections of.**—Dr. Cartier gives an extract from a post-graduate lecture of his on the treatment of these maladies, which presents several points of interest. He esteems *arsenicum* (6 to 30) very highly in phlebitis, where the burning pain is very marked. He recommends *zincum* (6) for painful varicose veins, and in the varicose ulcer finds *clematis*, within and without, superior to all other medicines.—*Revue Hom. Française*, Feb.

JOURNAL  
OF THE  
**British Homeopathic Society**

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No. 3.

JULY, 1899.

VOL. VII.

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*All communications and exchanges to be sent to DR. HUGHES,  
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THE MODERN THERAPEUTICS OF PULMONARY  
PHTHISIS.<sup>1</sup>

BY F. S. ARNOLD, B.A., M.B., B.CH.OXON.; M.R.C.S.ENG., L.S.A.

ACCORDING to the Registrar-General's returns phthisis kills at the present time 59,000 odd in this country every year. This mortality, huge as it is, is only about one third of the phthisical mortality of fifty years ago. Little wonder then that we are interested in the subject of the treatment of such a scourge. The enormous improvement that has taken place, and the vastness of the evil still remaining to be dealt with, alike challenge attention, and make tuberculosis at any time the most poignantly interesting of all diseases. Within the last few years the public and the mass of the medical profession have awoke to the fact, which was really established beyond any fair doubt or cavil by Brehmer forty-two years ago, that phthisis is a curable disease; and it is the hearing of this note by hitherto deaf ears that accounts for the tremendous outburst of interest in the tuberculosis question which we are at present witnessing in every civilized

<sup>1</sup> Presented to the Section of Medicine and Pathology, March 2, 1899.

country. Until comparatively recently, though a better way had long been pointed out, the usual treatment of a consumptive patient might have been summed up as "cod-liver oil and coddling," with Madeira to die in for the more well-to-do patients. Patients were directed to avoid chills and exposure, were kept in overheated rooms from which every breath of fresh air was religiously excluded, and had their stomachs upset, and their fickle appetites outraged, by enormous doses of cod-liver oil. Established consumption was regarded as practically incurable, most of the talk one did hear of its curability coming, of all places, from the *post-mortem* room, where one heard of healed tubercular lesions being found in the lungs of persons who had died of non-tubercular diseases. It is rather a dismal state of things when one has to look to the *post-mortem* room for hope, and it is hardly to be wondered at that medical men cast about for methods of combating phthisis which should give better results than the traditional treatment, if treatment it can justly be called. It is a few of these suggested improvements on the old methods that I wish to say a few words about to-night under the heading "Modern Therapeutics."

The treatment of phthisis by antiseptics, though some forms of it, such as Coghill's respirator, were adopted before the discovery by Koch of the tubercle bacillus, of course received an immense impetus from that discovery, and the number of antiseptic drugs which have been put forward as specifics is already legion. Iodine, iodoform, carbolic acid, creasote, guaiacol and its carbonate, perchloride of mercury, are perhaps the most largely used, but these do not by any means exhaust the list. Antiseptic treatment is applied in various ways; the drugs have been administered by the mouth, by inhalation, and by subcutaneous injection, direct injection into the lung and inunction, and I believe some enthusiast has even pumped sulphuretted hydrogen into the rectum. It is obvious that in the case of the antiseptic treatment of phthisis, the problem is to hit on a drug which will find out the tubercle bacillus in his lair, and slay him, without injuring the human cell in his vicinity. This problem has

not been up to now successfully solved, and the antiseptic treatment of phthisis must be held to be on the whole a failure, when the very extravagant claims made on its behalf are taken into consideration. In his very interesting presidential address delivered before the Liverpool Branch, and reported in the current number of our Journal, Dr. J. D. Hayward speaks highly of guaiacol and creasote and their carbonates, as adjuvants to open air treatment, and there is no doubt that these drugs, and others of their class, may be of use in lessening secretion and checking cough. Their drawbacks, however, seem to me often to exceed their advantages, and personally I cannot say that I have ever obtained results from them in any degree superior to those obtainable by other methods of drug treatment. The position seems to be accurately summed up by Dr. Percy Kidd, in his article on phthisis pulmonalis in Dr. Clifford Allbutt's monumental "System of Medicine." "The results have not differed greatly in respect of any of these methods. They have all passed through successive stages of exaggerated and hasty laudation, half-hearted approbation, and contemptuous neglect. The history of guaiacol is a good illustration: at first it was advocated as a specific; now the only claim seriously made in its favour is that it has a beneficial effect on cough and expectoration." Though no decided success can be claimed for antiseptic treatment up to the present, it is, I think, quite possible that such success will sooner or later be achieved. In this connection I may mention an interesting article by Dr. Murrell, which appeared in the *British Medical Journal* a few weeks back. The subject of the article is "The action of some essential oils and other substances on the growth of the bacillus tuberculosis, and in the treatment of phthisis." The substances experimented with by Dr. Murrell were, oil of cinnamon, oil of peppermint, and formic aldehyde. It was found that prolonged exposure of cultures of tubercle bacilli to an atmosphere saturated with the vapour of either of the essential oils had not the smallest effect in retarding or inhibiting the growth of the bacilli. In the case of the formaldehyde, however, it was quite otherwise. Cultures exposed to a formaldehyde atmosphere

by precisely the same method as had been adopted in the case of the oils showed no growth whatever, and subcultures made from them failed to grow, shewing that the bacilli had been killed. Concurrently with these bacteriological experiments, corresponding clinical experiments were made, and it was found that the results of the one series accorded closely with those of the other. Clinically speaking the essential oils were found to be entirely useless, while excellent results were obtained from formaldehyde inhalations. Of fourteen cases treated by formaldehyde, and receiving no other treatment beyond an occasional dose of picrotoxin to check night sweating, twelve were much benefited, whilst two only slightly improved. To quote Dr. Murrell: "Of the twelve successful cases, all of which were much improved, five were men and seven were women. Of the five men, three had cavities at both apices, and the other two had marked signs of consolidation at the left apex. Of the seven women, three had breaking down of both lungs, and four had consolidation of one lung only. One man and one woman had, in addition to the lung symptoms, tuberculous ulceration of the larynx. Some of these patients had previously had inhalations of oil of cinnamon or oil of peppermint without benefit." The four cases of which Dr. Murrell gives detailed histories are extremely striking, and one will look with interest for further reports of this method. A specially interesting point about this research of Dr. Murrell's is that it is an instance of the right and fruitful form of bacteriological work, into which the everlasting guinea-pig does not enter, to our moral confusion and logical undoing, from start to finish.

It is not necessary to waste much time over tuberculin, that typical outcome of guinea-pig bacteriology. The subject is an unsavoury one from different points of view, and I have little inclination to dwell on the unedifying exhibition the profession made of itself in 1890 and 1891. The bubble, which had shown signs of bursting, was effectually pricked by Virchow on January 7th, 1891, in a speech delivered before the Berlin Medical Society, at the discussion on a paper by Professor Fraenkel.



Virchow proved by *post-mortem* examination, in a considerable number of cases treated by Koch's "lymph," that Koch's statement that the bacilli were not killed by the injections was only too correct; so far from being killed they were in many cases set free to roam about the body, and form metastatic deposits in various parts, even at considerable distances from the original tuberculous focus. In one case of apical phthisis, where there had been no trace of consolidation in the lower lobes, persistent fever came on after six injections had been made, and infiltration of the lower lobe was diagnosed, a diagnosis which was shortly verified *post mortem*. In commenting on this case, the *British Medical Journal* says: "From a careful consideration of this case it would appear that the injection did its work in the usual fashion, but too well; the local reaction was obtained, death and separation of the tuberculous tissues in the wall of the cavity were obtained, but the sloughs, in place of being expectorated as they usually are in ordinary phthisis, where the disintegration and separation take place but slowly, were detached in large quantities and were drawn, partly by inspiration and partly by gravity, into the bronchi of the lower lobes of the lung. Thence they made their way into the smaller terminal branches, and set up the mixed fibrinous and catarrhal pneumonia characteristic of this condition. Other cases of a similar kind were shown, from which the lesson to be learned is only too obvious." Observations of a similar kind to those of Virchow crowd the medical periodicals of the year 1891, and by the end of the year the "remedy" had been practically universally discarded by a profession, disappointed, but unrepentant, and quite ready to swallow whole the next laboratory fairy tale, having apparently become constitutionally incapable of exercising its usual wholesome scepticism regarding new remedies in the case of those bearing the genuine guinea-pig stamp of origin. It is refreshing to turn from the consideration of a repulsive nostrum, such as tuberculin, to that of a method of treatment based on simple obedience to Nature's plain laws of healthy living. References of a more or less vague kind to the value of a plentiful supply of pure air, both as preventive

and curative of phthisis, may be found a long way back in medical literature. One of the first to draw emphatic attention in this country to the importance of impure air as an ætiological factor in phthisis was McCormac, father of Sir William McCormac, whose work "On the Nature, Treatment, and Prevention of Pulmonary Consumption," is extraordinarily interesting reading at the present time. One very striking example cited by McCormac relates to the monkeys confined in the Jardin du Roi in Paris. McCormac states that of those confined in cages in large, but ill-ventilated rooms, practically all died of phthisis, while those kept in huts sheltered only from the east and north-east winds enjoyed comparative immunity.

During the forties and fifties much statistical evidence was accumulated in proof of the thesis that impure air is a cause of phthisis. The evidence related mainly to soldiers, inmates of prisons, and certain classes of workmen. It is a very curious fact that though the important part played by deprivation of fresh air in the causation of phthisis was thus early recognised, it is only quite recently that the efficiency of simple fresh air as a curative agent in many even advanced cases of phthisis, apart from high altitude, dryness, warmth, or any other factor, has been at all widely admitted or contended for. Though cures are recorded in every conceivable kind of climate, climate has until quite recently been looked upon as *the* important factor, and not that which all climates have in common, namely, air. There seems some possibility of the pendulum swinging too far in the other direction at present, and of the claims of climate to be an important, if subordinate, factor in the therapeutics of pulmonary phthisis being practically ignored. Of the pioneers of aero-therapeutics in phthisis, Archibald Smith, Jourdanet, Lombard, Brehmer and others, the first place must, I think, be given to Brehmer, who founded the first sanatorium for consumptives, and who did more than any other authority to establish the hygienic treatment of phthisis on scientific lines. The importance and excellence of Brehmer's work has not always received due acknowledgment in this country: this is probably owing to the fact that his works have never

been translated from the original German. It occurred to me that it might be of interest to give a slight sketch of Brehmer's views as expressed in his work on "Phthisis and Tuberculosis of the Lungs; their Causes and Cure," of which the first edition was published in 1857, four years after Brehmer had begun his treatment at Görbersdorf. The first and second chapters deal respectively with the pathological anatomy and symptoms of phthisis, and need no special comment. The third chapter, on the causes of phthisis, is of considerable interest. After discussing the amount of importance to be attached to impure air as an ætiological factor, and arriving at a conclusion in accordance with our latest knowledge on the point, namely, that it is a predisposing but not the exciting cause, he goes on to argue that it is in a study of the anatomical characters of phthisical patients; of the *phthisical habitus*; that we are likely to find light shed upon the subject. The external characters of consumptives not helping us to any conclusion, we must study the internal anatomy. Brehmer quotes Louis (*Mem. de la Société Médicale d'observation*, tome i., p. 290) as follows:—"Out of 112 cases of phthisis, in only three was there found any increase in the heart's volume. In by far the greater number, the heart was found much smaller than normal, and frequently its volume was not more than one half or two thirds of the normal." By the word "volume," it is important to understand that ventricular capacity is here meant. Rokitansky also insists on the small heart as one of the characters of the phthisical habitus, the others being, a long but narrow chest, weakness of the walls of the arteries, muscular feebleness and tendency to hyperæmia and plastic inflammation of serous membranes.

Brehmer draws from these observations the conclusion, that the abnormal smallness of the heart, noticed in phthisical patients, is the fundamental cause of phthisis, involving as it does a permanently insufficient nutrition of lungs and general system. In answer to Rohden's objection that a small and feeble heart is characteristic of every wasting disease, and should be regarded as a consequence, not as the cause of phthisis; Brehmer retorts that the thinning of the heart

walls noticed in consumptives may well be a consequence of their disease, but that the abnormally small ventricular capacity, borne witness to by Louis, Rokitansky and Bizot, is a feature in which phthisis differs from other wasting diseases, cardiac muscular atrophy leading *per se* to an increase in ventricular capacity. The fact that, in consumptives, thinning of the heart walls and small ventricular capacity co-exist, forces one then to the conclusion that the latter condition precedes the former in time, and cannot, like it, be regarded as a consequence of the wasting disease.

Brehmer sums up at the end of this chapter as follows:—  
 “Any cause leading to prolonged or permanent enfeeblement of nutritional processes may bring about the development of phthisis. For phthisis is in its essence merely an expression of enfeebled nutrition, a kind of inanition of the whole system.”

Chapter IV. deals with the geographical distribution of phthisis. Its argument may be thus stated: In order to arrive at a rational treatment of consumption, it is advisable to consider the facts relating to its geographical distribution; for if we find certain areas of the earth's surface whose inhabitants do not suffer from the disease, a consideration of the conditions, social and meteorological, under which those inhabitants live, and of the points of agreement and of difference between the various areas in respect of such conditions, regard being had always to the conclusions as to the causation of phthisis arrived at in the above, should enable us to draw conclusions as to the special cause of immunity in each particular area. A knowledge of the reasons why phthisis does not attack the inhabitants of certain areas should obviously be of great assistance in the search for a rational treatment for the disease. Brehmer enumerates four areas in which consumption never or extremely seldom occurs: (1) Iceland; (2) the Faroe Islands; (3) the Kirghis Steppe; (4) high altitudes all over the world.

I have not been able to ascertain the present condition of the Faroe Islands in respect of phthisis. Dr. Percy Kidd states, in his article on phthisis in Allbutt's System of Medicine, that there is exceedingly little of the disease in

Iceland, a fact which is certainly striking when the mode of life of the inhabitants, extremely unhygienic as it is in very many respects, is taken into account.

Chapters V., VI., VII. and VIII. are devoted to accounts of the conditions of life prevailing in the above-mentioned areas. The conditions prevailing in Iceland and in the Faroe Islands are of course much alike, but both differ in almost every conceivable respect from those prevailing in the other two regions which, again, differ no less from each other. In the ninth chapter, entitled "Statement of the means adopted by nature for protection against phthisis," Brehmer attempts to educe order out of chaos. As he points out, a study of the conditions under which men live in the phthisis-free regions tempts one to believe that their freedom from the disease is more a matter of accident than of law, for it seems at first sight impossible to discover any single factor or influence in which all the regions agree. That factor cannot be temperature, dryness or moisture of the air, barometrical pressure, clearness or otherwise of the atmosphere, for in these respects every possible extreme is represented in the immune regions. Let us leave Iceland, the Faroe Islands, and the Kirghis Steppe on one side for the time, and confine our attention to the phthisis-free mountain regions which exist in every quarter of the globe, and which differ from each other in geographical position, mode of life and occupation of inhabitants, geological formation, and many other respects, at least as much as they differ as a whole from the lowlands. Is there any factor in which all mountain regions agree in differing from the lowlands? There is one, and only one, such factor; diminished barometrical pressure. We are, therefore, forced to the conclusion that the immunity of mountain regions is dependent on this diminished barometrical pressure; however much the cases of Iceland, the Faroe Islands, and the Kirghis Steppe seem to point against this view. What do we know about the effect of diminished air pressure on the organic life of man? We know from observations made by a large number of men of science, that one constant physiological effect is increased frequency and force of pulse

and respiration, with consequent increased rapidity of metabolism and heightened nutritional activity; but we have seen that phthisis is an expression of lowered nutritional activity; it is, therefore, easy to understand its absence from regions where cosmic influences rule whose constant tendency is to quicken metabolism and improve nutrition. In Dr. Theodore Williams's paper on "The Treatment of Phthisis at High Altitudes," read before the International Medical Congress of 1881, Brehmer's views receive strong confirmation. Dr. Williams shows that residence in high altitudes causes at first, in strangers, a quickening of the normal rate both of pulse and respiration; after a time the rate drops to normal again in both cases, the fall in pulse rate being accompanied by more powerful cardiac impulse and a fuller vascular system, while the respirations also gain in depth as they diminish in frequency. The large size of the chest of dwellers in high regions has been noted by many observers. Jourdanet's picturesque description of the Mexican-Indian in his *Les Altitudes de l'Amérique Tropicale* is worth quoting: "The Indian, whom one may regard as acclimatised, possesses a chest whose girth is out of all proportion to his small stature. Consequently, he performs feats of endurance without shrinking, which, in other countries, would cause amazement. He makes long journeys on foot, and rarely walks; running is his ordinary pace. On oppressively hot days he may be seen with body bent forward and forearms raised, a load on his back, undertaking a journey of from forty to sixty miles daily, in order to transact his modest business at the capital. His broad chest enables him to do this with ease in this rarefied atmosphere, and, even under the burning rays of the sun, to draw in with every breath energy which enables him to withstand the greatest fatigues, and brings him to a good old age."

To return to Brehmer's argument: granting that the immunity of mountain regions is due to the favourable influence on nutrition of a constantly acting cause, viz., diminished barometrical pressure, to what are we to ascribe the immunity of Iceland, the Faroe Islands, and the Kirghis Steppe. It is impossible to ascribe it in these cases to any

cosmic influence, and we are reduced to the inquiry: Is there any habit or mode of life of the peoples inhabiting these regions which we can credit with maintaining a high state of nutritional activity, which in fact performs the office filled in that respect in high altitudes by diminished air pressure?

According to Brehmer, we have such a factor in the enormous consumption of fat and butter by the Icelanders or Faroe Islanders, and of koomiss by the Kirghis nomads. Fatty foods increase pulse frequency and quicken metabolism. An Esquimaux will commonly eat as much as sixteen pounds of fish at a meal, an obvious impossibility in the absence of very rapid metabolism. It is well known that fatty foods tend to produce a feeling of warmth, and a conscious feeling of warmth is, as Lichtenfels and Fröhlich have pointed out, almost always associated with heightened frequency and force of pulse. Thomsen found that Icelanders have a slightly higher normal temperature than Europeans, twelve healthy individuals whose temperature was taken in the mouth giving an average of a little over 99°F. We have, then, in the foregoing facts clear indications for a rational treatment of consumption. By what means can we best combat and remove a condition of insufficient blood supply and lowered nutritional activity? Brehmer's answer is, by suitable powerfully nourishing diet, fresh air, and stimulating baths, and, in the more severe cases, by diminished barometrical pressure in addition to the foregoing. Brehmer's words concerning the second factor, fresh air, are worth quoting, bearing in mind that they were written in 1854. "Of equal importance with a suitable powerfully nourishing diet is the employment of fresh open air, which is so much neglected, but which cannot be strongly enough insisted on. For without this the best diet is powerless. The patient should be constantly in the open air. This is the only valid reason for sending patients to southern health resorts."

In the more severe cases of phthisis, in conjunction with suitable diet, fresh air and stimulation of the skin, a further means must be employed if we wish to bring about a cure. If we remember not only that phthisis is a slowing, a retarda-

tion of metabolism, but also that persons with hereditary tendency to the disease present, according to Louis and Rokitansky, a faulty proportion between two important organs, an abnormally small heart and a voluminous lung, which involves, according to the laws of mechanics, an insufficient and retarded blood stream in the lungs; we must conclude that this nutritional fault can best be counteracted or removed by a means whose action on the organism shall be constant and in the direction of increased blood supply; and this means can only be the atmosphere; for that is the only agent which exerts a never-ceasing influence on man. In order to exert a powerful heightening influence on metabolism, however, air must be under a condition of diminished barometrical pressure.

Theoretically, therefore, diminished barometrical pressure must be regarded as a physiological antidote to phthisis.

From the purely theoretical point of view, we should feel obliged to recommend this remedy, even if we did not know empirically that pulmonary phthisis does not occur in high altitudes. "Personally," says Brehmer, "I have followed this course, for in 1853, in my 'Doctor's Thesis,' after having discussed the real cause of phthisis, and having arrived at the same conclusion, namely, that it is a prolonged state of malnutrition dependent upon a diminished blood-supply, I had a strong conviction that upon this fact the cure of consumption must be based; I had at least shown what one had to fight against, and had in so doing substituted a definite object for the generally acknowledged, but vague, dyskrasia. I could not yet, however, assert by what means consumption would be cured. For then Vierordt's false conclusions concerning the action of the pulse under differing atmospheric pressures were regarded as sound, and at the universities the very name of geographical medicine was unknown.

"When I settled at Görbersdorf to study the effect of the various remedies, I missed in all works on the subject any notes on the influence of air upon the human body. And yet, clearly, this influence must be ascertained before we study the effect of any other agent; for we cannot eliminate the influence of the atmosphere from any of our experiments.



Consequently, I tried to fill this gap in our knowledge, and began to study the influence of the atmosphere, more especially as regards atmospheric pressure, for, though we can change all the other conditions in our work-rooms, we cannot alter the atmospheric pressure. I found that a fall of the barometer, that is, a thinning of the atmosphere, increased the rate of the pulse, *i.e.*, the circulation of the blood, and consequently the blood supply to the various parts, and so theoretically I had found the cure for phthisis. Then the works on geographical medicine grew more numerous, and they taught that consumption does not really occur at all in high altitudes. So theory and experience met and confirmed one another most satisfactorily, and I therefore resolved to devote myself to the treatment of phthisis."

Such is the genesis of the modern systematic treatment of phthisis on hygienic lines. Brehmer's arguments and conclusions may strike us as here and there somewhat fanciful, but, on the whole, time and experience have confirmed his views in a remarkable manner. His cardinal points, generous diet, open-air life, baths and douches and carefully regulated exercise, are also the cardinal points in the best and most successful sanatoria at the present day. With regard to the importance of diminished barometrical pressure, Brehmer's views have been a good deal misrepresented. He distinctly states that many early cases of phthisis can be cured under ordinary pressures. That he was right, however, in attaching great importance to residence in high altitudes, as providing a powerful, because constantly acting, auxiliary to other therapeutic measures, cannot be doubted in face of the facts cited by Dr. Theodore Williams.

The statistics also show that the best results in percentage of cures have been and are obtained in the highland sanatoria; Nordrach, 1,700 feet above sea level, for instance, receiving consumptives in all stages of the disease, curing 30 and improving 90 per cent. of them. Alpine, as distinguished from highland sanatoria, have many drawbacks. In the first place, they do harm rather than good to patients

with much tendency to fever or suffering from albuminuria ; again, they are all in places to which large numbers of practically healthy persons resort for the purpose of enjoying themselves, and the average consumptive seems incapable of resisting the temptation to overdo himself in the pursuit of pleasure, if that temptation is constantly placed in his way. The proper function of such places as Davos is, in my humble opinion, to restore to health merely suspected or very early cases of phthisis, or to provide what the Germans call a *nach kur*, to give tone and vigour to patients already practically cured at lower levels.

Brehmer founded his sanatorium at Görbersdorf in 1859, having been treating phthisis on the lines laid down in his work since 1854. The results obtained at Görbersdorf have led to the establishment of similar sanatoria in different parts of Germany, and there are now in that country seventeen sanatoria for paying patients, with 1,200 beds, and about twenty similar institutions for the poor, with 1,300 beds, while there are building about as many again, with some 1,100 beds ; there will, therefore, shortly be some forty sanatoria for the poor in Germany, with 2,400 beds. France has three sanatoria for paying patients, with 146 beds, and including Corsica, six more building, with 300 odd beds. A considerable number of sanatoria are in course of establishment in France, municipalities helping to find the funds in several instances. There are two admirable institutions for children of the poor at Ormesson and Villiers-sur-Marne respectively ; the former has 130 and the latter 220 beds. These institutions were founded and are maintained by the society *L'œuvre des Enfants Tuberculeux*. In the United States there are about eighteen sanatoria, with some 1,100 beds. In this country we have no sanatoria for the poor, while for paying patients we have three established, with twenty beds, and two being built, with thirty-five beds. There are some signs of a growing feeling in this country that our position in this matter is hardly one to be proud of, and one may reasonably hope that ere long we shall be able to make a better show. At the annual meeting of the Manchester Chest Hospital held a few days ago, it was

announced that a public-spirited citizen had offered to build a sanatorium for 100 beds if the up-keep of the institution were guaranteed.

In Germany a large proportion of the money devoted to the establishment of sanatoria for the poor has been found by the various sickness and old age insurance societies. Under a clause in the law of 1889 enforcing insurance against sickness and old age on all whose income is under £150 per annum, any insurance society may devote part of its funds to the treatment of the sick in lieu of sick pay. This provision has been taken advantage of very largely, and during 1897 about £65,000 was invested in sanatoria by insurance societies, while during last year the sum applied to this purpose was between £150,000 and £200,000. Our friendly societies might perhaps do worse than endeavour to arrange for an imitation of the German example, on a small scale. While we are waiting for the establishment of sanatoria over here, a good deal can be done to help our less well-to-do patients, by teaching them not to be afraid of fresh air. I have found even the smoky air of Manchester wonderfully efficacious in at any rate retarding the progress of consumption, when once the patient can be got to look upon it as a friend rather than as an enemy.

With regard to homœopathic therapeutics, I have not very much to say. The drugs I personally have found most useful are sanguinaria, jaborandi, and iodide of arsenic. I attach a very high value to sanguinaria, which I think has a definitely curative action in early phthisis. In several cases, in which the sputa contained bacilli, and in which no thorough hygienic treatment could be carried out, I have found it of the greatest possible value. One case, a youth who came under my care two years ago, with consolidation of left apex, sputa teeming with bacilli, and drenching night sweats, recovered with extraordinary rapidity under sanguinaria, and has for eighteen months past been perfectly well, following his employment as an electrical engineer. A young woman of 25, who came under treatment about the same time with signs of fairly advanced mischief in left lung, and infiltration of the larynx, and who has been taking san-

guinaria regularly from the commencement of treatment, has more than held her own during that time, and the sputa contain distinctly fewer bacilli than when first examined. The credit of this result so far as it goes must, I think, be given to sanguinaria, for it has been quite impossible to induce the patient to be anything but most abstemious in the matter of fresh air.

So far, I have never seen jaborandi fail to check night sweats, its action in this respect being often magical in its rapidity and thoroughness. These two drugs and the iodide of arsenic are tried friends, and practically complete my armamentarium.

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## THE DISPENSARY TREATMENT OF PHTHISIS.<sup>1</sup>

BY C. E. WHEELER, M.D., B.S., B.SC.LOND., M.R.C.S.ENG.,  
L.R.C.P.LOND.

ALTHOUGH it may very reasonably be contended that in a Society many of whose members are general practitioners more advantage is likely to result from the discussion of diseases of everyday occurrence, rather than of those of which the examples are incidents in a lifetime, yet there is one person whom the choice of such a subject as phthisis places in a difficult situation, namely, the writer of the paper which introduces the debate. The difficulty of the situation I feel to the full. What can I find to say that is not familiar in your ears to the verge of staleness? and to add to my trouble, not only has the last of the Society's publications contained a most excellent not to say exhaustive paper on phthisis by Dr. J. Hayward, but in addition I have tonight to follow a paper which has dealt with the open air treatment, the only point of the subject with any pretensions to novelty. I must add that Dr. Arnold most kindly offered me the benefit of this point, but as he was first in the field

<sup>1</sup> Presented to the Section of Medicine and Pathology, March 2, 1899.

I could do no less than leave him to pursue it. I am rewarded by the great pleasure and profit with which I have listened to his paper to-night, but I feel acutely that it has left me to confront you with a subject upon which I can have little to impart. I have even gone so far as to wonder why those who order these matters saw fit to have two papers on the same subject; but such vain questioning is beside the mark, and while I invite your pity I bow to their decree.

I have called my paper, Phthisis from a dispensary point of view, by which title I wish to accentuate the fact that a great number of our patients, the majority probably, are unable either to seek a climate better suited to them, or undergo a full and proper open air-course, for one simple reason, they cannot afford it. For those who can, I have not the slightest doubt that the open air treatment is by far the best; far better open air and no drugs, than all the drugs most carefully selected and a deficiency of open air. But as practical physicians, what are we to do for the phthisical who come in the towns to out-patient departments and in the country to dispensaries? Some day no doubt we shall have sanatoria for open air treatment which shall be free, and I think as a nation it would pay us to establish them, though I as a good socialist would prefer to see efforts directed rather to remedy the overcrowding and dirt which are such potent factors in producing the disease, aiming, that is, at prevention rather than cure. This savours of politics, but I hold that every good physician must be a politician to some extent as well.

In any case, whatever steps are taken in the future, here are our patients in the present. What can we do for them? the question recurs. They come to us in all stages of the disease, but in general among hospital and dispensary cases the proportion of advanced disease is high; those in an early stage come generally for symptoms other than chest symptoms, complaining of weakness, of dyspepsia, and so forth; and as homœopathsists we suffer in the matter of phthisis as of most diseases that we are to many a last resource, and are not consulted till other treatment has proved unavailing.

Let us consider first such cases as this. A young girl, 16 or 17, who comes complaining of cough, with scanty expectoration, troublesome at night, keeping her awake, some loss of flesh, and tendency to feel hot and to sweat at night; physical examination shows slightly increased vocal resonance and vocal vibration at one apex, with prolonged expiration sound and inspiration sound, not of a well-marked bronchial character, but inclining thereto, no *râles* (of all things in the world of medicine, by the way, I know nothing more difficult to be sure of than breath sounds which are on the border line between normal and bronchial). In about four cases out of five, perhaps more, you take such a patient, insist on regular and sufficient feeding, plenty of open air, teach her how to breathe deeply, get her (if possible) to give up her corset, prescribe probably iodide of arsenic, and she gets well, loses the cough, ceases to sweat at night, puts on weight, and finally leaves off coming. Your last examination, after all symptoms have subsided, very likely shows you pretty much what you found at first, and you wonder seriously whether the patient ever had tubercle at all, however mildly. Even if you find the bacillus in the sputum, you are not quite safe. I am quite sure that I have several times diagnosed commencing phthisis where there was none, and when the physical signs point to the right apex it is often very difficult. On the whole, I am inclined to regard any increase in vocal vibrations or vocal resonance, or any increased resistance on percussion (there is often a sense of resistance before any actual dulness), as more serious signs than a tendency of the breath sounds to become tubular in character, because the breath sounds have normally a range of variation in different individuals, and it is difficult or impossible in early stages to estimate the personal factor and give the sounds their proper value. Vocal resonance and vocal vibration are much more constant quantities. I believe, however, that although it is not right to put these cases down as cures of phthisis, they are very important, for they are caught just before the bacillus settles in. The patient, generally a girl, has begun to work, in a shop most likely, or in service, is getting a poor oxygen supply, is living on

tea and bread and butter with pickles for a pick-me-up, and has outgrown her corset, but has not thought it necessary to get a larger size. (I am thankful to say the bicycle has done something to mitigate the rigour of the corset, but its cult still obtains among the class of dispensary patients, and of all the pernicious doctrines connected with it there is none worse than the doctrine that the waist does not grow, though the rest of the body may). In such a girl the apices of the lungs are seldom properly expanded, and probably always more or less congested, or ready to be congested as soon as a little bronchitis partially blocks up a few air-tubes. Now is the psychological moment for the wily bacillus, and the physician is lucky if he can intervene in the nick of time. I lay stress on these cases, because if not actual, they are potential cases of phthisis. The large proportion of them do very well, and the treatment, especially if the patient continues the good habits of getting plenty of air and breathing it properly, seems often to establish the health upon a surer basis, and even members of a phthisical family become more assured in constitution. Every now and then comes a case like that I have described, which does not clear up, but goes steadily on, in spite of treatment, till signs of cavity and other definite physical signs of advanced mischief show themselves. These are the cases not to be distinguished at first from the others, where the tubercle bacillus has got hold before treatment begins, and the management of them falls into line with the management of advanced and definite cases of phthisis to which we may now address ourselves. I must premise that I exclude miliary tuberculosis from consideration. I believe it to be at present incurable. Further, there are the cases that used to be called "galloping consumption," those where the constitution seems to offer so favourable a field for development that the disease runs riot. I have recently attended such a case in the last stages. I do not know if homœopathy could have done anything earlier; personally I doubt it, but in any case it was not tried. I know nothing, unless perhaps a rapidly growing sarcoma, that devours the patient in a manner so truly awful.

I know of no special treatment for these cases, and can only continue to try the methods, to be presently discussed, that are sometimes successful when the system has any power of rallying against the disease; but when I speak of cases much improved and cured, I must be understood to speak of the chronic varieties of phthisis. The treatment can be most conveniently considered in two divisions—constitutional and general, and special or drug treatment—the last division being further subdivided into homœopathic drug treatment and non-homœopathic.

In the first place—by the hypothesis of this paper—the patient cannot be sent to any open air sanatorium; but, for all that, the first thing to insist on is that he or she shall get all the air possible. Long before the open-air treatment became so well known and widely used, I learnt in theory from Dr. Osler's text book, and in practice from Dr. Brunton, that phthisical patients cannot have too much air. If they can give up work for a time, they ought practically to live out of doors, whatever the weather, taking, of course, such obvious precautions as not to sit in wet clothes; if, as more usually happens, they have to keep at work, then a definite minimum of out of doors must be insisted on, if in early stages of disease they can bicycle, if more advanced walking may be all they can manage. Teach them to make a point of breathing deeply—filling especially the lower half of the chest, getting a good diaphragmatic down thrust in fact, and if the patient is a woman try and get her to do without stays. I need hardly say that, as the corset is thick, it is well to wear some extra underclothing on first leaving it off, though, as a general rule, I think we most of us wear too many clothes. To abandon the corset also means that the clothing must be re-arranged—and garments suspended otherwise than by strings round the waist—but your patients bless you in the long run, though it means extra trouble at first. Above all things in carrying out this air-treatment under difficulties, see that the windows are open all night. It is a mystery to me how human beings can bear an atmosphere as stuffy as they mostly prefer it. Extreme poverty wants stuffiness for its warmth (no wonder), but the middle classes, upper and lower,



often live, and nearly always sleep, in an atmosphere that would do credit to an Esquimaux hut. The frightful fear of a draught leads to extraordinary procedures. I knew two old ladies, whose visitors were always kept ten minutes in a heated room, before being shown in, lest they should bring in any cold air with them. An open window in the bedroom must be insisted on with the patients under consideration as they mostly sleep in very small rooms. The only cases that need caution in the matter of air are cases of senile phthisis. I have one case in my mind, an old lady with physical signs of phthisis at one apex. The diagnosis was confirmed by discovery of the bacilli in the sputum. She happened to be fond of open air, and I encouraged her to keep out of doors a good deal though the season was autumn. She did not improve at all, rather grew worse, and was finally laid up with a sharp attack of bronchitis. Dr. Hall, whose patient she was, returned from his holiday, took her in hand, and kept her in one room throughout the winter; by the spring the physical signs had entirely cleared up, and have not returned. Perhaps systematic inhalations of oxygen might be suitable for old people when there is danger of bronchitis, though, in my experience, oxygen is very disappointing in its effects in chronic phthisis. Sometimes a patient's life can be prolonged by it, but I have never seen its use followed by any permanent amelioration of the disease. As far as possible, and it often is not very far with dispensary patients, keep the patient apart. Above all, they need to be warned not to use handkerchiefs for sputum, but to spit into a vessel containing strong permanganate, or other solution to destroy the bacilli.

The point in the treatment next of importance to fresh air is feeding. Plenty of nourishing food is required, given at regular intervals; above all see that the patient takes it. If there is any dyspepsia, feed often and in small quantities, for, after all, it is what a patient absorbs that does good, not necessarily what is swallowed. Milk is the great thing. Patients nearly always say they cannot take it, and, if it is insisted on, they prove their inability by swallowing half a pint in three gulps, whereupon the stomach becomes filled

with one large curd, and the efforts at digestion are decidedly painful. The medical man gets the credit of having caused the pain, and is requested not to order milk any more. The best plan is one I learnt from Dr. Burford, and have found of the greatest use. Order half a pint in the middle of the morning, and again in the middle of the afternoon, mixed, if preferred, with a little soda water or barley water, and insist that the patient sits down to it and takes it with a dessert spoon like soup. In this way it very seldom fails to be comfortably digested. Feeding, apart from the milk, has to be suited to each case, and too often, unfortunately, with dispensary cases, to the patient's means. Mutton suet simmered in milk, after a plan first taught me by Dr. Clarke, I have found useful. Cod-liver oil is given almost as routine. It has often been suggested that its special value is due to the iodine it contains. I have several times tried the effect of stopping the oil where its good effect was marked, and prescribing iodine for a time instead, but it has never had the same effect. Personally, I think the value of the oil is as a fat food, and if cream can be afforded I believe it does just as well.

To pass now to treatment by medicine, I am not so vain as to think I can add much to your knowledge. I propose to mention the drugs that I have found useful, and I leave it to the discussion to confirm my recommendations or suggest others. First let me clear the way and dispose of drugs not homœopathic in their action. I have used creasote a good deal, carbonate of guaiacol not quite so much, both do good in some cases, but my experience has been in the main that the cases that do well do as well, or better, on more homœopathic remedies, and those that do not react to homœopathy do not get much good from creasote or guaiacol. I put forward this view with some diffidence. It is opposed to the statements of Dr. J. Hayward, and it may be that a wider range of cases will cause me to alter my opinion; so far, however, it is the statement that best expresses my experience. I give creasote in palatinoids, and, I must own, in smaller doses than Dr Hayward recommends, about 5 minims a day in divided doses, but I do not think the fact

that I give smaller doses completely explains my different results, for, where these quantities fail, I have tried larger with no improvement. Creasote also is a drug not quite free from danger. Once or twice I have tried iodoform in 2x trit.—5 grains three times a day. One case did well on it, but the results were not so striking as to lead me to think it is superior to creasote or guaiacol.

Among homœopathic drugs let me briefly summarise my experience. Phosphorus disappoints me nearly always. From iodine, too, I get no results, which always puzzles me, seeing how wonderfully it acts combined with arsenic. The iodide of arsenic is my favourite—3x trit. 3 grains three times a day. I like it best in early stages where there is much coughing with scanty expectoration and what there is is difficult to loosen; later on when the sputum is purulent and comes freely, I prefer stannum or hepar sulph. Stannum was a disappointment till I tried the iodide, but this I like very well. Dr. Blackley will remember, I hope, a case under his care when I was resident medical officer in the temporary hospital; it made a great impression on me. The patient was a little girl who came in for acute rheumatism, and was found to have a cavity in one lung and signs of disease in the other. She went out without a sign of disease except that, of course, the cavity, though dry and smaller, was discoverable. I put down her cure to ars. iod. and hepar sulph., which were given steadily, sometimes one, sometimes the other. I must add that she had also some doses of tuberculin, but she was definitely improving before these were given, and I could not satisfy myself that she made any quicker progress after them than before: and that is my general experience with tuberculin—I give nearly every case that I diagnose as phthisis the benefit of it and have tried it from once a week to once every other day, and in dilutions from twelve to thirty, mostly thirty. Cases that have it get better, but so do cases equally bad that do not; and when I get a case that resists treatment, I do not find tuberculin clears it up at all. Judging by a certain letter to the *Standard* some time ago, the experience of this hospital is more favourable. So I trust I shall presently learn how the remedy should be used.

Intercurrent remedies are often wanted in phthisis for troublesome night cough or night sweats. Hyoscyamus is perhaps most often given for the cough—it often does well. I prefer conium. A drug I often find indicated is drosera; and it answers admirably when the cough is spasmodic. I find none of these affect the physical signs, but they often do much for the patient's comfort. For sweating, ac. phos. or silica. Jaborandi is quite an old discovery of the orthodox now; and if sweating is bad enough to resist the first-named, it nearly always acts splendidly. For hæmoptysis I prefer ferr. acet. Millefol., too, I have used with success. In a case now under treatment, where there seems to be more tendency to formation of fibrous tissue than actual cavity, I have had a good deal of improvement from graph. 1 trit. I gave it because of its reported relation to fibrous tissue, and so far it has done well. It is only one case, and I do not know how far the improvement may go on. I give it you for what it is worth, as I have so little of any novelty to bring to your notice.

On the whole I am inclined to look more hopefully on pulmonary phthisis even among poor patients than I would have believed possible as a student. I know nothing so heart-breaking as to watch sufferers from phthisis in an out-patient department coming up week by week, failing more and more each time. Cod liver oil and maltine, antipyrin if temperature is raised (a piece of practice much beloved by Dr. Brunton when I was under him, but from which I never saw any benefit), all the routine treatment, and none of it any good. We have all seen it many times. Whether it be that the air of Kingston is better than that of London, or that my patients are not quite so poor as those who go to St. Bartholomew's, or that homœopathy can take the credit, it is a fact that I attack the disease now, if never with great confidence, yet generally with hopefulness.

There are, alas! cases that go steadily to the bad, but on the whole I think most improve for a good time, and a few there are, even with marked symptoms, that get apparently well. I have had the curiosity to look up a few of our hospital statistics, and can fitly end this paper by a recital

of them. Of the last 132 cases in this hospital registered as phthisis, fifteen died, one admitted in the last stage; another noted as admitted moribund; say 130 cases with thirteen deaths of those that were under systematic treatment. To the deaths must be added thirteen that went out unimproved, so that treatment failed in one case in five; fourteen are noted as cured. It is only once set down that bacilli disappeared before leaving, but presumably cured means that the lung had healed as far as physical signs could answer for it; five were very much improved; thirteen much improved, making with the cured thirty-two, or nearly one in four, where the treatment was a decided success; fifty-seven are put down as improved, by which I conclude that the treatment was at any rate a partial success. The cases are equally divided between the two sexes, but ten of the deaths were among the males. There were forty-two patients over 30, with six deaths, a noticeably higher rate, but I doubt if we have here enough cases to make detailed comparisons useful. Now considering that cases are not admitted to the hospital unless they are decidedly ill, I regard these figures as encouraging; my much smaller experience in dispensary practice brings me to the same conclusion, namely, that it is a mistake to regard phthisis as necessarily incurable. Even when circumstances of treatment are not fully favourable it is well known that it is by no means infrequent to meet with scars of old phthisis in the *post-mortem* room. These people have had the disease, and have recovered from it, and I submit that if the cure can ever be effected it is for us to bring a certain cautious hopefulness to the treatment. A case despaired of is a case lost. Too often phthisis leads us to despair, however bravely we begin its treatment. But now that the open air treatment has brought a new weapon to our aid—a weapon that we have reason to hope will be available for an ever increasing number of cases—I invite you to look over the older weapons and see if perchance some aid may be derived from them, an aid that may be welcome at any rate for the interval between the dawn of the general cure of phthisis and the full noon, when that consummation so devoutly to be wished shall be established.

Dr. DYCE BROWN said he was disappointed that homœopathic therapeutics had received so little attention in Dr. Arnold's paper, and Dr. Wheeler had only mentioned one of three medicines which he (Dr. Brown) had found most useful, viz., phosphorus, calcarea and nitric acid. He found phosphorus 3 to be one of the most valuable medicines in cases of marked cavities where there was a good deal of pneumonic congestion all round the part, and also in other parts of the lungs. He also placed calcarea high up in the list of valuable remedies for phthisis. Under the use of calcarea carbonica 30, he found cavities would diminish in size or heal altogether, the expectoration and night sweats become less, the temperature lower, and the general state of the patient improve. Calcarea iodata was of great value in particular classes of cases, also iodide of arsenic, to which both Dr. Arnold and Dr. Wheeler had referred. Nitric acid came in where the physical signs were not well marked, but where all the constitutional symptoms led one to believe that mischief had begun. The influence of nitric acid on coughs of various kinds and in the early stages of phthisis was most marked. It improved all the symptoms. With the remedies he had mentioned, he considered that a great deal could be done in the homœopathic treatment of phthisis. He differed from Dr. Wheeler in his allusions to the present plan of open-air treatment. In patients of the better class, whose bedrooms had sufficient cubic space, he maintained that in the winter months it was a great mistake to have the windows open. Invalids of this station of life were sitting in rooms sufficiently warm to be comfortable during a good part of the day, and by having the windows open at night they would be transferred into an atmosphere of a much lower temperature. Such a change was liable to set up bronchitis. In the middle of the night or the early morning the general powers of the patient were at their lowest ebb, and that was the time when a chill was most likely to be experienced. Many people who were not invalids found it necessary to put on extra bed-clothes about that time in the morning. Patients who were allowed to sleep in low temperatures ran a very great risk. Cold air and pure air were not at all synonymous; perfectly foul air might be respired where it was cold and pure air where it was warm. He thought it was better for phthisical patients at night to be in a warm temperature.

Dr. MADDEN thought, in spite of what Dr. Dyce Brown had said, that endeavours should be made to obtain the air for phthisical patients as fresh as possible, night and day. It was perfectly easy for those who could afford it to do so by means of

a gas calorigen stove in the bedroom, by means of which the windows might be kept open and yet a continuous current of warm air would be obtained. The air could be just as fresh when it came in warm as when it came in cold. The question of feeding was a most important one. It was not enough to say that patients must eat as much as they could. The great point which had been borne in upon medical men within the last few years was the question of over-feeding patients. In that connection the consideration of milk could not be avoided. There was a large preponderance of evidence that tubercular infection was present in a great proportion of the milk at present available, although milk, if good, was one of the best foods for phthical patients. Until milk was certainly free from tubercle, patients should be instructed how to sterilise it. He hoped to hear some report as to the beneficial results obtained from tuberculin. Personally he had not seen any definite results following its use. There must be great difficulty in comparing results noted by different observers in the use of tuberculin, because of the uncertainty of its origin. He considered the only safe tuberculin was Koch's preparation, which was the toxin of the bacillus without any attempt to introduce the ground-up or diluted bacillus itself. He was surprised to hear from Dr. Wheeler that he did not find arsenicum iodide 2x of any service in his cases. He (Dr. Madden) always used the 2x, and was perfectly satisfied with the results that followed.

Dr. CROUCHER (St. Leonards) said that as a resident at a southern health resort he had a great number of phthical cases under his treatment. He made a great point of advising them to be in the open air as much as possible, and to take exercise regularly in a specified manner. In addition to exercise on level ground he ordered them to begin by walking up hills gently and increasing the distances until they could be borne well. He certainly believed in the treatment of feeding up. He advised his patients to take as much food as they could possibly digest, and he also prescribed helps, such as Burroughs and Wellcome's tabloids of zymine or some preparation of pepsine. He believed milk to be a great help. Several of his patients were drinking four pints of milk a day in addition to their ordinary diet. Fats of all kinds were most useful, such as cream cheese, cream, the fat of meat, and, of course, cod-liver oil where the stomach could bear it; with plenty of fresh air and the moderate exercise he had spoken of, those things could be assimilated. No two cases of phthitis were alike, and one had to be guided as to the remedy

by the symptoms. Of all the remedies, he gave the palm to phosphorus, both in cases of threatened phthisis, as well as when the disease was in an advanced stage. For night-sweats he always began with phosphoric acid, and if they were unusually intractable, he gave a few drops of liquor picrotoxin aceticus and hyoscyamus in low dilutions. Even the extract of hyoscyamus he found most useful for night cough. Where there was any great laryngeal irritation, he prescribed a spray of paroleine and menthol, about 15 grains to the ounce. He was a firm believer in climate in the treatment of phthisis. In 1867 he himself had several attacks of hæmoptysis, and Dr. Kidd advised him to go to Australia or the south of England. The south of England being the more convenient of the two, he went there, and had had no return since. He thought he might say he was a good testimonial as to the efficacy of the climate of St. Leonards.

Dr. STONHAM said he would have the windows open at night for all cases of phthisis. It was easily possible to avoid a draught. There was a great deal of draught if the window was open only two inches, whereas if the window was fully open there was no draught at all. Draught was caused by the unequal temperature of the air of the room and the air outside. He confirmed what had been said with regard to the use of iodide of arsenic and also of calcarea. He had had good results in one or two cases where the disease had attacked the base of the right lung by using kali carb. 30. In very advanced cases, with a great deal of expectoration, he was surprised no one had mentioned silica. He thought it was a mistake to prescribe very much exercise in phthisical cases. The patients were in a low state as a rule, and very easily exhausted if they took long walks and did much hill climbing. They were likely to do themselves more harm than good, and perhaps bring on an attack of hæmoptysis. Phthisis was like anæmia, it required plenty of fresh air, but a great deal of rest. If patients were told to sit out in a hammock or on the beach instead of being ordered to walk so much they would get on very much better.

Dr. ROBERSON DAY emphasised the necessity of exercising the lungs. He would teach the patient to breathe and to take in the necessary supply of air. In watching a phthisical patient's chest, it would be seen that there was very little movement of the upper portion. Special instructions in singing or elocution or at a special gymnasium for deep respiration on the Ling system was very useful. One of his patients had improved very much under that combined treatment. He had used tuberculinum a great deal,



and he was *certain* it had a beneficial effect upon the tubercular diathesis. He used Koch's preparation in the dilutions of from 3 to 30 centesimal, about once or twice a week, and at the same time such inter-current remedies as iodide of arsenic, phosphorus or belladonna. He recently had a case of tubercular ulcer of the face, which had been under allopathic treatment for over a year without any benefit. He gave tuberculinum only once a week, and in about three or four weeks the ulcer was decreasing, and gradually disappeared altogether. It might be assumed that a tubercular ulcer of the face was akin to tubercular disease in the chest, and therefore that tuberculinum had a beneficial effect. He had found kali bichromicum of use, especially in laryngeal cases. One patient suffering from this form of the disease for years had done well under that treatment.

Mr. WILKINSON asked Dr. Arnold the strength of the sanguinaria which he used so successfully. On the nutritional side of the subject, he (Mr. Wilkinson) had found emulsion of petroleum very useful, more useful than could be attributed to the amount of petroleum which was taken. It seemed to stimulate an increase of metabolism and also absorption from ordinary food.

Mr. DUDLEY WRIGHT said that he had obtained from a few colleagues and others their views as to the results of the use of tuberculinum in phthisis. He did not treat phthisis himself. The almost unanimous opinion of his colleagues was that tuberculinum was of very little service. In complete contradistinction to that he would give his own experience in tuberculosis from a surgical point of view. Up to two years ago he never used tuberculinum at all. On seeing some reports in American journals with regard to tuberculous glands he thought he would try it, and since that time he had invariably used it, for he found that if given once or twice a week with other remedies, more particularly with iodide of arsenic, it did help very materially. He used Koch's tuberculinum third centesimal, and sometimes the sixth. As a peculiar point, he would note that he had not found it of any service in cases of laryngeal tuberculosis. He was inclined to the opinion that when tubercle attacked the mucous membrane of the respiratory tract tuberculinum had not such a beneficial action as when the connective tissues and other parts of the body were affected. Especially was this the case in lupus. He had treated a number of cases of lupus of the nose, and they had all benefited by the use of tuberculinum. That concurred with the experience of Dr. Roberson Day, and he believed that Dr. Blackley would concur that it was in skin cases that tuberculinum achieved the most signal successes.

Dr. GOLDSBROUGH considered phosphorus was of great use in phthisis, but for success it was necessary to discriminate between the character of the physical signs and the constitutional state more carefully than was done with iodide of arsenic. In addition to the cases suggested by Dr. Dyce Brown, he considered this drug useful in very chronic cases, which progressed very slowly, where the patient was particularly thin, pale, and inclined to be anæmic. The question of tuberculinum was a very interesting one. He gathered from the discussion that it was outside the range of phthisis as far as being a remedy for that form of tuberculosis. It was a remedy for other tubercular conditions, however. From the theoretical standpoint of the etiology of chronic disease he suggested that when the bacillus attacked the chest it was shown that the constitution and rallying power of the patient was less vigorous than when the bacillus attacked the more external parts of the body—for example, the skin. Tuberculinum, in his judgment, was a purely homœopathic and not simply an isopathic remedy. It was a toxin of the bacillus that was used; and the toxin might be presumed to be capable of producing a condition and symptoms similar to those produced by the bacillus when present, which, in their external manifestations, were largely in the nature of a reaction of the organism upon the bacillus, *e.g.*, the inflammatory states of lupus. As the object of the homœopathic remedy was to assist this reaction of the organism, and when the disease was focussed in the skin, this was evidence of a more vigorous reaction than when the lungs were attacked, and so a purely homœopathic remedy was more serviceable. This theoretical standpoint seemed to him to throw light on the value of tuberculin in tubercular conditions, and to suggest the class of cases to which its use should be restricted.

Dr. WILLS (a visitor) said he had no idea that tuberculinum was used homœopathically. He had been wondering whether the result of its use had to do with the amount of surface, and the amount of absorption from that surface which went on in the body. It had been said that when there were fairly large cavities or large surfaces in the lung to be infected by the tubercle the tuberculin would probably not do much good, but the remark had also been made that if lupus on the face was treated by tuberculin beneficial results followed. In the lung there was more absorption from the products of the bacillus than in the face or the skin, or mucous membranes, according to the amount of surface affected. Could it be possible that in the

former case the amount of toxin was exhausting the supply of antitoxin which could be produced in the latter; but when there was only a small surface affected there was more than enough antitoxin available? An important question was that of breathing. Only that afternoon, at Guy's Hospital, he had been talking to some colleagues about the inflation of the chest with relation to spinal curvature, and it was shown that corsets could be so constructed as to produce very little inflation of the chest and practically no abdominal motion. It was also shown that corsets could be put on in order that the chest should have its full inflation and the abdominal muscles used quite freely. That could be obtained if the patient was put against a wall, with the back perfectly square, and the garments and corsets were then adjusted according to the figure in that position. He was perfectly persuaded that a great many patients refused to undergo any alteration in their dress because their figures would be disturbed. He was also persuaded that if they could be shown that their garments could be used in a sensible way, they would be more inclined to adopt the rational treatment suggested by medical men.

Dr. MACNISH considered that when a case was diagnosed to be tubercular it was of great value to find out the origin of the disease, because on that depended the mode of treatment and the success or non-success of different drugs. In cases where the disease seemed to be merely a tubercular infection of the tissue, without any pre-disposing illness, he had found tuberculinum of value. The combination of tuberculin and phosphorus was of no value, but phosphorus combined with belladonna was very good. In all inflammatory cases he found that phosphorus was of extreme value. In inflammatory cases, tuberculinum, in his experience, was of no use whatever. He always found a difficulty in treating a case of phthisis where it began with an insidious attack of pleurisy. The patient usually complained of a cough, and there was rise of temperature amounting to  $99^{\circ}$  or  $99\frac{1}{4}^{\circ}$ . On examining the chest, perhaps an inch of dulness would be found at the base of either lung, and also fluid. He had found, especially in outside practice, that that kind of case usually terminated fatally. He also insisted on the importance of breathing, and that a good supply of blood should go through the lungs. The inflammatory conditions in phthisis were often Nature's way of trying to get rid of the bacillus. He had noticed in districts liable to phthisis, with phthisical families, that if any member of a family developed rheumatic fever, and as a result, mitral disease, the patient, as a rule, did not develop phthisis.

He had compiled statistics of different families where a great number of the people had died from phthisis, but all the cases in which rheumatic fever and mitral disease had occurred never suffered from phthisis. In that condition the lungs seemed to be kept fully supplied with blood which checked the bacillus. This passive congestion appeared to retard, if not check, the tubercular process. This method had also been successfully tried in the treatment of tubercular joint diseases.

Dr. WYNNE THOMAS had been very much interested in reading the account, in the *Homœopathic Review* for February, of the experience of a veterinary surgeon in the treatment of animals subject to tuberculosis. That gentleman suggested that tuberculin should be used as an injection to prove whether the cow was infected with tuberculosis. It had occurred to him (Dr. Thomas) that the same plan might be applied in the human subject. In the early stages of suspected phthisis a subcutaneous injection might be given which, if it produced an elevation of temperature, would be proof that the disease was tubercular.

Dr. BURFORD (in the chair) testified to the value of the open-air treatment of phthisis. The life of a member of his own family had, without the shadow of a doubt, been entirely saved by a seven months' course of open-air treatment among the Sussex woods, plus the administration of iodide of arsenic. Three elements seemed to him to have characterised the evening's discussion. The first, and the most striking, was the hopefulness of tone with regard to the treatment of phthisis as compared with the pessimism of earlier times. The second point was that the majority of experiences detailed had exceeded Dr. Arnold's views as to the appropriate place of therapeutics in the treatment of phthisis. The third point was that the whole problem was much more complex than appeared on the surface. This was emphasised particularly by Dr. Arnold when he dealt with the fact that the value of the open-air treatment of phthisis rested upon a diminution in barometric pressure.

Dr. WHEELER, in reply, said that his experience with phosphorus was very disappointing. He did not know whether it had anything to do with the dilution. He generally gave 3x or 6, and he could not say that he had had good results. After hearing the discussion that evening, he was certainly stimulated to try it again. As to the question of the open bedroom windows, Dr. Dyce Brown seemed to think it was necessary that the rooms should be absolutely cold. It would be quite possible to arrange that there should be no material difference in temperature in going from one room to another.

Dr. ARNOLD, in reply, thanked the speakers for their very kind expressions with regard to his paper. The view he wished to emphasise with regard to diminished barometric pressure was that it had its own importance, but that it could not be regarded as absolutely essential for the successful treatment of phthisis. Brehmer had often been charged with holding absurdly exaggerated views on this point, and with maintaining that residence at high altitudes was an essential factor in all successful treatment of phthisis. His published works, however, by no means bore out the charge, for in them he states expressly that a large number of early cases could be successfully treated at low levels by generous diet, open-air life, and stimulating baths. There was a tendency to go too far in decrying climate. There was no doubt that in some cases it was almost essential to success to go 1,700 or 2,000 feet up, in order to bring to one's aid the constantly acting favourable influence of diminished atmospheric pressure. Dr. Williams, in his paper, cited several instances of an increased girth of an inch in the chest being produced in the short period of four weeks by residence at high altitudes, and in the face of such facts and of the numerous agreeing observations as to the influence of diminished barometrical pressure on the pulse and respiration, it was absurd to deny that residence at high altitudes must be regarded as a factor of very great importance in the treatment of phthisis. With regard to the question of drugs, Dr. Dyce Brown had been surprised that he did not mention phosphorus. He might point out that Dr. Dyce Brown said nothing whatever about sanguinaria, a drug to which he (Dr. Arnold) attached the greatest possible importance. With the best intentions one was apt to get into grooves, so to speak, in one's use of drugs, and he had seen such excellent results from sanguinaria (1x dilution gtt. v. *ter in die*), that he relied upon it very widely indeed in conjunction with the iodide of arsenic as his general standby, using other medicines, phosphorus included, merely as intercurrent remedies. He was strongly in favour of keeping the bedroom windows open. In the case of old persons he would recommend the same caution as was emphasised by Dr. Wheeler. Young people could be very soon got into the way of liking fresh air—certainly 99 cases out of 100—and not to be sensitive to draught. There was only one case in which he had had the slightest difficulty in educating a patient in that treatment, and he had referred to that instance in his paper. With regard to the question of tuberculinum, it was interesting that the opinions expressed by Mr. Dudley Wright

and others were on all fours with Dr. Percy Kidd's statement on the subject of tuberculin in Clifford Allbutt's "System." It was stated there that tuberculin was now generally recognised as dangerous in the treatment of phthisis, but that it was still used by some surgeons in the treatment of surgical tuberculosis, and that they claimed good results from it. At the same time he would point out that the very strong statements made in the "allopathic" journals about tuberculin and its value in the treatment of lupus had not stood the test of time. He was speaking of tuberculin used in the doses recommended by Koch. Mr. Jonathan Hutchinson had pointed out that surprising and apparently brilliant as were the results obtained in the treatment of lupus by tuberculin, he had yet to meet with a case of permanent cure.

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## NON-PURULENT NASAL DISCHARGES.<sup>1</sup>

BY VINCENT GREEN, M.D.

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ANOMALIES of the nasal secretion are very common, and of the non-purulent varieties an excessive flow is the more frequently complained of. The presence of such a discharge is usually detected by the patient; but it should be borne in mind that secondary symptoms produced by the discharge may be the only ones complained of. Taking the chief morbid conditions affecting the nose which have this symptom, a non-purulent discharge, seriatim, I wish to emphasise a few of the chief points of differential diagnosis, and then say a word as to treatment.

Simple acute rhinitis, or cold in the head, is easy of diagnosis, though not always of successful treatment. The latter remark also applies to the acute rhinitis of epidemic influenza. Influenzal rhinitis is too often disregarded, as the symptoms are those of a cold in the head, but if the disease is not arrested the posterior and upper regions of the nasal

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, April 13, 1899.

cavity become affected, anosmia and post-nasal catarrh often resulting, concerning both of which a very guarded prognosis should be given.

The commonest cause of a chronic non-purulent nasal discharge is simple hypertrophy and hyperæmia of the mucosa covering the lower and middle turbinates, commonly called hypertrophic catarrh, and next in frequency stands mucous polypus. It is important to distinguish these two diseases, as their treatment is so entirely different. The use of a speculum with reflected light is essential for diagnosis. On looking into the nasal cavity in hypertrophic catarrh the turbinates are seen springing from the outer wall as smooth fleshy cushions, bright red in colour, and if touched with a probe are found to be firm and resistant. If anything of a disquieting nature should be said, or if the parts are sprayed with cocaine, the turbinates in a few moments become reduced in size, sometimes shrinking to almost the normal. This never occurs with polypi. In the case of mucous polypus the growth has a pearly translucent appearance, and retreats or slips aside before the advancing probe. The two conditions may be present together, when it is, often difficult to make an accurate diagnosis. In such cases it is a good plan to spray the nasal membrane with a 5 per cent. solution of cocaine. This, by reducing the turbinates, brings into view the back and upper parts of the nares where the polypi may be concealed. In a case of hypertrophic catarrh, where anosmia is present or there is a very copious discharge, small polypi high up and far back should be suspected and carefully searched for.

Hay fever or paroxysmal rhinitis, cerebro-spinal rhinorrhœa, and nasal hydrorrhœa, are all characterised by serous discharge.

In paroxysmal rhinitis there is intense local irritation, with swelling and hyperæmia of the nasal mucosa, and *the attacks come on in May and June, the commonest variety being due to grass pollen*; but it must be remembered that emanations from roses, peaches, and some of our domestic pets may be the exciting cause. In cerebro-spinal hydror-

rhœa there should be a history of injury. The fluid escaping is colourless, contains no albumen and no sugar, but reduces Fehling. There is no pain nor discomfort. True nasal hydrorrhœa may be defined as a profuse watery discharge secreted by the nasal mucosa which is unaccompanied by any other symptoms—this distinguishes it from hay fever—and is not dependent on an intra-nasal or any neighbouring source of irritation. The nasal cavities, every cranial nerve, indeed the whole system, should be examined before diagnosing this disease, as small septal spurs, small polypi high up and far back, optic neuritis, malaria, and possibly uricacidæmia, may be the cause of a profuse and painless serous discharge from the nose.

A very interesting condition accompanied by a serous discharge is where the scroll-like opening of one or other lower turbinate becomes sealed up as a shell might be. The turbinate is distended, a condition which might be called hydroturbinosis resulting. As in hypertrophic catarrh the turbinate is enlarged, but it is smoother, more globular, and if anything paler than normal. It feels harder to the probe and the local application of cocaine has no effect in reducing its size. It is important to distinguish the two conditions, as their treatment is quite different.

In the conditions referred to, the discharge is usually from the anterior nares. In chronic post-nasal catarrh there is a dripping of mucus down the back of the throat, with a constant desire to hawk and draw through the nose. It is commonly due to the extension back of a hypertrophic catarrh, when signs and symptoms of this disease will be present, but in addition, the pharyngeal wall is congested and sometimes granular, and with strings of grey tough mucus adherent to it. Deafness not uncommonly follows. Enlarged pharyngeal tonsil or adenoids will also cause a post-nasal catarrh, more especially in children. Post-nasal catarrh is common and often severe in infant life. This, perhaps, is partly due to the small space in the nose and naso-pharynx, a slight accumulation of mucus and desquamating epithelium causing irritation and enlargement of the lymph nodes or adenoids in the naso-pharynx, and conse-



quent blocking and catarrh. In this way in very young children the catarrh is the cause of the adenoids, whilst in older children the adenoids perpetuate the catarrh. In aggravated cases the facial expression with marked nasal obstruction makes diagnosis easy. Diagnosis, however, should always be confirmed by examining the naso-pharynx with the finger, which will feel as if filled with blanc-mange, and on withdrawal a few specks of blood will be seen on finger. These are the chief diseases having the symptom of a non-purulent nasal discharge. For their treatment accurate diagnosis is essential, for few or no cases can be treated on purely symptomatic lines. As a negative point in diagnosis, it may be stated as an axiom that in inflammation of the accessory cavities of the nose the discharge is always purulent.

Again taking the morbid conditions referred to seriatim, I wish now to touch on a few leading points in the treatment. The best place to treat a simple acute rhinitis is bed. Frequently repeated doses of camphor in the early stages may abort a cold, especially if due to change of weather. If well-established, a spray of 1 in 40 carbolic, with kali iod. and hep. s., low and in frequent alternation, are generally efficacious. I have seen distressing symptoms of pain in head, stuffiness, sneezing, and copious secretion instantly relieved by vigorously sniffing a good pinch of common salt up each nostril. Ammon. carb., sticta, euphrasia, and kali et merc. iod. should be thought of.

The acute rhinitis of influenza should be attacked as soon as recognised with a weak antiseptic and alkaline douche or spray, such as 5 grs. each of sodii bicarb. and sodii bibor., with  $\frac{1}{2}$  gr. of carbolic acid, in three ounces of water. Eupatorium, rhus, sticta and kali bich. are the drugs most commonly indicated.

*Hypertrophic Catarrh.*—As this condition is in many cases caused, and in all cases aggravated, by not breathing through the nose, the first thing is to render this possible by removal of adenoids, polypi, septal spurs, straightening a deflected septum, and if necessary, as in cases of complete obstruction, reducing the enlarged turbinates. The posterior

portion of the lower turbinate may be removed *en bloc* by the snare. This, however, is not always feasible, in which case the galvano-cautery should be used. The bone may be stroked with a flat burner, or if there is much erectile tissue a pointed burner may be plunged in as far as the periosteum. Where the middle turbinate is the cause of the obstruction the snare should be used. Having rendered nasal breathing possible, it cannot be too strongly impressed upon the patient that he must breathe through the nose. The cardiac patient is told to obtain exercise short of fatigue. In hypertrophic catarrh all exercise must be short of oral breathing. It is a good plan to order twenty to forty full deep inspirations thrice daily; a weak cocaine spray may be used just before the exercises in order to make the passage clearer. My favourite prescription in such cases is a snuff of the third centesimal trit. of kali bichromicum, used thrice daily, and kali bich. 30 internally. The efficacy of the snuff is increased by using a weak alkaline spray or douche before taking it. Another snuff worthy of trial is zinci sulpho-carbolas. Among fluid remedies that may be used locally as a spray are rectific. spts., 1 in 5 of water, common salt ʒj. to a pint of water, to which may be added a table-spoonful of Sanitas, acetotartrate of aluminium ʒss. to a pint of water; also Euthymol, a preparation of Parke and Davis, containing eucalyptus, thymol and boracic acid. Internally, besides kali bichromicum, which gives best results where there is a profuse acrid watery discharge, with aching and sense of stuffiness at the root of nose, fluoric acid, graphites, natrum mur., lycopodium, pulsatilla, and many others, may be indicated.

Medicinal treatment failing, the snare and galvano-cautery already referred to and chromic acid bead may become necessary. The latter is especially indicated by a profuse discharge; the hypertrophied parts should be just touched, and after an application the superfluous acid must be neutralised by mopping out the nose with a strong watery sol. of sodii bicarb. Often a great deal can be done by attending to the general health, and removal of a chronic irritation of erectile tissue elsewhere may effect a cure.

The only successful treatment of nasal polypus that I know of is removal. Cases have been reported in a recent *brochure*, for instance, where kali bich. has effected a cure. Marked relief of symptoms might follow where there was a co-existent hypertrophic catarrh; this would account for some cases reported. Error in diagnosis might account for the rest. The best instrument for the removal of nasal polypi is the Jarvis snare, used with piano wire.

*Hay Fever.*—In a general way, one might say, first eliminate all possible sources of irritation locally, such as hypertrophies, spurs, polypi and sensitive spots, and as regards the last the nasal mucosa should be systematically gone over with a probe, and every hyperæsthetic point chromicised. A spray of chromic acid, gr. j. to ʒviii., may be used to harden the mucosa generally. Defects in general health and hygiene should be corrected. Then during the paroxysm palliatives must be used. I will only mention the one that should not be used, namely cocaine.

*Hydroturbinosis.*—The only satisfactory treatment here is removal of the affected bone by the wire snare. From the nature of the condition, no good results can be expected from the use of sprays, snuffs, &c.

*Post-nasal Catarrh.*—Rendering the passage of air through the nares free will cure many cases. Locally, only sprays of paroleine or albolene, containing menthol or eucalyptus, besides the ordinary alkaline sprays, may be required.

A snuff of 1 of ol. eucalypt. in 3 of starch is often effectual, and in obstinate cases painting the naso-pharynx with iodine and iodide of potassium in glycerine should be tried. Guaiacum, phytolacca, sanguinaria, hydrastis and œsculus are the drugs I have used most.

In children, immediately symptoms of post-nasal catarrh appear, the nose should be irrigated once daily with warm salt and water, ʒj. to Oj. ; and even after the surgical removal of adenoids proper cleaning of the nasal passages must be persisted in to prevent the accumulation of germ-laden mucus in the naso-pharynx, which by irritation and obstruction will cause the reappearance of the adenoids.

Mr. DUDLEY WRIGHT said that at one time he suffered very frequently from severe colds in the head, which lasted about four days. They usually began in the naso-pharynx, and nearly always affected the left side. He had a small mass of adenoids removed, which considerably improved his condition. But previous to that he began a form of treatment on himself, which gave him extreme relief, by taking doses of atropine large enough to cause a physiological effect on the mucous membrane. He found out afterwards that the effect of the atropine was improved by the addition of a little morphia. A hypodermic tabloid containing  $\frac{1}{4}$  grain of morphia and  $\frac{1}{120}$ th grain of atropine would stop a cold, in the running stage, in three hours. A friend of his found that it was better to dissolve the tabloid in a tumbler of water and take sips every half hour. He had had a good deal of experience with hay fever, and he found that when polypi were present the prognosis was by no means good. The hypertrophic state of the mucous membrane of the nose might be got rid of, but if polypi were present and were removed, the hay fever was not so likely to be cured as it was in those cases in which the mucous membrane alone was hypertrophied without the presence of polypi. He had lately under his care a lady who had had the disease for many years. She was now 28 years of age, and had had the symptoms ever since she was 2 years old. More than a year ago she had the turbinates cauterised, and last year when the hay fever was on she was perfectly free from it. Euphrasia, in the mother tincture, if given frequently during the commencement of the attack of hay fever, was generally beneficial. Nasal breathing was of great importance. Much good could be done by simply teaching patients to breathe through the nose; and singing, if taught properly, was another means to the same end. With regard to baths, a large number of people advised that cold baths should be taken in the morning for getting rid of rhinitis. No doubt in a certain number of cases that had the desired effect, but, in his opinion, by far the best plan was to take a hot salt bath, finish up with a cold sponge, and get the circulation up afterwards by a good rub.

Dr. DYCE BROWN said he had always found the treatment of acute nasal catarrh with the old remedies quite satisfactory. In acute running catarrh he used belladonna with mercurius sol. 6 given in alternation frequently, and if there was a greater running at the eyes, euphrasia, or arsenicum when indicated by the symptoms. He never dreamed of using anything locally in acute catarrh. He quite agreed with Mr. Wright as to the

desirability of breathing forcibly through the nose, and, still better, smelling at the same time a bottle containing oil of eucalyptus. Chronic rhinitis, causing obstruction and the usual symptoms, was, in nine cases out of ten, partly due to constitutional disturbance. The throat, the stomach, the bowels, the liver, in fact the whole mucous membrane internally was involved in cases of chronic nasal catarrh. The treatment he usually adopted was to put the patient on a very careful light diet, prohibiting as far as possible all stimulating food, and exciting the skin to act freely by either Turkish or lamp baths. The only local application he ever used was a very weak mixture of glycerine and warm water. The applications Dr. Green spoke of sounded to him to be most alarming. He should hesitate before recommending such extremely strong local applications, seeing how exceedingly sensitive the nostril was.

Mr. KNOX SHAW thought bichromate of potash had a definite action upon the mucous membrane of the nose, which tended to prevent the formation of polypi, even if it did not go so far as to cure those already in existence. It had been his practice for some years to prescribe for those patients on whom he had operated for nasal polypi a nightly dose of bichromate of potash. In hypertrophic rhinitis he had frequently received help by using sanguinaria as a snuff. He was convinced that many children with adenoids in an early stage could be permanently cured by teaching them to breathe properly. He thought it most important that deep breathing and nasal breathing should be taught after an operation for adenoids had been performed.

Dr. LOUGH called attention to the need for bright sunlight and out-door exercise. The only case of recurring adenoids with which he had had to deal was a case on which Mr. Knox Shaw operated. In the course of a year the adenoids were as bad as before, and after being removed a second time with the curette they again developed, and had to be removed a third time. This child lived almost entirely in a dark kitchen, and had very little out-door exercise. He thoroughly agreed with what Mr. Wright and Mr. Shaw had said.

Dr. MASON quoted two instances of nasal polypi which had disappeared under the influence of local applications, especially of tannic acid. One medicine mentioned by Dr. Green he had found of much benefit in patients who had a tendency to catch cold on the least provocation, or without provocation at all, viz., natrum muriaticum. He used it in the sixth dilution. A condition best left alone surgically, and in which the patient's

constitution required to be treated, was that of hydrorrhœa of the nose.

Dr. WM. ROCHE coincided with Dr. Lough's remarks as to sunshine. He found that a large number of children, owing partly to their physical disability through adenoids, had become sluggish, for which condition two well-known remedies were very successful, viz., a skipping rope and a hoop. Quite recently he had had under his charge a child not more than nine years of age, who had been operated on three times. He insisted on the child rolling a hoop and running hard, and her condition had shown a marked improvement. Mr. Shaw's suggestion of writing down instructions to parents was a very good one, as it impressed people a great deal more than merely verbal instructions. In the treatment of polypi he recommended one medicine, which had not been referred to by Dr. Green, viz., thuja, taken as a snuff up the nose. Within the last three months he had seen two cases disappear under that treatment.

Dr. NEATBY said that gelsemium or sepia, taken every fifteen or twenty minutes at the onset, were good remedies for a common cold in the head. With respect to the treatment by deep breathing, he would remind Mr. Shaw that it was not necessary to go to the Swedes, who were flooding the country, and setting themselves up as quacks, when there were plenty of good English operators. The Swedes undoubtedly originated the system, but there were plenty of English girls and men, some of whom had been out to Stockholm, and who had as good a knowledge of the subject as the Swedes.

Dr. ROBERSON DAY gathered from what had been already remarked that nasal catarrh was really the origin of post-nasal adenoids. If the initial catarrh was taken in hand in time and cured, which it easily could be if attacked early, post-nasal adenoids would be much less frequent. He was also perfectly convinced of the recurrence of adenoids after operation. He saw many such cases which had been operated upon, and where adenoids were again found. They may recur after a second or third removal, simply because the idea is fixed in the minds of non-homœopathic surgeons that the adenoids have only to be removed and the case is cured. That was not so. There must be a subsequent treatment, often of a prolonged character, in order to get rid of that unhealthy state of the mucous membranes upon which their growth depends. A method he had found exceedingly satisfactory in rendering an obstructed nose pervious was rubbing in some simple unguent or glycerine, and then

applying hot fomentations. This promptly relieves the obstruction, and gives the patient at once a clear passage, after which the snuffs and local medication could be applied. He had generally found arsenicum answer in the early stages. He was encouraged to hear that the morning cold bath was not the desideratum which John Bull had always maintained. For many years he used to persevere with this cold bath, and suffered in consequence from fluent nasal coryza for some hours after. He observed that that happened when the temperature of the bath was very low, and that he did not suffer at all in the summer. He accordingly took the precaution of raising the temperature of the bath to about 50°, and since doing so he had escaped without any colds.

Mr. DUDLEY WRIGHT said that a large part of Dr. Green's and his time in the hospital on Wednesdays was spent in removing nasal polypi. He had heard so much that evening about the cures of polypi with remedies, and he had tried so often himself to cure them with remedies and failed, that he asked those gentlemen who could cure them to come to the hospital, where a great number of cases would be placed at their disposal.

Dr. DUDGEON said a gentleman once came to see him with one of his nostrils completely obstructed, and asked for advice. He advised him to have an operation performed, but, the patient not agreeing, he prescribed calcarea. In two or three days the gentleman returned with the polypus in a paper, and said that it had tumbled out on blowing his nose. Whether that was due to calcarea he could not say.

Mr. WYNNE THOMAS said that a cold was caught quite as often by coming indoors from the cold into a warm room and toasting oneself before the fire, as by getting warm indoors and going out into the cold.

The PRESIDENT agreed with Dr. Dyce Brown's remarks, especially with regard to chronic rhinitis being caused by the constitutional condition, and the necessity for attending to that particularly. He was not much in favour of sprays and lotions, and gargles and snuffs, although it was much easier than constitutional treatment. If one had to attend to the constitutional condition of the patient it required a much larger amount of time and attention. Mr. Wright knew full well that he (the President) had cured some cases of very bad posterior adenoids by a snuff of calc. phos. which Mr. Wright had advised should be taken out. Others had tried the same remedy and failed. Why? He believed it was very much due to the fact that

the work had not been half done. By pursuing that course indefatigably he had seen cases cured. He had seen polypi of years' standing cured by the local application of sanguinaria, generally used in the second or third decimal. The particular constitutional conditions required to be taken in hand quite as much as the local affection.

Dr. GREEN, in reply, thought his statements regarding the use of kali bichromicum for nasal polypus had been misunderstood. He quite agreed with Mr. Shaw that the growth might be prevented by the use of the drug, and nasal polypus being in many cases only a further stage of hypertrophic catarrh would strengthen this view, but what Dr. Green maintained was that a nasal polypus already in existence could not be cured by kali bichromicum. Tannic acid he had not tried; he should be afraid rather of aggravating the hypertrophic catarrh which usually accompanies the condition. One speaker had said that singing relieved hypertrophic catarrh. Unfortunately, many cases came because the presence of this condition prevented them from singing. He could not agree with those who deprecated the use of local applications. Such treatment was as rational and had as firm a basis as the antiseptic treatment in surgery; at the same time a great deal can always be done by internal treatment. He had seen at least three cases of acute rhinitis of epidemic influenza followed by permanent anosmia where no local applications had been used. In hypertrophy of turbinates, where there was increase of normal tissue, one might just as well try and reduce the size of the little finger by internal remedies. He was glad so many had laid stress on the importance of nasal breathing. It was all-important in the prevention and cure of diseases of the nasal passages. The recurrence of adenoids referred to was, he believed, owing to the growth being only smashed down with the finger nail or roughly torn off with Lowenberg's forceps. The pharyngeal wall must be thoroughly curetted with a Gottsbeere curette, and the child must be made to begin breathing through the nose at once, or else mucus laden with dust and germs gathered in the pharyngeal vault, and the lymphatic nodules normally present in the mucosa were irritated and became enlarged or adenoid again. No reference was made in his paper to the treatment of hydrorrhœa, chiefly because there is none. If he should have a case of this rare disease he should certainly carry out a quantitative analysis of the uric acid in urine after the methods of Mr. Wilkinson, with the hope that indications for treatment might be found by that means.



“HOW LONG ARE WE JUSTIFIED IN DELAYING OPERATIVE INTERFERENCE IN ORDER TO TRY THE EFFECT OF HOMŒOPATHIC DRUG TREATMENT?”<sup>1</sup>

BY H. WYNNE THOMAS, M.R.C.S.ENG., L.R.C.P.LOND.

*Medical Officer to the Phillips Memorial Hospital, Bromley, Kent.*

MR. CHAIRMAN AND GENTLEMEN,—I make no apology for bringing this question before you this evening because it is a subject which comes up before us almost every day and is of universal interest to us all, and it is in order that by discussing this question from a practical standpoint, and by hearing each other's experiences, we may be able in future to arrive at some more definite ideas than we have at present.

I take it that the true ideal of every homœopath is to apply the “law of similars” so that his patient regains perfect health simply by the introduction into his system of some single drug which acts simply and gently on the refractory tissue which has strayed from the path of physiological virtue. That this ideal is not always attainable in the present day all here this evening can testify; though from records in past homœopathic literature one might well be excused from thinking that in days gone by all had not failed; and even at the present day from the accounts of some of our patients it would seem that it is still possible to cure every disease if only the patient will continue long enough under treatment, and not be down-hearted if he still finds that at the end of one, two, or even three years he is not quite cured. “Rome was not built in a day,” and if the exostosis still remains who can say that it might not have been much larger if the patient had not continued to swallow his globule once a week, and pay his guinea once a month.

Now by considering a few common everyday cases, let us see if we are doing the right thing by our patient in

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, April 13, 1899.

advising him, at, perhaps, the first interview, to submit to the surgeon's knife, rather than persevere for some time with medicines on the chance that he may be cured.

If a patient who came complaining of severe  
**GLAUCOMA.** pain in the eye was found to have markedly increased tension, with a shallow anterior chamber, I should consider the practitioner very greatly to blame if he did not urge his client to have an iridectomy performed as soon as possible; time in these cases is so precious that the risk and small chance of drugs doing any real good is not worth the delay, or the sight may be impaired or lost for life, and unless the internal drainage in the eye be permanently restored the same trouble may again

**CATARACT.** at any time recur. On the other hand few ophthalmic surgeons advocate the removal of the lens for cataract until it is sufficiently ripe; now in these cases we have a chance of watching the effect of medicine, and I am sure that in some cases the opacity may be arrested and even clear up. One case comes before my mind in which I can have no doubt of the good effects of medicines. I was attending a lady of 57, in the early part of 1893, for carbuncle and erysipelas, which were eventually traced to a cesspool just below her bedroom window, though I was assured that the drains had been examined and declared perfect eighteen months previously. Of course she was immediately removed to another house, but as a result of the erysipelatous attack she became absolutely blind in the right eye from optic atrophy. In November of the same year she came to me saying that she was losing the sight of her one remaining eye; on examination there was a well marked cataract. Mr. Knox Shaw will no doubt remember seeing this case at that time; she persevered with caust. 3c and silicea 3c for nine months, during which time her sight very greatly improved, since which she has taken no medicine as she says her sight is all right, and she can read comfortably.

Dr. Ussher reports an interesting case in the *Homœopathic World* for 1890, a female, age 20, with cataract of the left eye, the capsule of lens wrinkled and white, sight almost *nil*—observable to everybody by reason of its whiteness. Her

mother said she was born without defect ; but had erysipelas at 3 years of age and had been blind ever since ; though the right eye was perfect. He began giving silicea 6x in May, and, with the exception of a few doses of phos. 6 and graph. 12, from July till November he continued with silicea 30, and then on examination could only make out a slight central opacity with some haziness around, and the patient could read ordinary type. My father has told me that he has on several occasions seen a cataract clear up under sulph. and phos. There are many cases scattered throughout homœopathic literature which have been cured or benefited by medicines, most notably by sulph., calcarea, phos., caust., nat. mur., and silicea, and I think you will all agree with me that it is worth while at least trying what can be done with medicines before resorting to operation.

I would like to ask those who take **MEIBOMIAN CYSTS.** special interest in eye diseases if they are usually successful in curing Meibomian cysts by drugs, or whether they generally puncture them and squeeze out the contents. I cannot say I have been very fortunate in my treatment with medicines.

Next I should like your kind consideration of **ADENOIDS.** the question of post-nasal adenoids. This is a disease that, I might say, was hardly known when I was at college, and yet now how many families are there where there are children who can say, "We have not had any adenoids in our family or near relations." I have frequently had patients come to me with their children saying that they think the child has "adenoids" or "a growth something like currants" at the back of its nose, and on asking why they suspected anything wrong, "Oh, my brother's child or my sister's child had them, and was operated on by a London specialist, and my boy does not learn his lessons quickly, and sometimes snores at night." There must have been thousands of children scraped for adenoids during the last ten years, and thousands of guineas changing hands in consequence. Now, is all this scraping necessary? I very much doubt it. Surely, in a large number of cases the properly selected drug should cure these conditions. I do

not deny that some bad cases should be dealt with surgically, but surely with thuja, calc., kali bich. and ac. nit. we ought to cure a goodly number.

It is a short step from adenoids to tonsils, ENLARGED and I must confess that I would like to TONSILS. know of some method of curing chronically enlarged tonsils other than by the guillotine.

I quite agree with Dr. Madden that I cannot say that I have ever seen the least effect from baryta carb. or calc. phos. in chronic cases. I am in the habit of using baryta carb. in acute attacks of amygdalitis threatening to go on to quinsy, and in the 12c or 30c, and find it of real service. I have frequently removed chronically hypertrophied tonsils, and cannot say that I have ever seen any ill effects result, such as one occasionally hears of in a vague sort of way, such as making the patient more liable to phthisis. I should have thought that in consequence of their removal the chest would be better expanded, and the lungs therefore better aerated.

In strumous glands in the neck much can STRUMOUS be done in the early stages by such medicines GLANDS. as calc., of which I think the calc. iod. is the most useful; also baryta carb., kali iod., arsen. and silicea are of service, but what I have seen of more good than anything is a month or two at Margate. There is something peculiar in the air of this seaside resort which seems specially good for these cases, and I have seen cases derive more benefit from a stay of a few weeks there than from months of cod-liver oil and medicines at home; but as soon as glands begin to break down I believe the right treatment is to excise them or scrape them, and my own plan is to cut down on the glands as soon as I find them becoming adherent to the surrounding tissues, as then, I believe, the inflammatory action is beginning to spread outside the gland itself, and pus is being formed; and I still believe in the golden rule in surgery, "when pus is formed, wait no longer, but give it vent"; it is bound to make a way out for itself in time somewhere, and the sooner it is got rid of the better for the patient. I can see

no good whatever, and only harm, in allowing it to burrow about, and convert a small abscess into a large one. I have a great horror of poulticing such things; in fact, I am quite sure that the days of poultices are numbered, and a linseed poultice will soon be a thing of the past. I do not think I have used a poultice for years.

Now let us turn our attention for a few minutes  
**TUMOURS** to tumours of the breast, and I think it will be a  
**OF THE** good rule to follow whenever a woman presents  
**BREAST.** herself with a swelling in her breast to at once  
 ask ourselves the question, Is it or is it not malignant? If it should *appear* to be of a malignant nature or even suspicious of cancer, then I would unhesitatingly urge operative measures as soon as possible. Some of you will think this rather an extreme course to begin with, but I believe that if cases were taken early there would be more lives saved; if you wait till the glands in the axilla are sufficiently large to be easily felt, the chance of eradicating the disease is getting small. What I would urge is first incise the tumour, and then if your suspicions are confirmed proceed to remove the whole breast, and at the same time excise any gland you can find; do not do as I once saw a well-known surgeon do, amputate the breast, and then afterwards cut into the tumour and find it to be a simple cyst; it reminds me of the story of a celebrated French surgeon going round the wards one day with a crowd of young doctors at his heels, and stopping at one bed, he said, "Gentlemen, this is a case of amputation through the hip: unfortunately there was a slight mistake made here, we took off the wrong leg, but it does not signify, we shall cure the other one." I know quite well that there are many cases reported in our literature of cancer of the breast being cured by hydrastis, condurango, conium, arsenic, chian turpentine, &c.; but though these may have cured a few cases here and there, they have all more frequently been useless in arresting this terrible disease, therefore I say do not delay while you try this or that medicine, but first remove the growth, and then I would say give your patient a prolonged course of treatment with the hope of eradicating the cause, for although the patient will

tell you in a large number of cases that a fall or blow was the cause of the growth, this would not produce a malignant disease in a perfectly healthy person; there must be a something in the system which under a slight provocation breaks out into activity and manifests itself in this manner, and something I think can be done by appropriate medicines to counteract or at least keep this tendency in check. Of course if the patient is not willing to submit to an operation, then you must fall back on medicines, and I would say carefully select your drug and persevere with it, varying the potency from time to time, rather than trying many remedies. I was much struck by reading of a case reported by Dr. Dudgeon in the *Homœopathic World* for 1889 cured by condurango. A woman, age 69, first consulted him in December, 1886, saying that she had been under treatment for several months for a swelling in the left mamma, and her doctor told her that unless it was removed it would kill her in a fortnight. The breast was tender to the touch, nipple retracted so as to be invisible, a hard, painful swelling on outer side of gland the size of an egg, skin over its centre drawn in, and frequent darts of lancinating pain. He began with *phytolacca* 1 and *ung. hydrastis*, 20 drops of  $\phi$  to *vaseline* 3j. This was soon changed for *hydras.* internally, as the ointment produced an itching eruption with small black pustules. By the end of January the tumour was larger, *croton tig.* 2 was then given; in March for a fortnight she took *hydrastis* 3x, but the tumour increasing in size, and being more painful, she was given *conium* 1. This she took till September with great relief to the pain, though the tumour did not alter much. By February, 1888, a red nodule had grown out to the size of a walnut, and looked as if it would burst. From then till June she took *condurango* 1, two drops three times a day, and the tumour got decidedly less by November. The red lump had quite gone, and by the following July hardly a trace of the lump could be felt. The cicatrix-like depression of the skin is still there, but no pain and no tenderness. I think this case reflects great credit on Dr. Dudgeon, and should encourage us in pegging on with a remedy in seemingly unpromising

cases. I have never used condurango myself, but I have found great benefit from hydrastis. In one woman a suspicious swelling, the size of a walnut, disappeared under 5-drop doses of 1x taken for three months, and after an interval of two years she came again with another small hard irregular growth, and under the same treatment that disappeared also.

I will not weary you by relating more cases of this kind, but the same rule will apply to malignant growths in other regions of the body. If the tumour is of a non-malignant type I think it is well worth persevering with drugs before operating; in fact since antiseptic surgery has made such advance the last few years, and the risks of operating become so much less than formerly, I am afraid we run a risk of being carried along with the flood of fashion, and do not give drugs a fair chance. It is impossible in a short paper such as I was asked to read this evening to even touch on numerous diseases which are usually called surgical, but which have been cured simply by drug treatment; but in all diseases in which pus is formed, whether from a rotten stump, a caseating gland, an empyema, or a pyosalpinx, only harm is likely to result by leaving it alone, and the sooner it is removed the less harm it will do to the patient. I only saw a child yesterday suffering from multiple strumous abscesses. She first came to me two years ago, then aged 10 months, with a collection of pus in the thigh, and every few weeks she developed an abscess in some other part of the body; usually they were connected with bone, though not always. In two years that child has been under chloroform thirteen times, and twelve months ago I thought she would lose her foot. She had a large cavity in the os calcis and extending along the sole of the foot to the base of the great toe, and for some weeks she wore a tube from the heel to the inner side of the great toe; a probe passed also from the same opening at the outer side of the heel to the inner malleolus. These I thoroughly scraped with a curette, and kept bandaged to a splint for six months. Five times this gathered up, and the same treatment was adopted. During the last four months I have

kept the foot and leg in a plaster of Paris case, leaving a window for dressings, and I am glad to say that to-day, with the exception of the scars, the foot appears as healthy as the other one. She has been taking for the last twelve months calc. phos. 30, twice daily.

It now only remains for me to thank you for so patiently listening to my paper; no one knows more than myself its shortcomings and fragmentary character. However, if I can elicit a candid criticism and draw upon the experience of those who have been foremost in the battle of practice, I shall feel that my small effort may prove of some value to the members of this Society.

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Dr. DUDGON said that, as Mr. Thomas had alluded to a case of his where the disease was apparently cancer of the breast, and which seemed to have been cured, he might mention that the lady had since died, but not of cancer. The tumour did not give her any trouble, but she died of old age and bronchitis. Mr. Thomas had mentioned the treatment of cataract by medicines before advising an operation. A lady came to him about ten or twelve years ago who had been to see an eminent oculist, who told her that she would be quite blind in six months, if she was not operated on immediately. However, he (the speaker) thought it worth while to see if something could not be done to avoid the operation. The cataract was a striated one. He gave her chiefly fluoride of calcium, and the opacity gradually disappeared. The patient could now see perfectly well.

Mr. KNOX SHAW, touching upon the question of the curability of cataract by medicine, referred to a paper he had published in the London Homœopathic Hospital Reports a few years ago. He stated there that a man had to be thoroughly conversant with the natural history of a disease before he could talk of whether it was likely to be cured by any remedy at all. On studying the natural history of cataract it was very difficult to say for certain whether remedies were likely to do any good. In the paper referred to he had collected some published figures. Dr. Norton, of New York, published some statistics giving the number of cases treated, the percentage of those that improved, the percentage of those that remained stationary, and the percentage of those that deteriorated. Mr. Brailey, of Guy's



Hospital, had also published similar figures the same way. Dr. Norton gave all his patients very carefully selected homœopathic remedies. Mr. Brailey gave his patients no medicine at all, but very seriously curtailed the use of the eyes. Dr. Norton said that his good results came from treatment by medicine; Mr. Brailey said that his good results came from making his patients abstain from work. He (Mr. Shaw) had been able to collect facts with regard to 125 patients. He had rarely given the patients medicine, had allowed them to have the free use of their eyes, but very carefully corrected all errors of refraction. The interesting point was that the three sets of figures gave almost precisely the same result. Out of the 125 cases that he was able to trace, not one came to operation, so that it was very difficult now to say what effect remedies had. With regard to cancer, he thought early operation offered a better chance of prolonged life than remedies, however carefully selected. Under these circumstances he was afraid he considered a belief in therapeutic measures a disadvantage to the patient.

Dr. NEATBY said that where the general health of a patient on whom operation was inevitable might be improved by drug treatment, it was justifiable to delay surgical interference to that extent. On the other hand, a great deal of harm might be done by delaying surgical interference in cases such as post-nasal adenoid. The breathing might be improved by remedies, but the question was whether a great deal more harm was not being done in preventing a proper expansion of the chest by allowing a diminished breath way to remain instead of proceeding to prompt operation and then pursuing the constitutional treatment. Great harm might also be done by delaying operation in cases of uterine fibroids. The number of patients who came to him whose health had been practically ruined by careful and persistent treatment, both homœopathic and allopathic, was distressing. The hæmorrhage or pain might have been benefited, but there was such a strain on the patient's system from a prolonged hæmorrhage that the health was weakened and the heart became hypertrophied. Where it mattered nothing, comparatively, as to the general health, one was justified in waiting. Very little would be lost in cases of cataract, for instance, by delay. Where good could be done to the patient's health, or where even there was no likelihood of the health suffering, he advised delay, and that the patient should be treated with homœopathic remedies; but where there was a prospect of the patient suffering in general health, either in the case of malignant disease or other conditions which had a remote effect on other

organs of the body, a surgical operation should be promptly performed.

Dr. DYCE BROWN said he was frequently consulted, in cases of cancer of the breast, as to whether an operation was desirable, or if internal treatment would be successful. He thought patients ought to be given the chance of internal treatment for at least a month unless the disease was so far advanced that immediate operation was desirable.

Dr. GALLEY BLACKLEY said that a class of cases which had not been mentioned was that of enlarged tonsils in children at about the age of puberty. On many occasions children had been brought to him by parents after having been examined by specialists for diseases of the throat, who had recommended that the tonsils or adenoids should be removed without a moment's delay. Where the family history was good on both sides and the chest on examination was well developed and otherwise healthy, he (Dr. Blackley) had made it a practice to give the patient the benefit of a little expectant treatment, because there was, without the slightest doubt, a natural tendency for the lymphoid growths to disappear during, or immediately after, the age of puberty. He had known these growths to disappear without any drug treatment whatever, simply by insisting on the child having plenty of fresh air, exercise, sunshine and sea water. Certainly, the diseases disappeared more rapidly if the patient was sent to live at the seaside, at such places as Margate, Broadstairs and Worthing, and other places on that coast. He suspected that a great many of the so-called drug cures of these growths were of this class.

Mr. DUDLEY WRIGHT concurred with Dr. Blackley's remarks. Mr. Thomas's plan of treatment in gland cases exactly coincided with his own. He had lately somewhat modified his treatment of such cases. Four or five years ago he used to recommend that all glands should be removed, but he very rarely removed them now. He also combated the statement that the removal of glands before they had suppurated left a smaller scar than when they were treated after suppuration. Less scar was usually left after opening a suppurating gland than after removal of a gland. His usual plan now was to open suppurating glands by a small incision, cleansing the cavity thoroughly with biniodide solution, and closing with sutures, and all the rest he treated with internal remedies. A large number of the glands undoubtedly disappeared under drug treatment. As regards the disappearance of tumours, he once had a case of adenoma of the thyroid gland which he was about to remove. Shortly before operation the

tumour began to diminish in size, and on its removal it was found that the decrease in size was due to the fact that some vessels had ruptured inside it. Hæmorrhage had taken place, and the tumour, with the exception of the part around the circumference, was liquefied and unrecognisable and was being gradually absorbed. It struck him that, inasmuch as large doses of arnica, five drops of mother tincture, had undoubtedly been the cause of the disappearance of cases of malignant tumours, it was very probable that the arnica had actually induced a pathogenetic action on the blood-vessels, causing a rupture and thus inducing disappearance of the growth. Hydrastis might have a similar action.

The PRESIDENT felt very strongly that in malignant tumours of the breast medical treatment should be tried before operation.

Mr. WYNNE THOMAS, in reply, agreed with Mr. Knox Shaw that in a case of cataract it was advisable to give the patient the benefit of medical treatment. Even if the medicine was not doing any good, it would often encourage a patient and keep up his hopes. If a patient suffering from a malignant disease was told in an early stage that his case was hopeless, it would depress him, and consequently hasten his end. With regard to Mr. Wright's remarks, when a patient found his tumour disappearing it was not always that he would allow an operation to be performed to ascertain the reason. It would be interesting to find out whether electrolysis hastened the disappearance of tumours by rupturing the vessels.

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## OXALIC ACID.<sup>1</sup>

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MY attention having been directed of late to the usefulness of oxalic acid in the treatment of certain cases of neurasthenia, I have thought it of interest to bring under your notice this evening a review of the pathogenetic action of this substance, together with a few thoughts upon its

<sup>1</sup> Presented to the Liverpool Branch, April 13, 1899.

possibilities as a therapeutic agent. With the exception of the article on oxalic acid in Hughes' "Pharmacodynamics" (5th ed., 129), and a paper read before this Society by Dr. J. Compton Burnett in March, 1877 (*Brit. Journ. Hom.*, xxxv., 309), there appears to be very little reference in our periodical literature or works on materia medica to the use of oxalic acid in medicine; and this is singular when we consider how frequently it has been used as a poison, and the care with which its physiological action has been studied from a medico-legal standpoint. Chief among the observers from this side must be placed Drs. Christison and Coindet, whose experiments, and their conclusions therefrom, are recorded in the *Edin. Med. and Surg. Journ.*, xix., 182.

From the study of cases of human poisoning—accidental and intentional—and of experiments on animals, it would appear that when oxalic acid is taken in concentrated solution it acts as an irritant, producing violent inflammation, with corrosion and softening of the mucous membranes with which it comes in contact. Thus we have in one case of poisoning "the mucous membrane of the pharynx and œsophagus as if scalded, the villous coat of the stomach pulpy, in some places blackened, in others highly injected"; while in another case, where death took place after half an ounce of the acid had been taken, there was "complete destruction of the villous coat of the stomach."

But if oxalic acid be administered in a more diluted condition, a totally different (and from our point of view a more interesting) series of phenomena is produced, for the main stress of the poison appears to fall upon the cerebro-spinal nervous system. If the dose be a large one death may take place within a few minutes from paralysis of the heart, and *post mortem* this organ will be found in a flaccid condition and full of blood. Hermann believes that in these cases the poison acts directly upon the intrinsic cardiac ganglia. But if the amount of the poison taken be less quickly lethal a state of motor irritability is set up—commencing usually as stiffness of the lower extremities, then a condition of tonic spasm gradually involving the muscles of the trunk, and sometimes (as in strychnia

poisoning) to such a degree as to cause death by asphyxia from spasm of the respiratory muscles. In other cases the spasm is gradually succeeded by paralysis—in which the sensory system is also involved, as shown by the anæsthesia so frequently observed in cases of poisoning; the general sensibility becomes blunted, a state of stupor comes on and death takes place in a condition of coma. Dr. Neatby refers (*Hom. Review*, November, 1889, 655) to a case of poisoning by oxalic acid recorded in the *Hom. Physician* for September of the same year, in which the nervous phenomena included tonic and clonic spasms of upper and lower limbs, exaggeration of patellar reflexes on both sides, anæsthesia of the tips of the fingers and toes, and of the palmar surface of the hands and plantar surface of the feet, with greatly diminished sensibility of the skin of the legs.

Though oxalic acid is occasionally a very rapid poison, recovery has taken place after as much as two (or in one case three) drachms have been taken.

*Post-mortem* examination when death has followed the administration of diluted oxalic acid does not appear to show any very characteristic lesion; and, though the arachnoid has been found to contain an increased quantity of fluid, and the brain substance has been described as softened, further careful observations—and especially microscopic—of the brain and spinal cord are necessary to determine the exact manner of the attack of the poison upon these structures. I feel sure, from a study of the symptoms and the *post-mortem* condition, that the main action of oxalic acid will be found to be an excitement followed by exhaustion of the motor nuclei of the brain and cord—with perhaps a similar condition of the sensory nerve cells. Whether the anæsthesia of the tips of the extremities is central or depends upon a local neuritis is at present quite uncertain. Some writers have believed that oxalic acid has a definite and special action upon the lungs, but, though the surface of the lungs has been found reddened in patches, and in one case, where death took place thirteen hours after half an ounce of the acid had been taken, the mucous membrane of the larynx and trachea, and the lungs themselves, were described as

intensely inflamed, these appearances (as also the aphonia which is present in many cases) are just those which would be produced by any condition leading to paralysis of the motor fibres of the vagus nerve; and the paralysed heart muscle may well depend upon the same cause.

But, interesting as these speculations may be, and valuable as the records of poisoning and experiment are in giving us the coarser features of the action of oxalic acid, it is from the carefully observed effect of the action of the drug upon healthy persons that we, as homœopaths, would expect to get the information most likely to be useful to us in the treatment of disease, and we are fortunate in having several well-conducted provings of oxalic acid by Drs. Neidhard, Koch, Dubs, and Reil (the latter of whom took sixty-five grains of pure oxalic acid within six days). These provings, with some records of cases of poisoning, and the conclusions based upon the experiments of Drs. Christison and Coindet, are contained in the "Cyclopædia of Drug Pathogenesy" (I., 45 *et seq.*), and from this source I have compiled the following schematic arrangement of the symptoms produced in fourteen of the persons who proved or were poisoned by oxalic acid, indicating by a small number attached to each symptom the frequency of its occurrence in these individuals.

#### SYMPTOMS PRODUCED BY OXALIC ACID.

##### *Mental and General.*

Increased mental power<sup>1</sup> [increase of animation<sup>1</sup> (51, 21)\*; unusual vivacity, cheerfulness<sup>1</sup> (53, 22); hilarity<sup>2</sup> (53, 11 and 54, 11)].

Cerebral excitement<sup>1</sup> (56, 15).

Delirium<sup>1</sup> (56, 27).

Hallucinations<sup>1</sup> (55, 39).

Aversion to mental exertion<sup>2</sup> (45, 29; 53, 16).

Disinclination for conversation<sup>1</sup> (47, 46).

Power of apprehension failed while reading<sup>1</sup> (49, 10).

\* The numbers in brackets refer to the page and line in the "Cyclopædia of Drug Pathogenesy," vol. i., where the symptom occurs.

Irresolution<sup>1</sup> (49, 24).

Anxiety and dread<sup>4</sup> (50, 47 ; 54, 46 ; 55, 49 ; 56, 23).

Indisposition to work<sup>1</sup> (49, 24).

Malaise<sup>1</sup> (49, 17 and 50, 4).

Lassitude<sup>8</sup> (45, 40 ; *id.*, 46 ; 46, 45 ; 49, 29 ; 50, 21).

Prostration, with feeling as if the spine were too weak to carry the body<sup>1</sup> (46, 31).

Exhaustion, with trembling of the whole body<sup>1</sup> (55, 19).

Muscular prostration<sup>8</sup> [weakness in legs spread over the whole body, the usual work exhausted him, and left a feeling of muscular fatigue (47, 25) ; with weight and powerlessness of the limbs<sup>2</sup> (54, 35 ; 56, 43)].

### *Head.*

#### *(General.)*

Confusion<sup>1</sup> (49, 21).

Faintness<sup>1</sup> (53, 2).

Vertigo<sup>5</sup> (49, 12 ; 50, 20 ; 50, 48 ; 54, 20 ; 56, 41).

Headache, general<sup>3</sup> [(53, 15) ; with heat (52, 36) ; violent pulsating headache after taking some wine (50, 32)].

Sensation of heat in the head<sup>1</sup> (51, 5).

#### *(Frontal region.)*

Forehead and eyes smarting, as from coryza<sup>1</sup> (45, 27).

Fulness in forehead above the eyes<sup>1</sup> (53, 25).

Frontal headache<sup>5</sup> [sharp pain in forehead and vertex, and especially over left eye (51, 13 ; *id.*, 48) ; dull pressive pain in forehead<sup>4</sup> (45, 27 ; *id.*, 36 ; 50, 36 ; 51, 18 ; *id.*, 20 ; 52, 19 ; 53, 16) ; throbbing<sup>2</sup> (49, 10) ; with confusion<sup>1</sup> (49, 43)].

#### *(Vertex.)*

Headache<sup>8</sup> [53, 2 ; 54, 5 ; in forehead and vertex (51, 13)].

#### *(Temples.)*

Headache<sup>8</sup> [extending from right side of forehead to mastoid process (50, 46) ; left temple<sup>3</sup> (50, 14 ; extending to lower jaw, 53, 25).]

Jerking in left temple<sup>1</sup> (53, 26).

#### *(Occiput.)*

Pain along the base of the occipital bone<sup>1</sup> (54, 72).

### *Eyes.*

Eyes and forehead smarting as from coryza<sup>1</sup> (45, 10).

Eyes weak<sup>1</sup> (49, 25).

Eyes sunken<sup>a</sup> (50, 25 ; *id.*, 27 ; with blue rings, 49, 31).

Tensive pain and soreness in eyes<sup>1</sup> (53, 15).

Pain in both orbits, worse in left<sup>1</sup> (54, 13).

#### *Ears.*

Fine stitches in left ear<sup>1</sup> (49, 13).

Pain deep in the ears, as in the eustachian tube, worse right side<sup>1</sup> (48, 2).

#### *Nose.*

Watery discharge from nose, with sneezing, while walking in the open air<sup>1</sup> (53, 3).

Vesicle in right nostril, shooting and burning when touched. The *alæ nasi* swollen, especially the left. This recurred every second or third day for two weeks ; on the eleventh day the nose was very painful, shooting and burning, swollen and shiny red (50, 14 *et seq.*).

#### *Face.*

Red face<sup>1</sup> (51, 5).

Heat in face and hands<sup>1</sup> (50, 24).

Pale face with sunken eyes<sup>1</sup> (50, 24).

Contractions of the facial muscles, of the jaws and of the mouth, causing the mouth to be closed, with drawing down of the angles, corrugation of the eyebrows, dilated *alæ nasi* (56, 12 *et seq.*).

#### *Mouth.*

Burning in mouth<sup>a</sup> (55, 13 ; 55, 46).

Inflamed buccal cavity<sup>1</sup> (50, 27).

Gums painful and swollen, with pustules surrounded by red areolæ<sup>1</sup> (49, 45).

Burning in left half of tongue, as from pepper<sup>1</sup> (49, 8).

Tongue white-coated<sup>1</sup> (51, 2).

Tongue patchy<sup>1</sup> (55, 38).

Tongue brown-coated, with red dry tip<sup>1</sup> (56, 22).

Tongue dry, sore, and excoriated<sup>1</sup> (51, 28).

Tongue abnormally red, and irritable-looking for several days<sup>1</sup> (56, 44).

Toothache<sup>a</sup> (49, 44 ; 50, 38 ; worse on right side, 51, 24).

Sour taste<sup>a</sup> (49, 33 , 50, 44).

#### *Throat.*

Sore throat<sup>a</sup> [51, 23 ; with roughness or scraped sensation<sup>a</sup> (46, 9 ; 50, 34 ; 50, 43)].



Pain and difficulty in swallowing<sup>2</sup> (46, 9 ; on empty deglutition 50, 23 ; 55, 46).

Tonsils and velum slightly reddened and covered with adherent mucus, which can only be detached by violent effort<sup>1</sup> (46, 9).

Drawing pain with rigidity near the angle of the lower jaw on both sides<sup>1</sup> (53, 7).

Burning in mouth and throat<sup>1</sup> (55, 46).

Burning in gullet<sup>1</sup> (55, 13).

*Clinical remark.*—According to Peters (Mat. Med., 61), oxalic acid in the third trituration has proved useful in chronic inflammation of the mucous membrane of the throat and tonsils.

#### *Stomach.*

Loss of appetite<sup>2</sup> (46, 14 ; 50, 25 ; 53, 34).

Empty feeling in stomach<sup>2</sup> (45, 38 ; 47, 23 *et seq.*).

Gnawing sensation simulating hunger<sup>1</sup> (46, 15).

Warmth in the stomach<sup>1</sup> (49, 7).

Burning in the stomach<sup>1</sup> (55, 14).

\*Eruetation<sup>2</sup> (sour<sup>1</sup> 50, 6 ; of tasteless wind after meals<sup>1</sup> 51, 36).

Nausea<sup>2</sup>.

Pyrosis<sup>1</sup> (53, 33).

Vomiting<sup>4</sup> (of thick black fluid, 50, 40 ; of blood, 55, 28 ; 56, 39 ; of grass green fluid, 56, 21).

Pain in epigastrium<sup>2</sup> (excruciating, 55, 47 ; violent, relieved by discharge of flatulence, 53, 30).

Thirst<sup>2</sup> (50, 21 ; 53, 35 ; 56, 23).

*Clinical remarks.*—Peters (Mat. Med., 62) refers to the cure by oxalic acid 12 of long-standing dyspepsia with burning in the stomach, eructations tasting of food after every meal, distension of stomach and bowels with wind, pressure at the pit of the stomach, and sour taste soon after eating. Dr. Nardo, of Turin, for years successfully employed oxalic acid in grain doses three times a day in gastritis. In the *Journal of the British Homœopathic Society*, January, 1897, 85, is reported from the *North American Journal of Homœopathy*, September, 1896, 596, a case of nocturnal gastralgia,

\*Several other provers experienced eructations, but whether liquid or aseous is not stated.

with vomiting, sour taste, and thickly-coated yellowish tongue, with much epigastric sensitiveness, which had lasted for months, but which was cured in ten days by oxalic acid 30.

#### *Abdomen.*

##### *General.*

Distension<sup>s</sup> (45, 35 ; 52, 4 ; 54, 34).

Rumbling<sup>a</sup> (45, 30 ; 45, 37 ; 49, 33 ; 52, 43).

Soreness in abdomen<sup>1</sup> (53, 37).

Pain in abdomen<sup>o</sup> [aching in whole abdomen, but worse round umbilicus<sup>1</sup> (51, 42); relieved by pressure<sup>1</sup> (54, 40); 55, 14; shooting pain in whole abdomen, extending to region of the spleen (50, 40); cutting in bowels<sup>s</sup> (49, 17 ; 50, 50)].

\* Colic<sup>1</sup> [flatulent colic<sup>s</sup> (52, 1 ; 53, 41 ; 54, 6); colic with urging to stool<sup>1</sup> (49, 22, *et seq.*); increased after food<sup>1</sup> (46, 4); causing him to sit doubled up (46, 22)].

##### *(Umbilical region.)*

Pain<sup>s</sup> [pinching<sup>s</sup> (45, 39 ; 51, 27); shooting<sup>1</sup> (49, 13); in whole abdomen, but worse round umbilicus (51, 42)].

##### *(Hypochondria.)*

Pain in left hypochondrium<sup>1</sup> (53, 38).

##### *(Iliac region.)*

Colic-like pain in both iliac regions, chiefly the right<sup>1</sup> (51, 36).  
Dull aching in right side of abdomen, in a small spot<sup>1</sup> (53, 35).

#### *Rectum and Anus.*

Tenesmus, urging to stool<sup>o</sup> (without evacuation,<sup>1</sup> 46, 37).

Frequent pains in anus<sup>1</sup> (46, 40).

Itching at anus, with crawling as if from worms, relieved by rubbing<sup>1</sup> (52, 6).

Burning in anus<sup>1</sup> (46, 46).

*Clinical remark.*—I have lately prescribed oxalic acid in a case of membranous colitis, where with some colic and much tenesmus there is a daily discharge of long strings of toughened mucus, forming a cast of the bowel. As is usual in such cases, which are not frequently met with, the

\* In one prover there was marked increase of the colic by rest, and relief from moving about and in the open air.

patient is distinctly of neurotic temperament, and has symptoms of neurasthenia, which ought to be helped by oxalic acid.

#### *Stool.*

Loose, pappy<sup>12</sup> [with much mucus<sup>1</sup> (43, 35); clayey<sup>3</sup> (49, 16; 50, 8; 50, 29); of undigested food<sup>1</sup> (49, 19)].

Copious diarrhoea<sup>3</sup> (49, 28; 50, 25; of thick black offensive fluid, with bloody shreds, 54, 45).

Serous, with streaks of blood<sup>1</sup> (46, 30).

Involuntary discharge of fluid stool<sup>1</sup> (53, 49).

Firm, with much mucus and some blood<sup>1</sup> (49, 41).

#### *Urinary Organs.\**

Increased frequency of micturition<sup>3</sup> (47, 13; 51, 39; 52, 11).

Urging to pass water<sup>3</sup> (53, 44; with stomach-ache, waking him frequently, 56, 12).

Slight burning while urinating<sup>2</sup> (urine clear and straw-coloured, 52, 12; through urethra to its orifice as if a drop of acrid urine wanted to come out, 49, 25).

Violent burning while urinating<sup>2</sup> (56, 43<sup>1</sup>; urine passing by drops, 49, 42).

Retention, the bladder distended, but cannot pass urine<sup>1</sup> (56, 34).

Suppression, complete<sup>1</sup> (56, 20).

Urine increased in quantity<sup>2</sup> (51, 39; 52, 11; 53, 45).

Urine strongly acid, with copious deposit of uric acid and oxalate of lime<sup>2</sup> (45, 46, *et seq.*).

#### *Sexual Organs.*

Sense of contusion in both testicles—of heaviness, with shooting along the spermatic cord, worse on right side<sup>1</sup> (53, 46).

Increased sexual desire<sup>3</sup> (51, 44; 53 45; excessive, 52, 19).

*Clinical Remark.*—In one case, a man of 50, of nervous temperament, who had suffered for years from sexual excitement, with seminal emissions about once a week, which symptoms were followed next day by frontal headaches, and

\* Since this paper was written I have found records of two cases of poisoning by oxalic acid and one by "salt of sorrel" (potassium binoxalate), in which there was produced acute desquamative nephritis with albuminuria (*Journal of the British Homœopathic Society*, ii., 477, and *id.* v., 85). In a case of poisoning (Hebb, *London Medical Reports*, N. S., ii., 475) the pelvis of the kidneys were found to be considerably more vascular than usual, and this condition extended a little way through the ureter.

profuse perspiration from the slightest exertion, I prescribed oxalic acid 3, *ter die*, with the result that he had no emission for a fortnight, then two with a short interval, and then none for two months, since which time I have not heard from him.

*Circulatory Organs.*

Palpitation<sup>2</sup> (54, 24 ; on three consecutive nights after lying down, 53, 50).

Pulse depressed<sup>4</sup> (then irregular—afterwards more frequent and fuller, 49, 6).

Pulse quickened.<sup>5</sup>

Pulse quickened and with increased tension<sup>8</sup> (50, 28 ; 53, 11 ; 56, 22).

Pulse small and contracted<sup>3</sup> (51, 4 ; 54, 33).

*Clinical remarks.*—Palpitation of the heart when lying down, dependent upon a rheumatic affection of the heart, was cured by Neidhard with oxalic acid (Burnett, *loc. cit.*, 320). Dr. Simpson has referred me to a case reported by Dr. Hale, of cardiac disturbance alternating with aphonia, in which oxalic acid 6 proved curative after other drugs had failed (*Amer. Homœopath*, Jan., 1879).

*Respiratory Organs.*

Tightness, difficulty of breathing<sup>4</sup> (49, 8 ; 54, 6 ; 54, 46 ; 56, 29).

Tickling in larynx, exciting cough<sup>3</sup> (49, 13 ; 50, 6 ; 53, 4 ; 53, 49).

Cough<sup>4</sup> (53, 4 ; 53, 49 ; 49, 13 ; constant dry cough on exertion, 49, 39).

Hoarse rough voice<sup>3</sup> (50, 24 ; 55, 36).

Rough, scrapy throat, can only speak with effort<sup>1</sup> (50, 43).

Alteration of voice.<sup>1</sup> "The man previous to taking the poison possessed a remarkably deep bass voice ; it was now reduced to a very low key, giving one the idea of a person talking in an undertone. This symptom remained for nearly a month without any amelioration. Nine weeks from the time of taking the acid his voice, though stronger, was still a complete old man's voice" (56, 2).

*Clinical remarks.*—I have already referred to the congestion of the mucous membrane of the air passages and of

the lung itself found after death from oxalic acid, and there seems to be some evidence of benefit derived from the use of oxalic acid in pulmonary cases. Dr. Burnett relates (*op. cit.*, 321), three cases in his own experience where rapid clearing up of congested states of the lung took place from oxalic acid after other medicines had failed. Peters (*Mat. Med.*, 64), speaks favourably of the acid in cases of chronic bronchitis and tubercular phthisis. He remarks, "Where cavities have existed in the lung we have several times observed the expectoration to diminish, the respiration to improve, the strength and flesh to return, and the cavity to dry up," under oxalic acid usually prescribed in the 12th dilution. Dr. John Hastings (*Lancet*, March, 1855), records three cases of tubercular phthisis with cavities in the lungs very materially benefited by half-grain doses of oxalic acid given three times a day.

*Chest.*

Stitches in left side of chest<sup>a</sup> (52, 13; 53, 5).

Aching in chest as if ulcerated<sup>1</sup> (49, 20).

Dull pain in middle of chest, extending to between the scapulæ<sup>1</sup> (49, 11).

Sore feeling at præcordia<sup>1</sup> (49, 14).

Sharp shooting pain in left lung extending to the epigastrium<sup>1</sup> (52, 8).

*Back.*

Weakness in loins and hips, extending to lower extremities<sup>1</sup> (52, 18).

Numbness of back<sup>a</sup> (in sacral region, 53, 51; and lower extremities, 55, 20).

Burning pain deep behind scapula<sup>1</sup> (49, 23).

Pain in region of kidneys<sup>a</sup> (45, 39; 56, 39; right kidney, 53, 44).

Shooting pains from loins to lower extremities<sup>1</sup> (55, 8).

Excruciating agony in lower part of back, extending down the thighs<sup>1</sup> (54, 31).

*Extremities.*

(*Upper.*)

Shooting pain in right shoulder joint<sup>1</sup> (51, 10).

Twitchings in both deltoids, chiefly the left, while lying in bed<sup>1</sup> (53, 12).

Pain as if beaten in muscles of upper arm<sup>1</sup> (50, 26).

Numbness in left arm<sup>1</sup> (55, 36).

Heaviness in left hand, fingers obey the will only heavily and slowly, and draw inwards<sup>1</sup> (50, 41).

Spasmodic contraction of hands<sup>1</sup> (56, 45).

Icy cold hands<sup>1</sup> (51, 6).

Tingling of finger-tips<sup>1</sup> (55, 34).

Pain in fleshy part of left thumb, with numbness and sensation of swelling<sup>1</sup> (53, 13).

Shooting, burning pain in right middle finger, mostly in last phalanx, like gout<sup>1</sup> (49, 35).

(*Lower.*)

Weakness in legs<sup>4</sup> (47, 19 ; 55, 20 ; 56, 40 ; spreading over whole body, 47, 25).

Uneasiness in legs and feet, can keep quiet for only a few minutes at a time<sup>1</sup> (51, 39).

Legs used to go to sleep for several hours a day, for nearly a month after the poisoning<sup>1</sup> (56, 5).

Numbness and tingling in lower extremities<sup>2</sup> (55, 20 ; legs drawn up towards abdomen,<sup>1</sup> 55, 48).

Toes of right foot spasmodically drawn downwards<sup>1</sup> (50, 21).

Slight lameness and stiffness in lower extremities<sup>1</sup> (53, 51).

Sticking pain in right hip joint<sup>1</sup> (54, 16).

Cramp in legs<sup>2</sup> (49, 30 ; 56, 46).

Shooting pain in right instep<sup>1</sup> (52, 10).

Aching in right ankle-joint, with feeling as if foot were swollen<sup>1</sup> (52, 1).

Cold feet<sup>1</sup> (49, 34).

#### *Skin.*

Increased perspiration all over body, especially in axilla<sup>1</sup> (47, 20).

Profuse night sweat<sup>4</sup> (49, 37).

Itching on neck<sup>1</sup> (53, 52).

Eruptions<sup>4</sup> [deep red mottled eruption on skin, in circular patches<sup>1</sup> (55, 9) ; skin of arms, chest, and face mottled<sup>1</sup> (54, 33) ; papular and itchy eruption all over body, which it reddened<sup>1</sup> (55, 40) ; skin of face, head, chest and nates covered with red spots or petechiæ, appearing as if bespattered with blood<sup>1</sup> (56, 28)].

#### *Sleep.*

Constant unpleasant dreams, with starting and waking up with fright<sup>1</sup> (51, 12).

Frightful vivid dreams<sup>1</sup> (53, 54).

Voluptuous dreams, for three nights and mornings in succession<sup>1</sup> (51, 45).

*Chill, Fever, &c.*

Chilliness after diarrhœa<sup>1</sup> (49, 19).

Creeping of cold upwards, from lower part of spine<sup>1</sup> (53, 57).

Body cold with clammy sweat<sup>1</sup> (54, 32).

Violent rigor, with contracted pulse and icy cold hands<sup>1</sup> (51, 4).

Chilliness, with heat on slight exertion<sup>1</sup> (50, 28).

Alternate chill and heat<sup>1</sup> (51, 1).

Flushes of heat and perspiration<sup>1</sup> (51, 48).

*Clinical Remark.*—Dr Burnett records a case of chills in the calves of the legs and across the lower part of the back by day, replaced at night by feeling of heat in the same parts, of many months' duration, cured within a fortnight by oxalic acid 3 (*loc. cit.*, 320).

I have purposely omitted any clinical remarks under the headings "General and Mental," "Head," "Back" and "Extremities," for the reason that the derangement set up by oxalic acid presents such an admirable picture of the *status morbi* known as neurasthenia that the resemblance is worth special consideration. For instance, we have the aversion to mental and physical exertion—the muscular prostration, headache variously located and the sense of heat in the head, the dyspeptic symptoms, the sexual excitement (as often a consequence as a cause of nervous exhaustion), the palpitation, the pain and weakness in the back, the numbness and tingling in the extremities, the easily produced perspiration, and the restless sleep with unpleasant dreams—all common symptoms in sufferers from neurasthenia, and all prominent in the provings of oxalic acid.\* In the whole range of our *materia medica* I do not know of one single drug which so distinctly "covers the symptoms,"

\* A fatal case of poisoning by oxalic acid absorbed through the hands, where a saturated solution had been freely used for chemical purposes, is recorded by Dr. Boericke in *Med. Cent.* for August 1, 1894. There were intense pains in the head, hyperæsthesia, especially to light, spasms of pain down the extremities, along the throat muscles, and through the spermatic cord, and sensitive spots on the spine.

to use a common expression, of nervous exhaustion as we usually meet with it, as does oxalic acid; and, indeed, if my contention be correct, that the poison acts as a primary stimulant, followed, like all over-stimulation, by exhaustion of the nerve cells, we can easily understand the resemblance between its pathogenetic symptoms and those of nervous exhaustion produced by the various worries and habits of modern life. We have here, I take it, what we always ought to strive for in our practice, the homœopathic simile in symptoms *and in pathology as well*. Oxalic acid, then, ought to prove a valuable aid in our medicinal treatment of neurasthenia, and though my experience of it has only been of short duration, I have had several cases where it has done great service. One case of Dr. Burnett's and two of my own sufficiently show the benefit to be derived from oxalic acid in the treatment of this most troublesome condition.

(1) Mary W., aged 16, complains of aching in lower back for three months, pain between shoulders, pain and tenderness along the cervical vertebræ, pain in occiput, vertex, and forehead off and on for weeks; all pains increased or brought on by exertion. Ac. oxalic. 3, a pilule every four hours. After two days' aggravation of the pain in the neck and back, the pains completely disappeared (Burnett, *loc. cit.*, 319).

(2) Miss S. Severe headaches for a long time, principally occipital, with much mental depression. Sleeps badly, with frightful dreams. Ac. oxalic. 6, every four hours. In three weeks she reported, "headaches have been much better; I am much less depressed, am sleeping better and have fewer dreams. I never had a medicine that produced such a good effect." I ordered the oxalic acid to be continued at less frequent intervals, and have not heard from the patient since.

(3) Mrs. E. For several years has suffered from constant dull aching of lower part of back, with pain extending to occiput, with some numbness; aching of the backs of the knees and thighs after the slightest exertion. A slight improvement followed the administration of phos. acid and zincum met., but relief was not really obtained until I ordered oxalic acid 6, three times a day. A month later she reported great improvement in spite of the long continued dull depressing weather, which usually made



her worse; the backache and numbness had not been felt for the last ten days, and she can get up stairs quite easily. Repeat prescription. I have not heard from her since.

From my experience of oxalic acid in the above cases, and in others of which I have not kept careful notes, I have every confidence in recommending it to your notice in cases of neurasthenia; but we must bear in mind the fact that these patients are usually so sensitive to the action of drugs that harm rather than good, or at any rate a temporary aggravation of the symptoms, may follow the use of the drug in too low a dilution. I have usually found good results from the 3rd and 6th centesimal.

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In the discussion which followed, the suggestions contained in the paper as to the probable beneficial results to be obtained from the use of oxalic acid in such troublesome cases as the various forms of neurasthenia, gastritis, and membranous colitis were specially commented upon and welcomed. Reference was also made to the treatment of oxaluria by means of oxalic acid—a proceeding which had been adopted personally by one of the speakers, though without appreciable benefit. The similarity existing between the pathogenetic effects of picric and oxalic acids was noted, and it was suggested that the latter might prove useful in the treatment of diseases of the spinal cord.

Dr. HAWKES, quoting from Dr. Burnett's paper on oxalic acid, said that burning pain extending from the stomach upwards was the guiding symptom for its use in gastric cases.

Dr. COX gave the notes of a case of aphonia, following upon diphtheria, in which oxalic acid 2 had proved curative. The patient was a female of neurotic temperament, whose general condition also improved considerably under the oxalic acid.

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## A NOTE ON FUNCTIONAL DYSMENORRŒEA, ESPECIALLY FROM THE POINT OF VIEW OF DRUG THERAPEUTICS.<sup>1</sup>

BY EDWIN A. NEATBY, M.D.

WHEN, in a moment of weakness, I accepted the honour proposed to me by the acting sectional secretary, of presenting to you a paper as representing the *Materia Medica and Therapeutical Section*, and also agreed to the subject of the treatment of dysmenorrhœa, my eyes had not been opened. It was one of our greatest of English philosophers, if I remember rightly, who said, "Reading maketh a full man, writing maketh an accurate man, and speaking a ready man," or words to this effect. When I faced my subject, I realised that I was empty, vague and tardy, and that I was going to "make bricks without straw." Now, although this Society is a long-suffering body, and if it errs, it errs in an excess of kindness to its contributors, yet there is a point beyond which it is not safe to go in trying its indulgent patience. I have known "vacant chaff," though "well meant for grain," to be received with scathing scorn and killing ridicule. In self-defence to-night I wish to point out that if my paper is somewhat empty, it is not *all* my fault. To prove my position, may I say that the "Cyclopædia of Drug Pathogenesy" supplies us with only twelve drugs to meet this condition (dysmenorrhœa), viz.,—asarum, bromine, cactus, carbo-animalis, actæa, curare, cyclamen, lappa, phosphorus, sulphur, viburnum, xanthoxylum.

*Asarum* is a drug in small type in the "Cyclopædia," and it is said not yet to have found a place in the homœopathic materia medica. The one symptom, menses premature, free, dark and painful, is given, and the dose of the provers was from ʒj. to ʒiv. daily, but in how many this symptom occurred, we do not know.

Of *bromine* we are told that in doses of ten drops daily

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, May 4, 1899.

of a solution of one drop to one pint of water and continued for weeks, it will "almost certainly produce membranous dysmenorrhœa." No evidence is given.

*Cactus* was proved by one woman in a manner not stated, and we can only infer that the "horrible pains with menstruation" were the result of the drug. Possibly by analogy we may use this drug in spasmodic dysmenorrhœa.

*Carbo-animalis* has a symptom from the "Chronic Diseases" supplied by Hartlaub and Trinks, and hence probably by Nenning (Hughes). The pain is of a pressing character to the groins and back (sacrum).

The *actœa* symptom, "more pain during menses," was obtained after one dose of the tincture.

*Curare* bears evidence of genuineness, and deserves a study.

*Cyclamen*.—Here menstruation one week late was accompanied by labour-like pains and clots, after two doses of cyclamen. It is highly improbable that the medicine had anything to do with this symptom.

*Lappa*.—The burdock dysmenorrhœa is a pain in the back. This drug also merits study.

*Phosphorus*.—In the case related menstruation was attended by pain in uterine and renal regions, and was a genuine result of the poisoning, but menstruation was scanty.

*Sulphur*.—Scanty, painful menstruation is said to be due to drinking Harrogate water.

*Viburnum*.—After four doses of ten drops, terrible sudden crampy pain came on in the lower abdomen. With confirmation this might be a valuable guide.

The *xanthoxylum* symptoms are the most striking of all, and deserve our confidence.

With material such as this we are asked to treat dysmenorrhœa! Is not a record such as this enough to rouse us to seek careful experimentation with drugs acting on the female reproductive organs? Were we each one to secure one intelligent woman prover, the chief difficulty would be overcome. For the sake of our own reputation and of suffering womanhood, let us seek volunteers at once.

There are two methods of undertaking the treatment of a case: one is to treat the patient and the other is to treat the disease. Now, as homœopaths, we shall probably all admit that the former is the better way. It was Hahnemann's way; for to select a remedy by the totality of the symptoms is to treat the patient. But this is not a fruitful method for communication to others—for teaching purposes. Hahnemann's lectures on Therapeutics, in the main, are summed up in the laconic dictum—"Study the *materia medica*." The best possible advice, no doubt; but we want also the next best sometimes. In our consulting rooms we probably unconsciously adopt now one method, now the other. Let me give an example of the former, or constitutional, method. Mrs. G., aged 31, presented herself in the out-patient department, fifteen months ago, to be treated for menstrual pain and pain in the left side of the abdomen. There were no leading menstrual symptoms; the pain was situated in the hypogastric and lumbo-sacral regions, began two days before the period, and had a total duration of three. The pain was fairly constant. Retroflexion of the uterus was present. Stannum, calc. phos., sepia and nux vom. were her medicines, given on general indications. She wore a Hodge's pessary part of the time, but it did not prevent the displacement, and for ten months she has been free from dysmenorrhœa. This I call treating the patient. Some of the remedies may have had a direct reference to the pelvis as well; the others had none. If you ask what were the indications, I do not know. Ordinarily we trust to our knowledge of the *materia medica* and to empiricism. Sometimes we consult the *materia medica* even in front of the patient; occasionally we repertorise. But there is not time for much of this kind of thing in out-patient work. When we do it, it is because a case hangs fire, or we feel out of our depth. As a fact, the following are the remedies which, on looking over my case-books of the past five years, I find to have been mostly given in cases of dysmenorrhœa, *where relief has followed*:—Nux vom., natr. mur., ign., ferr., calc. phos., calc. carb., verat., hydrast., puls., sepia, bryonia, nitric acid., sulph., cocculus, rhus, phosph., graph., ars.,

lycopod., silicea. This is a list as confusing and as uninteresting as a text-book, and has not even the merit of being in alphabetical order; indeed, it is in no order whatever. Now, one is tempted here to repeat Hahnemann's instructions, when answering the question, "What are the indications?" They are to be found in the materia medica and symptom lists in Hughes, Wood, Farrington, Lilienthal, &c. But you do not come here to-night to be told this. I can only place before you my own general ideas of how I have prescribed these medicines, and do prescribe them, whatever is the name of the patient's malady. The reason I bring them before you here, and now, is that I find that the exhibition of these drugs has been followed by relief or cure in a considerable number of cases where women have come complaining of various ailments, with dysmenorrhœa prominent. Others quite different may be indicated in subsequent cases, but I submit for your criticism the results obtained in practice for what they are worth.

In selecting a drug one often, by instinct, groups one's choice round a particular system—for instance, the digestive. In women with pelvic trouble the digestion is often disturbed. Of the drugs already mentioned, nux vomica, pulsatilla, bryonia, and lycopodium are the most prominent digestive remedies. *Nux vomica*.—My indications are:—(1) Morning headache, passing off after breakfast, often accompanied by nausea; the pain becomes throbbing with active exercise in the open air. (2) Indigestion, where dull heavy pain and fulness follow food, or where there is acute crampy pain in the upper part of the abdomen (often known as "spasms"); with this are constipation, often associated with ineffectual urging, and hæmorrhoids, when bleeding is not prominent. (3) The tongue has a yellowish coat towards the back. (4) The sleep is disturbed in the early morning with heavy sleep later and want of refreshment by the sleep. (5) In thin, dark-complexioned women, of irritable, active, worrying temperament, it is especially useful. (6) In the reproductive sphere, nux vomica is characterised by *free* menstruation and by thick yellow leucorrhœa, and with striking irritability and restlessness at the menopause.

*Pulsatilla*, as you know, has many of its indications opposed to *nux vomica*. (1) Its headache is worse in the evening, worse from hot rooms, and markedly better from gentle open-air exercise. It is also often unilateral (not "semi-lateral," as often stated in the books); either side, perhaps more often the left. (2) The indigestion is not usually accompanied by constipation, though this is no contra-indication if other symptoms are well-marked. Nausea and sour taste, with flatulent pain in the evening, relieved by the passing of flatus in the morning, salivation, tasteless eructations, and feeling of a weight or hard lump, likened to the presence of a stone, in the epigastrium or lower down, are also striking *pulsatilla* symptoms. (3) The tongue has a coat of white, not specially localised. (4) The sleep is worse at the early part of the night, keeping the patient awake for an hour or two. The mind is too busy (like *coffea* and *bell.*) or the awaking is associated with a confused feeling (like *lachesis*). (5) These symptoms are often in women of the pale, fat, fair type, who are chilly and are mild in manner. This does not prevent these ladies from being very irritable at times, but they easily dissolve in tears. (6) Pelvic symptoms are scanty, irregular menstruation, blood pale in colour; and leucorrhœa, free, constant, thin, white or yellow in colour, usually bland, but liable to be acrid near the period.

*Bryonia*.—(1) The headache of *bryonia* is chiefly occipital, but a shooting pain, extending from the front to the back, is a characteristic symptom, contrasting in this with *silica*. All the head symptoms are worse from movement, from exertion, and in the morning after beginning to move about. Moving the eyeballs also increases the head pain. (2) The indigestion of *bryonia* is chiefly a sharp cutting pain, through from the epigastrium to the back, aggravated by movement, especially on any jarring; sour eructations are a conspicuous feature. Although it is for constipation that *bryonia* is chiefly used, it must not be forgotten that it is an intestinal irritant, and that a sudden urgent colicky diarrhœa (especially nocturnal) is caused and cured by this drug. (3) The tongue is dry. (4) There is drowsiness in the daytime, with rest-

lessness the early part of the night. (5) The temperament of bryonia patients considerably resembles that of nux cases, but the face is often red, especially after meals. (6) In the pelvic sphere profuse and premature menstruation are found.

*Lycopodium*.—(1) The chief feature of a lycopodium headache is the unusual one of being aggravated by lying down. The dyspepsia is a slow intestinal digestion with flatulent distension occurring from one to two hours after a meal, accompanied with extreme afternoon drowsiness. There are rumblings in the abdomen, and the presence of gas pressing down into the rectum. Colicky pains often pass from right to left, and if the well-known 4 to 8 o'clock aggravation of these symptoms be found clinically, the fact would strongly confirm the choice of lycopodium. The bowels are constipated, and no inclination to start is felt. (3) I do not know any special tongue symptoms. (4) Sleep is heavy. (5) Dislike to solitude, and a general nonchalance or indifference, are further indications. (6) The pelvic indications are chiefly the well-known urinary ones—uric acid and also urates. I do not use any special menstrual symptoms, though I think the tendency is towards excess.

Of the drugs which group themselves round the menstrual condition, calcarea carb. comes first, in my judgment. Briefly considered, it is required with profuse premature menstruation; the aggravation by emotion or excitement, which will bring back the flow if just stopped, or increase it if present, is a most valuable indication. If to this be added, cold damp feet, slow digestion, acid eructations, and a pale flabby appearance and easy perspirations, calcarea will prove invaluable. I consider it one of our most valuable drugs, especially from the 6x to the 12c dilutions. In nitric acid the flow is also increased, and there is a tendency to salivation, sore mouth, bleeding gums and acidity. The tongue is covered with a thick dirty yellowish coating, and may be indented; ulceration of mucous membrane of mouth is common, and there is a free acrid leucorrhœa.

The *hydrastis* symptoms are very closely allied to those of nitric acid, but without the acidity, the tendency to

ulceration or the acidity of the leucorrhœa. In both, the bowels are constipated.

The next remedy with menstrual excess is *phosphorus*. Its mental symptoms shew remarkable alterations of depression and exhilaration, the head symptoms (very various) are worse from noise, or stooping, or walking. Protruding hæmorrhoids very sensitive to touch, though not inflamed, call for the remedy; so also does cough in a tall, fair, pale, thin-skinned woman of strumous type.

*Natrum mur.*, *sepia*, *graphites*, have lessened menstruation and constipation. The complexion of all tends to be pale and sallow. The *sepia* patient has, in addition, a sinking in the epigastrium, especially in the middle of the morning, frequent micturition with deposit of urates in the urine, frequent flushes of heat and cravings for air, sense of constriction of clothing round neck or chest. The patient is spare and dark by preference. With *graphites* the skin is often irritable, with moist scabby eruptions, the feet perspire, piles may be present, and dyschezia due or not to fissure and a thin acrid leucorrhœa are often present.

#### Cases. (General Constitutional.)

Miss C., aged 22. November, 1896. Dysmenorrhœa acquired after the first two years. Menstruation premature and profuse; pain before the period lasting until the second or third day, fairly constant. Has leucorrhœa, yellow and irritating; worse at night. Patient is always chilly, cold damp feet and hands. Palpitations; constipation, with ineffectual urging; perspires easily. Took calc. carb. 6 until March, 1897. At the end of this time was brighter and stronger; she had very much less pain, and the periods were not premature. A cervical "erosion" disappeared during the treatment.

Fräulein H. S., aged 42. On June 11, 1898, came for menorrhagia and dysmenorrhœa; chief pain in hypogastrium, very severe for several hours; onset with the flow; no vomiting. The severe paroxysm may be at the first, second or third day; yellow acrid leucorrhœa; bowels constipated; perspirations under arms and on chest. The remedies were hydrastis and sulphur. In three months greatly improved.

A. J., aged 28, single. No pain if catamenia were early; but



if normal or late, pain before and during period. *Site*—Hypogastric, left iliac and dorsal regions. *Nature*—Dull, heavy, worse on pressure; uterus found anteflexed; also hyperplastic cervicitis. *Treatment*—Chiefly ferrum picricum. *Result*—Gradual decrease of pain at catamenia during three months; was easily tired; perspired readily, and had alopecia. Acid. phos. 1x next month; felt better, and had had much less pain at last catamenia.

M. M., aged 25, single. Dysmenorrhœa; had had acute rheumatism. *Time*—Day before, gradually diminishing. *Site*—Lower part of abdomen. *Nature*—Paroxysmal; on examination nothing abnormal found. *Treatment*—Nux vom. 3, night and morning; xanthox. 1x three times a day. *Result*—Much less pain at the two succeeding periods.<sup>1</sup>

Turning now to treatment of the disease,—of the pelvic condition, a few words are first necessary as to classification. The title of this paper excludes marked lesions, *e.g.*, real stenosis, congenital or post-operative, due to cancer or fibroids; and demonstrable inflammation, whether uterine or perimetrial, &c. The bulk of the cases of functional dysmenorrhœa can be divided into spasmodic and congestive. Either may be original or acquired. In the spasmodic cases the pain comes in paroxysms, which vary from three to thirty minutes; more commonly they last only five to ten minutes, and the intervals vary in length. The pain is severe as a rule, and is variously described; the patient may walk about bent, or sit “bent double,” or roll about the bed in agony. It is sometimes bad enough to cause fainting, and often causes vomiting. Relief may temporarily ensue with the vomiting. In the intervals the patient is comparatively free, with only a substratum of aching. The paroxysms are spread over twelve to twenty-four hours, seldom as long as the latter, and the onset of the pain usually coincides with the onset of the flow. The suffering is not relieved by lying down, nor appreciably by hot applications; it is relieved by alcohol, and aggravated by ergot. This form of dysmenorrhœa is most common in single women, and in those of good health, which, however, may become impaired by the repeated pain, a neurotic condition

<sup>1</sup> For the notes of the last two cases I am indebted to Miss Edith Neild.

and sleeplessness being developed. Newly-married women, of course, may suffer, and married life usually causes aggravation in my experience, though this is denied by some. A long period of sterility certainly does so, while child-birth almost always cures, permanently and entirely.

*Congestive dysmenorrhœa* differs in many important clinical features from the spasmodic. The pain is less severe, but lasts much longer, and is constant instead of paroxysmal. It begins before the onset of the flow, from one to seven days, is gradually relieved by the persistence of the hæmorrhage, by lying down, and by hot applications. It tends to be aggravated by alcohol, by married life, and is not cured by child-bearing. These two forms of pain may be pure (*i.e.*, separate) or mixed. Spasmodic attacks may be associated with the less active congestive form. In the former, menstruation is usually scanty; in the latter it is more often free or excessive. The pathological condition in the former seems to be, as its name implies, one of spasm. Champneys has assumed what he terms a state of polarity normally existing, whereby when the body of the uterus contracts the cervix is relaxed and *vice versa*. In the spasmodic form of menstrual pain the polarity is supposed to be disturbed, and while the internal os is tightly closed, the body strongly and paroxysmally contracts. Hence the intermittent pains with comparatively free intervals. Now it occurred to me that a condition analogous to this—one of intermittent spasm—is induced by ergot, and I noticed that a recent text-book stated (as I have already mentioned) that this form of pain is aggravated by ergot. I concluded that, in accordance with our guiding rule, ergot should be a remedy for these cases. On the whole I have not been disappointed.

On the other hand, sabina has less spasm and more congestion. I have therefore used this drug as the chief remedy in the congestive cases. If the cases are mixed, I give the sabina during the intervals and add secale for the paroxysms when they arrive. I have not used sabina higher than the third decimal dilution, but secale I have given from the 2x to the 12x, and am not yet sure which acts best. I prefer to keep low where I can.

During last year Dr. Wilkinson, of Windsor, sent me a young married woman with dysmenorrhœa of the congestive type, where the pain was very severe and the flow excessive. She was thin, weak and losing flesh, and much pulled down by the periods. I made several alternative suggestions in case of failure, for I was not very hopeful about the case, and amongst these advised hot douches. On enquiring not long ago Dr. Wilkinson very kindly wrote to me saying she was better, and that "calcareæ phos. and sabina cured her by themselves."

Miss B., aged 31, single, acquired spasmodic dysmenorrhœa; pain occurs in fits and starts of ten to fifteen minutes; relieved by passing clots; intervals vary from one to four hours. Menstruation is profuse; even if lying down she uses three to four diapers daily. She is pale but well nourished; is able to walk all day long between the periods. Decided improvement after *secale 2x* in the interval and *secale 3x* every hour at the period. Less pain, less hæmorrhage and less clots.

E. C., aged 24, single. *Pain*—Worst the first day; lies in bed; aching and forcing pain in hypogastric region, back and legs. First catamenia at 14 years, but no pain till 17. *Examination*—Sound caused pain; ovaries tender. *Treatment*—Galvanism, also *nux vom.*, *aurum* and *ign.* at different times; much better for four or five months, when again much pain. *Secale 3x*  $\eta$  iii. t. i. d. and every hour at period did not give much improvement, but with *secale 6* pain was much less.

M. H., aged 33, married. Dysmenorrhœa always, but much worse the last three or four years. The pain commences from two to three hours before the flow, and continues for about four days. It is chiefly in the hypogastric and sacral regions, sharp paroxysms during which the flow was greater. Passage of sound caused pain "like period," sound not gripped. *Treatment*. With *cocc. ind.* the pain was as bad as ever, but *secale 3x*  $\eta$  ii. every half hour relieved; then *secale 3*  $\eta$  v. night and morning. After next period no pain except a little on second day (always the worst). Had never had a painless period before.

Let me state in conclusion as a summary:—

(1) Our pathogenetic material bearing on dysmenorrhœa is lamentably deficient, and urgently calls for fresh provings on women in a scientific manner.

(2) A large proportion of our cures are made by prescribing "for the patient," *i.e.*, on general constitutional indications.

(3) There are two important drugs which correspond respectively with spasmodic and congestive dysmenorrhœa, *viz.*, *secale* and *sabina*. These are best given between the periods two or three times a day, and at the time every half hour or hour. The higher dilutions of *secale* seem to act better for the immediate relief of pain. The typical spasmodic case must be accurately selected for on the lines laid down to secure the success of the remedy.

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Dr. HUGHES said that the "Cyclopædia" might seem to have been rather impugned because it only gave twelve medicines that produced painful menstruation. That was not the fault of the "Cyclopædia." It was because the editors could find no more than twelve remedies throughout the whole series of genuine accepted provings which were reported to have produced dysmenorrhœa. He noticed with interest the classification which Dr. Neatby made, and he thought that the two medicines which he had indicated as chiefly valuable for the spasmodic and congestive forms of dysmenorrhœa would commend themselves to most of the members. He had not used *secale* much, because he found *caulophyllum* so useful in the spasmodic form. Moreover, *secale* induced unintermittent contraction in labour, and therefore had to be used cautiously. He did not think that such intermittent spasmodic contraction as was present in dysmenorrhœa was so specially characteristic of *secale* that that medicine should be preferred to any other. Where the menstrual flow was scanty it was generally dark, and then he found *pulsatilla* in low dilutions better than any other medicine. When the flow was profuse the medicine he generally used was *xanthoxylum*. For spasmodic dysmenorrhœa, *gelsemium* was of the greatest use as a temporary palliative. At the International Congress at Philadelphia in 1876, the general consensus of opinion was that for dysmenorrhœa, *gelsemium* was the most comforting medicine during the period itself. The suggestion was made that it should be given in hot water. That was an important point, because the least amount of cold liquid taken on the stomach at the time of the period would invariably bring on the spasmodic pain. If the water was held in the mouth until it was warm, that cause was obviated. He looked

upon gelsemium in the first decimal rather as an antipathic palliative. Given every hour during the period it was quite harmless to the system, and, in suitable cases, was nearly always useful. When the pain was distinctly ovarian, he had great confidence in hamamelis.

Dr. LOUGH, unlike Dr. Hughes, had used gelsemium in the strongest preparation obtainable, viz., Keith's mother tincture. His usual dose was from 3 to 5 drops three or four times daily, and, up to the present, he had never prescribed it in a case of dysmenorrhœa without considerable benefit, and very often with the effect of relieving all the symptoms. He usually gave it for five days before, and during the first two days of, the period.

Dr. BURFORD said that Dr. Neatby's discovery of ergot as a remedy in the treatment of dysmenorrhœa entirely coincided with his own experiments. His results, however, had not been so satisfactory; in fact, ergot had almost fallen out of the usual list of remedies with which he treated a case of dysmenorrhœa. Possibly it might be that the range of dose had not been sufficiently ample. Gelsemium, viburnum and xanthoxylum he regarded as palliatives. An excellent *curative* medicine was caulophyllum. In cases of spasmodic dysmenorrhœa, he had seen caulophyllum cure case after case, even of those which were severe enough for operation. His usual dose was 3x during the interval, and 1x at the time of the period. Dr. Neatby's division of cases of dysmenorrhœa into either spasmodic or congestive was an eminently clinically correct one. In dealing with a case, the first thing to be determined was whether it was of the spasmodic or congestive type. If that differentiation was not made the treatment would probably be sterile. The remedies calculated to help the spasmodic condition were perfectly useless when applied to the congestive type. A painstaking enquiry into the probable cause of the dysmenia was essential. In fifty per cent. of the cases the cause was constitutional. Prolonged standing was one of the predisposing causes which must be remedied if the cure was to be permanent. If internal examination was—and it was not invariably a justifiable procedure—impossible, a very correct delineation of the local causes might be obtained by a careful study of the clinical history. The defective development of the uterus was a most frequent local cause. He had seen cases in which the patients had begun to menstruate with acute aches and pains, which continued without any amelioration, and in such cases the uterus was often of an infantile type. Very little could be done by medicinal treatment for the amelioration of

such pain, because menstruation, as a function, had occurred before the uterus, as an organ, had reached its maturity. He cordially agreed as to the value of Dr. Neatby's paper.

Dr. MADDEN entirely agreed with Dr. Burford that gelsemium, viburnum, and medicines of that class, were purely palliative remedies. Belladonna was also quite on a par, if not in advance of, gelsemium in that connection. He could also endorse the recommendation of caulophyllum as being really curative in certain cases.

Dr. NEATBY, in reply, said that with respect to gelsemium he was sorry that he had not been able to record many successes in marked cases of spasmodic dysmenorrhœa. The pains were so agonising, and the time that most medicines took to act was so considerable, that he had often been disappointed. More good would be obtained, he thought, by the intermediate treatment, whether the cases were constitutional, or based on the mere local conditions at the time. With respect to Dr. Hughes' hint about ovarian pain, one sometimes did not know that a pain situated in that position was an ovarian pain at all, and it must be accepted as a clinical fact without basing any pathological conclusion upon it. The value of a treatment such as he had alluded to was that in many instances where it could not be decided what was the precise pathological deviation that the patient had, by a careful selection the condition could be cured without it being known scientifically what the disease was. With regard to secale, by reference to the notes of the cases which he mentioned he found that the higher dilutions, 3 and 6, acted best. He did prescribe caulophyllum, but there was not much pathogenetic information on the subject. It was not one of the famous twelve remedies of the Cyclopædia. He agreed with what had been said as to constitutional treatment. Of course, in practice he strove to ascertain the cause and to remove it. He was sure that in many instances the statement that the patient had menstrual pain might be ignored, and the pain cured by selecting a remedy which met other deviations in the patient's health. Where one was uncertain as to the physical condition, a rectal examination had not the objections which a vaginal examination had, and all the information required could be obtained by that method.

The PRESIDENT remarked that in the course of a long experience his remedies had been actæa, cocculus, gelsemium, and, very occasionally, viburnum and xanthoxylum; but he held with Dr. Burford that for the cure of dysmenorrhœa, rather than mere relief, constitutional treatment was needed.

CASE OF AN ENORMOUS MEDIAN DERMOID OF THE MOUTH.<sup>1</sup>

BY JOHN D. HAYWARD, M.D.LOND.

DERMOID cysts of the mouth (generally classed with ranulæ) are sufficiently uncommon for an exceptionally large specimen to be worthy of a short note.

Mrs. H., aged 59, has had a small growth beneath the tongue for about forty years. This increased very slowly in size, and has been regarded and treated as an ordinary mucous cyst or ranula. When she was 17 years of age a seton was passed and various caustics were employed, without any advantage. Very slowly the tumour grew larger, and the woman refused any interference; because, so she says, everyone told her that such interference would be fatal. A year ago the growth was the size of a hen's egg; it then began to grow rather more rapidly, and, during the last three months it has much increased in size. From first to last it has not been painful or tender.

The patient was first seen by me on the morning of April 18, 1899; her condition for a few days previous had been alarming, and a doctor inserted a seton which seemed doing no good. I found a thin, ill-looking woman, propped up in bed and disfigured by an enormous growth protruding from the mouth. There was some difficulty and rattling on breathing, and I was informed that she had been in a distressful condition, and almost choked during the last two nights.

The tumour fluctuated below, but seemed thick and solid above. The mouth was widely distended, the lips thin, stretched and everted, and superficially ulcerated where they surrounded the growth; there was also a line of superficial ulceration on the tumour, where the lips rested upon it. A thin spatula could not be passed in between the swelling and the lips or gums in any direction. The woman had not been

<sup>1</sup> Read to the Liverpool Branch, Thursday, May 11.

able to articulate for a fortnight, and, for the last eight days, it had been impossible to get in even liquid food. The patient was evidently very feeble, and I urged immediate operation ; for which she and her relations were now desirous, as they considered her to be moribund. She was removed to the hospital, and, before I interfered, Dr. Ellis kindly took the photograph of which I exhibit a print, which will demonstrate the great size of the growth better than any description. The members of the hospital staff were afforded an opportunity of seeing the case.

We are often amazed at the amount of easily remediable discomfort and suffering which an individual will endure rather than permit any interference, however slight, which can justify the dreaded word "operation." I have quite recently had considerable trouble in replacing a dislocated patella, which had been out of place for about three months ; the woman remaining in bed helpless, and with a swollen and painful knee, firmly refusing that any doctor should be called in, for fear he would want to "do something." The photograph will evidence that this is a remarkable instance of similar perversity, and I am unaware of so large a ranula being figured.

The treatment I have adopted, in the few ranulæ that have come my way, is:—In moderate-sized specimens to inject a few drops of pure carbolic acid by a hypodermic needle ; this is simple and painless, and generally ensures speedy shrinkage and cure. In larger-sized specimens I excise a portion of the anterior wall, and swab out the cavity with iodine or carbolic acid. Setons are tedious, dirty, and unsatisfactory, while a simple incision is futile, as are drugs. In the present case a few inhalations of chloroform were administered, but the obstruction to breathing was so pronounced that further anæsthetic was inadvisable.

I made an incision into the more prominent upper portion of the tumour, and, to my surprise, found that this was the tongue ; flattened, stretched, and so altered in appearance by exposure that we did not recognise it. I then made an incision lower down, in a more distinctly elastic region, and out spurted several ounces of watery





Cystic Tumour of the Mouth.



fluid, containing a large number of small, round bodies, the size and colour of small dried peas, and the whole smelling so abominably that I had it removed from the theatre and the window opened before proceeding. This fluid was milky and slightly purulent; the contained bodies were putty-like, and felt fatty. They were apparently what are known as "epithelial pearls" and on examination were found to consist of organic matter, with a basis of phosphates and traces of lime salts. I have a number of them here for your inspection.

I emptied the cavity, swabbed it well out with boracic lotion, and then mopped its surface with pure carbolic acid. A large sac remained extending far back to the root of the tongue. With scissors I cut out a piece of the wall, the size of a five-shilling piece, and then I plugged it with iodoform gauze and stitched up the incision in the tongue. Two vessels in the thick fleshy walls required ligature. There was a patch of sloughy ulceration in the left roof of the mouth, evidently from pressure, and two molars and a bicuspid in the left upper maxilla were pressed out of their sockets; I picked them off with pressure forceps. These were the only teeth left in the mouth except a few decayed stumps.

After the operation the mouth could still not be closed by a couple of inches over the swollen tongue and folds of thick, fleshy mucous membrane. A nutrient enema was given, followed by beef-tea and milk through a tube. The mouth was frequently washed out with Condy and the ulcerated lips smeared with calendula ointment.

Next day the mass was sensibly less, and a drain of gauze was left in each corner inserted to the back of the sac. A wash of peroxide of hydrogen was used for the unhealthy mouth and sac. There was some pyrexia for four days, but the patient did very well. In a few days she could talk, and in less than a week could shut her mouth. She took a good deal of food, and rapidly improved in appearance and strength. In a little over a week she returned home, being anxious to celebrate her birthday. She returned every other day for inspection. Three weeks after operation there was

still a considerable cavity and some redundant membrane ; but these are now almost unnoticeable, reduced to fleshy folds round a cavity the size of a walnut, and in a week or two will no doubt be imperceptible.

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CLINICAL CASES, SPECIMENS, &c., EXHIBITED  
AT VARIOUS MEETINGS.

*A case of Jacksonian epilepsy caused by a cyst of the cortex cerebri.*<sup>1</sup>

E. A., aged 20, female, single, of no occupation, attended the out-patients' department of the London Homœopathic Hospital on May 5, 1898, stating she had suffered from "fits" for eleven years.

*History.*—Patient had a fall at 5 years of age, when she knocked some teeth out. The present illness began with loss of power in the left hand and tingling, which occurred in transitory attacks of half an hour's duration. Later on the same thing occurred, with loss of consciousness and biting of the tongue. Two years ago the attacks ceased as far as loss of consciousness was concerned, but since then and continuing until now she has attacks of convulsions which are limited to the left upper extremity, and accompanied with weakness of the left leg. The attacks occur sometimes every day, sometimes only once in fourteen days. They seem to be aggravated by any emotional disturbance, and at the menstrual period. An attack begins with a sensation of "deadness" in the left infra-mammary region, which seems to pass up the side to the head. There is always much headache of a throbbing character on the right side of the forehead, and general languor after an attack. The symptoms observed were, weakness of the left arm and hand, grasp of the left hand is much feebler than the right, and that hand is appreciably smaller and thinner than the other. Common sensation is dull at the back of the thumb and index finger, tactile sensation is normal; reflexes are normal; there is no optic neuritis. A

<sup>1</sup>(Exhibited at the Clinical evening, June 2, 1898, by Dr. GOLDSBROUGH. The notes of this case were omitted from the Journal of the Society for October, 1898, but as the patient has since died, with the result of the *post-mortem* examination they are deemed worthy of record.)

convulsive attack was observed on the occasion of one of the patient's visits. It consisted of clonic contractions of the left thumb and index finger, rhythmical in character, about sixty to the minute at first, gradually subsiding in rapidity, but increasing in strength with the subsidence.

The patient was under observation until the beginning of April of the present year. The attacks varied in frequency under treatment. She had a complete attack of epilepsy on December 13, 1898, with much headache afterwards. For a month or two before death she had frequent jerking of the limbs.

On April 8 she had a severe attack of complete epilepsy, beginning in the left side. She never recovered consciousness, and died in about two hours.

A *post-mortem* examination was made by Dr. Peter Harper, of Hornsey, who has favoured Dr. Goldsbrough with the following report:—"Death was immediately due to rupture of one or more vessels in the motor area of the brain—there was an excessive amount of hæmorrhage, more than usual in such cases. A cyst was found on the motor area about the size of a hen's egg."

Dr. Harper considered this cyst to be a porencephalic cyst of the German writers.

*Uterine fibroid removed by hysterectomy—recovery.*<sup>1</sup>

The symptoms were chiefly those due to pressure, vesical troubles being most pronounced. The patient was unable to follow her avocation for this reason. At operation the bladder was found extensively adherent to the uterus. The patient made a good recovery: and returned to the active duties of life.

*Double pyosalpinx; two suppurating Fallopian tubes removed from a patient aged 27; abdominal section—recovery.*<sup>2</sup>

The patient had had two children, the last only thirteen months previous to operation. The chief symptoms were acute and constant burning pain in the lower abdomen; and irregular uterine hæmorrhage.

*Necrosed vomer and other bones.*<sup>3</sup>

The bones were removed from a case of syphilitic disease of the nose.

<sup>1</sup> Exhibited by Dr. BURFORD, April 13, 1899.

<sup>2</sup> Exhibited by Drs. MADDEN and BURFORD, April 13, 1899.

<sup>3</sup> Exhibited by Mr. JOHNSTONE, April 13, 1899.

*Interstitial fibro-myoma of uterus, removed by the retro-peritoneal method of hysterectomy.<sup>1</sup>*

A. P., aged 41 years, single. *History*.—Retention of urine once or twice. *Catamenia*.—Not excessive. No pain. Not much leucorrhœa. *Micturition* usually difficult, catheter necessary once or twice. *On examination*:—Hard mass in lower abdomen: felt continuous with cervix. Chiefly corporeal, extending more forward than back.

Tumour removed by the retro-peritoneal method. Uninterrupted recovery.

*Interstitial fibro-myoma of uterus, removed by the retro-peritoneal method of hysterectomy.<sup>2</sup>*

L. B., aged 39 years, single. *History*.—Menorrhagia, profuse leucorrhœa, duration two and a quarter years; swelling of abdomen, one and one-twelfth years. *Catamenia*.—Must lie up first three days. Very profuse. Recurred every three weeks. *On examination*.—Central soft, elastic swelling, movable, not filling pelvis. Distinctly larger after interval of two months. Under hydrastinin, menses much less profuse.

Fibroid removed by retro-peritoneal method. Uninterrupted recovery.

*Uterine polypoid myoma; ovarian cystoma; carcinoma of sigmoid flexure.<sup>3</sup>*

Mrs. W., aged 63; ante-climacteric hæmorrhage; for one year tenesmus and bloody mucus from bowel.

Death from perforative peritonitis.

*Seventeen gall stones removed by cholecystotomy.<sup>4</sup>*

A. S., aged 28 years, married five years. *History* of attacks of pain in right hypochondrium, shooting downwards. No shivering, vomiting, or jaundice. *On examination*, a small, tender mass was felt in the region of the gall-bladder.

Gall-stones removed by cholecystotomy. Uninterrupted recovery.

<sup>1</sup> Exhibited by Dr. NEATBY, April 13, 1899.

<sup>2</sup> Exhibited by Dr. NEATBY, April 13, 1899.

<sup>3</sup> Shown by Dr. NEATBY and Dr. STONHAM.

<sup>4</sup> Exhibited by Dr. NEATBY, April 13, 1899.

*Hydronephrotic kidney removed by abdominal nephrectomy.*<sup>1</sup>

Removed from a woman, aged 26, who had had an abdominal tumour for three years. The tumour occupied the left side of the abdomen, reaching as far forward as the umbilicus.

The tumour was removed by abdominal nephrectomy, after a lumbar exploration. The patient made a rapid recovery.

*Vermiform appendix removed from the sac of a femoral hernia.*<sup>2</sup>

Removed from the sac of a right-sided femoral hernia in a woman, aged 53. The hernia was irreducible, and contained nothing but the appendix, which was adherent to the sac from a previous attack of appendicitis in the sac.

The patient made an excellent recovery.

*Flaccid ovarian cyst removed from a patient aged 52.*<sup>3</sup>

This was a specimen of flaccid ovarian cyst, removed from a patient aged 52. On abdominal examination no clearly-defined or well-delineated tumour could be made out. The abdomen was somewhat enlarged, giving a doughy sensation on pressure. Percussion note dull over the umbilical and hypogastric regions, resonant above and in the flanks (the typical "corona" of resonance with pelvic tumour). Diagnosis, flaccid ovarian cyst.

This was verified on operation, when the cyst, monolocular in character, with clear fluid contents, was removed. Recovery was unbroken.

*Ovarian cyst with universal adhesions.*<sup>4</sup>

The patient, a single woman, aged 61, came into hospital in 1897 for the removal of an ovarian tumour. The cardiac condition was unsatisfactory; but judging that this was due in great measure to the upward thrust of the tumour, operation was undertaken. The cyst was discovered to have practically universal and dense adhesions; and as the anæsthetist was already concerned about the diminishing pulse, the abdomen was forthwith closed. A few days after the largest loculus in the cyst was tapped.

<sup>1</sup> Exhibited by Mr. C. KNOX SHAW, April 13, 1899.

<sup>2</sup> Exhibited by Mr. C. KNOX SHAW, April 13, 1899.

<sup>3</sup> Exhibited by Dr. BURFORD, June 1, 1899.

<sup>4</sup> Exhibited by Dr. BURFORD, June 1, 1899.

In the present year the patient returned for further relief. The cyst had not perceptibly enlarged, but the general health had unaidedly deteriorated. After consultation with Dr. Moir, it was decided, at his suggestion, to "feed up" the heart for some time, with a view to radical operation. Strophanthus and strychnine were the chief remedies given.

After three weeks of the preparatory treatment, abdominal section was performed, and the cyst removed with considerable difficulty. The stress of operation was borne very well, and for some time convalescence was unimpaired. Ten days after operation a seizure, apparently influenzal, with accompanying broncho-pneumonia, occurred; which, however, soon subsided, only to recur after irregular intervals of normal pulse and temperature.

The patient has left hospital. It is hoped that change of air and scene may bring about entire recuperation. She has, however, the senile habit well marked.

*Abscess of left ovary; abdominal section—recovery.*<sup>1</sup>

In this instance, the patient, a married woman, aged 36, had an attack of pelvic peritonitis five years ago, since when her health has been very varied. For some time past she has had drenching periods, for which, three years ago, she was curetted elsewhere, with no permanent result. On admission to hospital the last period had just subsided, and while the pulse was weak and the heart sounds feeble, there was no bruit. Pelvic examination showed the uterus drawn to left side; in Douglas' pouch, a fixed tender ill-defined mass, bound down to contiguous parts. Diagnosis, a distended Fallopian tube with diseased ovary incorporated.

Operation on April 6. A dense network of adhesions involved the uterus and left appendages, out of which, with much trouble, the tube and ovary were isolated. The tube was enlarged and thickened, the ovary firmly adherent to the broad ligament; and the uterus was about the size of a Tangerine orange. After removal, on section, it was found to contain pus. The right appendages were also bound down by adhesion; they were liberated and restored to position, not showing any signs of essential disease.

The patient made a very good recovery, and is regaining her former health and strength.

<sup>1</sup> Exhibited by Dr. BURFORD, June 1, 1899.



*Uterine fibroid with appendages, removed mainly on account of progressive melancholia.*<sup>1</sup>

The patient was single, aged 45 years, and had for some time suffered from menorrhagia. Pelvic examination revealed the presence of a fibroid, the size of a large cocoa-nut. The paramount symptom, however, was melancholia of an acute and progressive type. For some six months past this mental condition had been developing, until it culminated in persistent insomnia, and suicidal tendencies. On consultation, it was deemed probable that the removal of the tumour, with the arrest of the blood loss, would probably materially improve the pelvic condition.

Total removal of uterus and appendages was accordingly carried out: and closely following operation, a marked improvement in the cerebral condition set in. The insomnia has quite disappeared, the facial aspect is pleasing, and the melancholic state of mind has undergone a great change for the better. This general condition of betterment is progressing; and the ultimate issue will be reported on at a future date.

<sup>1</sup> Exhibited by Dr. BURFORD, June 1, 1899.

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**SOCIETY NEWS.***Death of Dr. R. Ludlam.*

DR. LUDLAM, of Chicago, had been a corresponding member of the Society since 1875. His death was reported at the meeting held on June 1. Dr. Ludlam will be remembered by British practitioners as the author of a volume of clinical lectures on the diseases of women, which contained many valuable practical hints. His death took place under peculiar circumstances. He had recently recovered from an operation which had been performed on himself, and had resumed practice, and while performing an operation suddenly felt ill and quickly expired.

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*Death of Mr. Boughton Kyngdon.*

A letter had been received from Mr. Frederick H. Kyngdon which was read at the June meeting announcing the death of Mr. Boughton Kyngdon, L.S.A., of Bowral, near Sydney, New South Wales, on March 11 last. Mr. Kyngdon had been a member of the Society since 1872. He had been a consistent practitioner of homeopathy since 1849. For twenty years he resided at Exeter, where he was succeeded by Dr. Woodgates. He afterwards removed to Croydon, where for seven years he was associated in practice with Dr. C. Wolston. He removed to Sydney on account of ill health, and although sixty years of age, at once established a large and lucrative practice, which he actively maintained, finally retiring in 1891. Four years ago he had an attack of hemiplegia, his health gradually failing afterwards, a second "stroke" being the immediate cause of death.

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*The New Materia Medica.*

The "Committee for a New Materia Medica and New Provings," in view of the importance and magnitude of the work which they have undertaken, make an appeal for assistance from Members of the Society, each volunteer to be asked to undertake the preparation of a single drug before the close of the year. Full details with MS. specimens and instructions will be gladly given by Dr. Th. Ord, Greenstead, Madeira Road, Bournemouth, who has been appointed editor of the work. In the completed work due recognition will be given to the authorship of each drug.

## SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

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“GATHER UP THE FRAGMENTS, THAT NOTHING BE LOST.”

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MARCH—MAY, 1899.

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### PHARMACODYNAMICS.

**Acidum boricum.**—The *Lancet* of January 7 contains a number of observations of the pathogenetic action of boric acid, which should caution against its too bold use, and should afford material for its homœopathic employment. The skin and the kidneys seem to bear the main stress of its irritation.—*Hahn. Monthly*, May, p. 315.

**Aloe.**—“Mrs. M., aged 40. Morning diarrhœa for many years past, coming on after rising and continuing till 10 a.m. Stools yellowish, thin, fœcal, accompanied by much flatus; immediate, irrepressible desire for stool, cannot delay one minute. Aloe 30 was prescribed night and morning. Having taken only four doses, the stool became of normal consistence; but a scabies-like eruption broke out all over the body. Upon enquiry it was ascertained that patient had had itch when about 16; that it was treated by sulphur ointment; and that soon after the chronic diarrhœa set in. She received no further medicine, and in three days the skin had resumed a normal appearance, and the diarrhœa had not recurred.”—Whiting, *Calcutta Journal of Medicine*, Feb.

Dr. S. Van den Berghe relates one case, and refers to another, where associated incontinence of urine and fœces yielded rapidly to aloe 30. In the former instance the frontal headache of the drug was also present.—*Journal Belge d'Homœopathie*, Jan.—Feb.

**Antimonium tartaricum.**—An old-school physician, Dr. Connell, was led to give tartar emetic, in gr.  $\frac{1}{100}$  doses, in an epidemic of variola, in which he treated thirty-three cases. He was highly gratified with the results.—*N. Amer. Journ. of Hom.*, May, p. 341.

**Antitoxin.**—In the *Journal of the American Medical Association*, Dr. Kassowitz denounces antitoxin, stating that the published percentages are misleading, and that the actual mortality from diphtheria has not diminished of late years, as claimed. In Vienna and Paris, in which the mortality has been lower in recent years, the disease has been of a milder type.—*Hahn. Monthly*, March, p. 203.

**Argentum nitricum.**—Dr. G. M. Hill has revived the repute of argentum nitricum in chronic gastric affections—as gastralgia, flatulent dyspepsia and hyper-chlorhydria. He gives the 3x trituration (acknowledging its instability) or the 1st dilution in distilled water.—*The Clinique*, March.

**Arsenicum.**—Our old-school colleagues are beginning to find the good effects of arsenic in acute disease, and are teaching us that it need not be given—to obtain these—always in infinitesimal dosage. A Dr. Murrell of Memphis gave it to seventy-five patients with yellow fever in the epidemic of 1878, without losing one, administering three drops of Fowler's solution every two hours. Dr. Belot, of Havana, often finds "unhoped-for amelioration from doses of about gr.  $\frac{1}{150}$  every half hour when vomiting is obstinate in this disease."—*Amer. Homœopathist*, March 15.

**Arsenicum iodatum.**—The power of this preparation over pityriasis, mentioned in our last number,<sup>1</sup> is further illustrated in *The Clinique* for March by cases where its 3x trit. proved very effective.

A warm testimony to the value of this drug in tuberculosis is borne by Dr. Carl Crisard in the *New England Medical Gazette* of May. In twenty-eight cases of pulmonary disease, all in whom tubercle bacilli were absent recovered under it, and three out of seventeen in which this feature appeared are alive and well at

<sup>1</sup> P. 229.

this day. Dr. Crisard gives the low triturations in increasing doses.

**Aurum.**—Dr. Halbert thinks that in aurum muriaticum we have about the best remedy extant for degenerative disease of the nervous system. He relates cases of multiple sclerosis, exudative localised meningitis, and Morvan's disease, in which the 2x dilution effected remarkable improvement.—*The Clinique*, March.

**China.**—Dr. Tessier cites a case in which urticaria appeared more than once as an effect of the wine of cinchona. Dr. Gabalda, its observer, was thus led to give the drug, in infinitesimal doses, as a remedy for the idiopathic disorder, and with gratifying results.—*L'Art Médical*, March, p. 100.

**Chininum.**—A case of acute poisoning by a tablespoonful of the sulphate of quinine, taken by mistake for Epsom salts, is related in the *North American Journal of Homœopathy* for May. "Fireworks before the eyes" were as pronounced as tinnitus aurium; and a sense as if the top of the head were being lifted off was complained of.

**Cocaine.**—Dr. J. Farrar relates several cases which seem to show that by a one-tenth solution of cocaine muriate applied to the os during parturition, any rigidity on its part may be rapidly overcome, and delivery greatly hastened.—*Hom. Journ. of Obstetrics, &c.*, March, p. 197.

**Cratægus.**—This new remedy continues to give satisfaction in dilated and irritable heart. Dr. Halbert relates a good case of the kind in *The Clinique* for March. "In my experience," he writes, "in this case and others, I do not believe we have ever had so safe and so sure a remedy as cratægus for such conditions."

**Euphrasia.**—This is a remedy which is ever displaying new virtues. Dr. Ames, prescribing it for coryza, had a grateful acknowledgment from the patient (aged 70) of the good it had done to an old prostatic trouble of his. Dr. Ames has since given it in such cases (3x dil.), and has rarely failed to relieve the nocturnal irritability of bladder, and the dribbling emission of the urine.—*Medical Century*, April.

**Ferrum phosphoricum.**—Dr. Sands Mills' third article on single drugs<sup>1</sup> has Schüssler's ferric phosphate for its subject. He confirms from his experience Dr. Houghton's commendation of it in acute otitis media; but relates a curious case of the kind in which its administration (3rd trit.) seemed to cause delirium. He praises it in furuncle of the meatus, and in incipient circumscribed pneumonia.—*N. Amer. Journ. of Hom.*, March.

**Hydrastis.**—Mr. Dudley Wright comes forward in the *Monthly Homœopathic Review*, for March, with further testimony to the value of hydrastis (equal parts of the liquid extract and glycerine) as a local application in chronic urethritis and gleet; and in the May number a case is recorded in which the same preparation, given in 20 drop doses to a patient with bronchorrhœa, caused a severe attack of dyspnœa with signs of cardiac weakness and of congestion and œdema of the lungs.

**Kali Iodatum.**—A case of exanthematic purpura, engrafted upon impetigo contagiosa, is recorded by Dr. Pritchard, in which the action of kali iodatum was very remarkable. Ten grains were dissolved in 4 oz. of syrup, and half a teaspoonful given to the patient (a child of 9) every two hours.—*Hahn. Monthly*, May.

Dr. Gandy communicates some cases of uterine fibroid, in which the 3x trit. of kali iodatum produced remarkable effects. Larger doses had generally been given first, but had been without influence save for evil.—*Journal Belge d'Homœopathie*, March—April.

**Lycopodium.**—Dr. C. D. Collins narrates some cases which show a really potent influence exerted by lycopodium 15 over acne vulgaris.—*The Clinique*, March.

**Onosmodium.**—This rather well-proved medicine has found little therapeutic employment as yet; but Dr. Halbert affirms and illustrates its usefulness in migraine. He gives it in the 1x dil.—*Ibid.*, p. 103.

**Quinine.**—Holden (*Arch. f. Ophthalmology*, Nov., 1898) has studied the pathological changes in the retina produced by injecting quinine hypodermically in dogs. Although the arteries were constricted, no histological changes were found in them,

<sup>1</sup> See p. 87 of our present volume.

there being neither thickening of the vessel walls nor proliferation of the endothelium. There was, however, a highly albuminous serous exudation into the nerve fibre layer, and a degeneration of the ganglion cells, together with their axis cylinder processes which become the centripetal fibres of the optic nerve. These changes were not prevented by the exhibition of nitrite of sodium.—*Calcutta Journ. of Medicine*, March.

Murri has studied the relation of quinine to hæmoglobinuria. In the causation of this condition by the drug he firmly believes, but only in malarious subjects.—*Monthly Hom. Review*, May.

**Sabal serrulata.**—Dr. Reily relates three cases of prostatic enlargement and irritation—the patients being of 56, 45 and 35 years respectively—in which the action of the saw palmetto, in doses of 5 drops of the mother tincture night and morning, was all that could be desired.—*Calcutta Journ. of Medicine*, February.

**Senecio.**—Dr. Lyman Watkins has profound faith in this medicine for dysmenorrhœa—not to give immediate relief, but taken in the intervals as a preventive. It often, also, shows a tonic influence of a marked kind.—*Amer. Homœopathist*, February 15.

Dr. Jas. S. Barnard relates a proving of senecio (aureus) on a healthy woman of 24. Ten grains of the 3x trit. were given at first, then 30 drops of the mother-tincture. The results are given in schema-form, but chronologically within each section. Those of the sexual system were by far the most pronounced, and were of a decidedly irritative nature.—*Amer. Med. Monthly*, May.

**Silica marina.**—This is a trituration of beach sand, which contains silica, calcarea, iodine, and bromine. Dr. Deschere is said to be “most enthusiastic about the action of this remedy in adenitis.”—*Medical Century*, May, p. 153.

**Staphisagria.**—“An ‘eclectic’ practitioner gives his favourable experience with this drug in prostatorrhœa, spermatorrhœa, and other genito-urinary troubles. He prescribes one drachm of the tincture in four ounces of water, giving a teaspoonful every four hours. He states: ‘We prescribe no other remedy with greater confidence, and we add no other to it. It relieves ‘the blues’ and gloomy forebodings. It quiets disturbances and uneasy feelings about the bladder, urethra, testes and vesiculæ

seminales. It is often the remedy for gonorrhœa, especially in the later or gleet stages. Use it internally when your injections do not seem to act as you expect. The nervous effects of gonorrhœa frequently counteract all the effects of medicines. This remedy quiets the nerves; and, besides, it acts upon the kidneys, so that a freer flow of water follows, and the local applications have a better chance to relieve or cure urethral irritation.'"—*Amer. Homœopathist*, May 1.

**Strychnine.**—A case is extracted, in the *Homœopathic World* of March, from the *British Medical Journal* of December 31, 1898, where the habitual medicinal use of strychnia brought on an emphysematous condition in the chest, following on tendency to take abnormally deep inspirations, and symptoms of brain-strain.

**Tabacum.**—"According to *Médecine Moderne*, out of 150 employees of a tobacco factory not one exhibited, on examination, normal vision. All either smoked or chewed. In forty-five cases the acuteness of vision was perceptibly lessened; in thirty, dyschromatopsy was very pronounced—to some, red appearing as brown or green; to others, green seeming to be blue or orange. The majority were incapable of distinguishing a white point in the centre of a black carbon."—*Amer. Homœopathist*, March 15.

**Thuja.**—A case is reported of universal psoriasis vulgaris, with general weakness and depression, where, after administration of various drugs, thuja 3x was given twice a day for four weeks, with the result that the whole eruption had by that time vanished, save round the knees and on the extensor side of the arms. A continuance of the remedy soon removed all traces of the eruption. The condition was hereditary from the father's side. A vegetable diet, with milk and eggs, was ordered.—*Hahn. Monthly*, March, p. 159.

**Thyroidin.**—"M. Beclère has observed a myxœdematous patient, treated with success by active thyroidian medication, become thereafter the subject of exophthalmic goitre, and at the same time of hysteria."—*L'Art Médical*, May, p. 384.

**Wyethia.**—We mentioned in our second volume (pp. 363 and 499) Dr. Selfridge's favourable experience with wyethia in irritable



sore-throats. In the *Pacific Coast Journal of Homœopathy* for April this physician relates a new proving conducted by him with the drug, which would seem, therefrom, to be more active the further its dilution is carried.

**Zincum picricum.**—Two cases of a paralytic nature are recorded in *The Clinique* of April, in both of which the 3x trit. of picrate of zinc was very effective. One was a simple and recent facial palsy from cold; but the other was an instance of genuine paralysis agitans in a woman, aged 45. It had not been cured, even after a year's treatment; but so much improvement had occurred that Dr. Halbert expected to arrest the advance of the disease and make the patient very comfortable. She could already rest her hands in her lap and walk without the peculiar propulsive and staggering gait she had at first.

### THERAPEUTICS.

**Asthma.**—A merchant, aged 40, had suffered from asthma for seven years. The probable cause was excitement and vexation, which had often kept him awake at night. During the attacks in winter, after some symptoms of the disease during the day, he had to sit up in bed at night, and to keep his chest bare. The attack would last several days, always worse at night; then he would have intervals of freedom from asthma for eight to fourteen days. Irritable humour, aggravation during wet and cold weather, sweaty feet; much pale urine during the attack; cannot bear anything tight about his neck. Various remedies given without relief. He then got lachesis 30, this was followed by a severe attack succeeded by gradual cure.—Hesse, *Zeitsch. d. Berliner Ver.*, xviii., 163.

**Diabetes.**—The mineral water Dr. Clifford Mitchell found so surprisingly beneficial in diabetes, but whose name he forgot to mention, was that of Allouez. Nothing is said of its composition save that it is magnesian.—*Medical Counselor*, March, p. 91.

**Dysentery.**—Dr. Bliem, of San Antonio, Texas, writes to communicate the anti-dysenteric virtues of a plant indigenous to south-west Texas and Northern Mexico—the chaparro amargoso. Its botanical name is *Castela Nicholsonii*, Hook, belonging to the natural order Simarubæ. It is in high local

repute, and he relates several cases bearing out the claim made for it.—*N. Amer. Journ. of Homœopathy*, March.

Dr. B. K. Baptist, an Indian practitioner, writes to communicate his experience with this disease. He finds merc. corr. and ipec. too slow in their action, but that hamamelis (1x) not only promptly arrests the hæmorrhage but assuages the other symptoms also. Cuprum met. 3 is sometimes required to complete the cure.—*Hom. Recorder*, March.

**Dyspepsia.**—In one of the public lectures now being given in Paris, printed in *L'Art Médical* for April, Dr. Cartier discourses on the aid homœopathy can bring to dyspeptics, and gives some useful experiences. For acidity and heartburn, he mainly commends capsicum and conium—the latter when the distress is markedly relieved by eating. Calling this “hyperchlorhydria” (as is now customary) he classes the old bradypepsia as “hypochlorhydria,” and adds gratiola to its other remedies, especially when it occurs in women. The whole article is well worth consideration in difficult cases of this malady.

**Epistaxis.**—A young lady, aged 19, who had formerly suffered from epistaxis and boils, came on account of daily epistaxis. The nose was sore, face red sometimes even blue, especially after eating, tendency to congestion of blood to head; menstruation retarded and scanty. Ferr. phos. 6 twice a day. This cured the hæmorrhage and the sore nose.—Hesse, *Zeitsch. d. Berliner Ver.*, xviii., 163.

**Grief.**—Dr. Talcott has an interesting paper in the *North American Journal of Homœopathy* for April on “The Psychological Aspects of Grief.” He presents the characteristic indications of six medicines for the cure or amelioration of morbid mental conditions of this kind. They are arsenicum, ignatia, natrum muriaticum, pulsatilla, stramonium, and veratrum album. The restlessness, anxiety, and emaciation of the first; the silent suppressed unhappiness of the second; the morose gloom and tearfulness of the third; the varying moods of the fourth; the excitement and illusions of the fifth; and the religious despair of the sixth, are well depicted.

**Hydrocele.**—Dr. Berlin relates a case of hydrocele in an infant in which arnica 3x internally produced no effect, but

compresses of a stronger solution soon dispersed the effusion.—*Hom. Recorder*, April.

**Influenza.**—Dr. Laidlaw, of New York, relates in the *Medical Century* for April his experience in last winter's epidemic of "the grip." *Asclepias θ* (we suppose he means *A. tuberosa*) is his favourite alternative to aconite; *antimonium sulphuratum aureum* his remedy for obstinate coughs; and coca his "tonic" during convalescence.

**Laryngitis.**—Dr. F. D. Lewis, of Buffalo, describes a pharyngo-laryngeal catarrh which he thinks peculiar to his district, coming on in many persons during spring and autumn when the wind blows over water. The interesting point about it is that atropine, which is certainly exquisitely homœopathic to the condition, proves its curative remedy. He gives the 6x trit.—*N. Amer. Journ. of Homœopathy*, March.

**Ozæna.**—The insufflation of equal parts of citric acid and sugar of milk has been found to exert a most happy effect upon the nasal mucous membrane in ozæna, diminishing the purulent secretion and suppressing all trace of fœtor. The insufflations should be practised three times a day, and the nostrils washed out every morning. The effect is lasting.—*L'Art Médical*, May, p. 386.

**Scarlatina.**—Dr. Tessier, who has a great deal of scarlatina to treat at the Hôpital St. Jacques, does not find in malignant cases much help from *ailanthus* and *arum triphyllum*; but has the utmost confidence in *arsenicum*.—*Ibid.*, March.

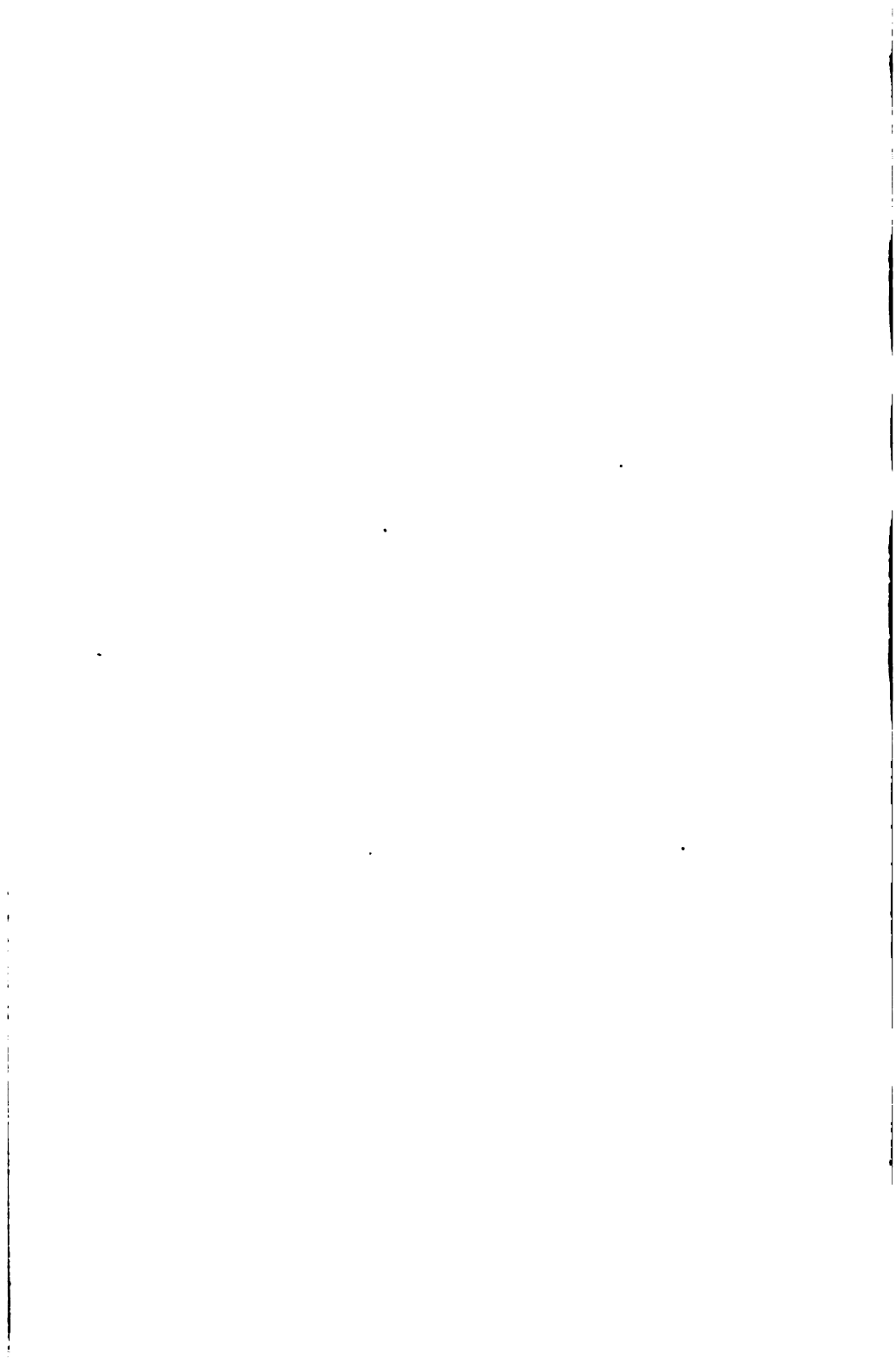
**Tuberculous Peritonitis.**—H. H., aged 8, May 9, 1898. Father died of phthisis. The child hitherto healthy, now always tired; has become emaciated, pale. Anæmia; night sweats. Abdomen projects enormously, circumference 78 cm.; much fluid in abdomen; stomach prominent. Right lung inferiorly, percussion dull four fingers' breadth, respiration indistinct; at both apices intense vesicular respiration. Diagnosis: ascites, tuberculosis peritonei, hydrothorax. Treatment: arsen. iod. 5, 4 drops three times a day. May 15.—No appetite, cough, diarrhœa, otherwise same symptoms; bryon. 3, apis 3, sulf. 5, each for eight days. May 30.—Abdomen 1 cm. larger; no night sweats; appetite and sleep improved; urine scanty,  $\frac{1}{2}$  lit. daily; canth. 5, apis 3, 4 drops alternately every three hours. June 3.—

Abdomen 5 cm. smaller, urine increased, no albumen; rep. med. June 9.—Abdomen 62.5 cm., streaks many on skin. Health improved. On the right side an inguinal hernia became developed a few days ago, the half of it is in scrotum. Stool normal. Taxis failed to reduce hernia; clysters, hot compresses; nux. v. 3 every two hours. June 24.—Hernia reduced; abdominal circumference 58 cm. No free fluid in abdomen perceptible; lungs free; health greatly improved, apis 3, canth. 7. July 18.—Some ascites; phos. 10, sulf. 10. Aug. 19.—Ars. iod. 5. Oct. 6.—Abdominal circumference 56 cm., rep. med. Nov. 6.—54 cm. Dec. 4.—Sulf. 10. Jan. 22, 1899.—Circumference 53 cm. No more ascites. General health excellent.—Gisevius, *Zeitsch. d. Berliner Ver. Hom. Aerzte*, xviii., 108.

## NOTICE.

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For the future, the JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY will review books sent to the Editor for the purpose. The attention of publishers is directed to this notice.



JOURNAL  
OF THE  
**British Homœopathic Society**

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No. 4.

OCTOBER, 1899.

VOL. VII.

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

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SOME EXPERIENCES WITH THE SO-CALLED  
TISSUE REMEDIES OF SCHÜSSLER.<sup>1</sup>

BY GEORGE BLACK, M.B., C.M. EDIN.

*First Announcement under the title of "A Shortened  
Homœopathic Therapeutics."*

IN March, 1873, an article appeared in the Leipzig *Homœopathic Gazette* entitled, "A Shortened Homœopathic Therapeutics."

The writer, Dr. Schüssler, of Oldenburg, says, "About a year ago I endeavoured to discover by experiments on the sick, if it were not possible to heal them, provided their diseases were curable at all, with those substances that are the natural, *i.e.*, the physiological function remedies."

I do not know if the time will ever come when with these twelve remedies in our pocket we shall go in and out

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, May 4, 1899.

amongst our patients feeling that we are in a position to combat all the ills that flesh is heir to.

I do not know that their greatest exponent and advocate, Schüssler, would himself consider that he was fully equipped as a physician if reduced to the number and the sort of remedies that stand in his name.

Although the average practitioner in the school to which we have the honour to belong would not thus like to be limited in the exercise of his profession there is no doubt that the man, with an intimate knowledge of the possibilities of a dozen remedies such as these, is in a better position to treat successfully those who are entrusted to his care, than he who, employing a much larger number, has no very precise or comprehensive knowledge of any.

We may give to a child, or to another ignorant of their possibilities, a whole box-full of colours, but what would be the effect upon the canvas compared with that of the master mind in the handling of half-a-dozen? Not long since I had the privilege of looking upon a water-colour drawing in which the artist had only made use of yellow, blue, and brown, but so exquisite was his method, so subtle and delicate his blending of the means to which he had restricted himself, that it is difficult to imagine a finer or more striking effect.

### *General Theory.*

“The idea upon which the biochemic method is based is the physiological fact that both the structure and vitality of the organs of the body are dependent upon certain necessary quantities and apportionment of its inorganic constituents.

“According to Schüssler’s theory any disturbance in the molecular motion of these cell salts in living tissues constitutes disease, which can be rectified and the requisite equilibrium re-established by administering the same mineral salts in small quantities.

“This is supposed to be brought about by virtue of the operation of chemical affinity in the domain of histology, and is supposed by him to be in harmony with well-known



facts and laws in physiological chemistry and allied sciences."

He does not say, at any rate in this connection, in what way this disturbance takes place, whether it is due to an impression conveyed by the nervous system to the molecules of the cells or is produced otherwise.

### *Tissue Building.*

The blood is the great storehouse of material necessary for the growth, development, and functional performance of every organ and tissue of the body by means of the intimate ramifications of the capillary vessels and the transudation of a portion of its plasma through the walls into the surrounding tissues.

In the plasma or protoplasm fine granules appear which unite to form germs. From *these*, cells develop, by whose union are formed the tissues of every kind needed for the upbuilding of the whole organism.

"Two kinds of substances are needed in this process of tissue-building, viz., the organic and the inorganic constituents, and both are found in the blood.

"Wherever, then, in the animal organism new cells are to be generated and formed there must be present in sufficient quantity and proper relation both these organic and inorganic substances.

"By their presence in the blood all the organs, viscera, and tissues in the body are formed, fixed, and made permanent in their functions, and a disturbance here causes disturbed function."

### *Inorganic Constituents of Cells.*

In order to an intelligent appreciation of the biochemic method of treating disease we must know what the inorganic constituents of each particular cell are. These I will now give you as tabulated in the book, "The Twelve Tissue Remedies of Schüssler," by Drs. Boericke and Dewey, to which also I am indebted for much else that appears in this paper.

"The inorganic materials of nerve cells," according to

this authority "are magnes. phos., kali phos., natrum and ferrum. Muscle cells contain the same with the addition of kali mur. Connective tissue cells have for their specific substance silicea, while that of the elastic tissue cells is probably calc. fluor. In bone cells we have calc. fluor. and magnes. phos., and a large proportion of calc. phos. This latter is found in small quantities in the cells of muscle, nerve, brain, and connective tissue. Cartilage and mucous cells have for their specific inorganic material natr. mur., which is found also in all solid and fluid parts of the body. Hair and the crystalline lens contain among other inorganic substances also ferrum."

A good deal of this looks very well on paper, although even here doubt and uncertainty are expressed in regard to the constituents of at least one of the tissues of the body.

But if there is uncertainty in a chemical laboratory in determining what enters into the formation of the elastic tissue cells, it must be difficult in practice to apportion a remedy when a structure into which these cells enter is diseased.

Then again we are told that the muscle cells contain the same ingredients as the nerve cells + kali mur.; so that it might become a nice point to determine the appropriate remedy in a case of lumbago or sciatica from the knowledge of the inorganic constituents of a nerve or muscle cell.

But, just as in the wider homœopathic therapeutics the remedy is determined by the totality of the symptoms, so, I suppose, it must be in the modified form we are at present considering. In the latter case we should not only have to determine the organ or tissue of the body that was affected, which in lumbago would give us a choice of no less than six remedies out of the dozen that are supposed to be sufficient to cure all diseases, but other factors would come in to enable us to arrive at a more satisfactory conclusion, unless we are prepared to adopt the polypharmacy of former years.

Of those factors the state of the pulse and the degree of temperature would have an important bearing upon our choice of the remedy, as also the character of the pain and the concomitants; but before proceeding further in

our consideration of the disease and its remedy, it will be well for us to look at the

### *Formation of the Tissue-Cells.*

As far as I understand this process, it is as follows:—Oxygen taken into the lungs in the act of inspiration is carried by means of the blood to all the organs and tissues of the body, and, acting upon the organic substances which are to engage in the formation of new cells, we have resulting the organic materials which form the physical basis of muscle, nerve, connective tissue, and mucous substance. “Each of these substances is the basis of a particular group of cells to which, by means of chemical affinity, the cell-salts are united and new cells produced.”

This might perhaps have been made clearer. There does not seem to be a sufficient distinction between organic substances and organic materials to enable one to form a very definite idea of what actually has occurred. A substance is matter, and matter is substance, but here the material is represented as resulting from the action of oxygen upon the substance, which confuses and makes things hazy, and the process described consequently more difficult to understand.

However, what follows is clear enough:—Oxygen acting upon organic substances forming the basis of cells results in the formation of new and the destruction of old cells, and perhaps this is just what the other and longer sentence in essence amounts to.

We are told that “the ultimate results of this combustion are the formation of urea, uric acid, sulphuric, phosphoric, lactic, and carbonic acids, and water.”

The first three, viz., urea, uric acid, and sulphuric acid are the outcome of oxidation of albuminous substances, phosphoric acid from lecithin contained in the brain, spinal cord and blood-corpuscles, while lactic acid results from the fermentation of milk sugar.

I would not trouble you with these statements, familiar

as they are to you, but for the bearing they have upon the treatment of disease according to this method.

Sodium urate, formed by the union of uric acid with sodium, is eliminated in health, but accumulates in the neighbourhood of joints when this process is incomplete, giving rise to gout.

“Sodium sulphate,” we are told, “removes the water resulting from the oxidation of the organic substances of the body, and a disturbance of its molecules may be followed by a retarded removal of this water of oxidation.”

In this connection it is interesting to compare the action of the sulphate with the muriate, which latter enters the tissues dissolved in the water from the blood plasma, in order that the requisite degree of moisture proper for each tissue may be maintained.

“By means of the presence of *natr. phos.* in the system lactic acid is decomposed into carbonic acid and water.

“The final products of the oxidation of the organic substances are urea, carbonic acid, and water.

“The products of this retrograde tissue change are conveyed through the lymphatics, the connective tissue, and the veins to the gall-bladder, lungs, kidneys, bladder, and skin, and are thereby removed from the organism.

“The connective tissue appears now as the matrix, in which the minute capillaries carry the plasma from the blood to the tissues and return the same to the blood vessels; it serves also as one of the most important breeding places of young cells.”

### *Health and Disease.*

According to this theory “Health is the state characterised by normal cell metamorphosis; disease is the result of a disturbance of the molecular motion of one of the inorganic tissue salts; the cure consists in restoring the equilibrium by administering a minimal dose of the same inorganic substance.”

The thing that strikes one about this is that disease is

regarded as a condition or state of deficiency, and that brings Schüssler's idea into line with Dr. Bayes', who regards disease as a negative state—a condition of debility—and says that "Specific restorative stimulation is the true indication for its cure." By this he simply means the restoration of the healthy balance.

Schüssler seems to me to go a step further back than Bayes, who says, "All medicinal stimulation should be directed specifically to the weakened or debilitated tract, part or organ, and should stimulate it alone, leaving such tracts, parts or organs as are already in a state of proper tension untouched and without medicinal perturbation."

The question naturally arises "How is this to be done?" In the former case we must know the chemical constituents of the cells entering into the formation of the organs and tissues of the body, and be acquainted with the phenomena resulting from their derangement; in the latter we advance to considerations of a less minute character, and if we are familiar with the physiological working of the organs and tissues of the body, and know of remedies that act specifically upon them, we shall be able to adapt these to the pathological condition that happens to exist in any particular instance.

But while one organ may bear the brunt of disease and be the *fons et origo* of our patients' symptoms, how are we to determine, supposing we decide that the liver is at fault, which of the remedies in the *materia medica* having a specific action upon that organ is the one to be administered in this particular case?

You may say that the pathogenetic effects of the drugs and their correspondence with the patient's condition would determine which we ought to give, but this would be homœopathy in its larger sense, not in the more restricted meaning that I imagine an organopathist would attach to it.

Besides, how are we to determine whether the pathogenetic effects of a drug are those of stimulation resulting in over-action or of depression? For instance, when alcohol is introduced into the system by the ordinary channels, according to the late Sir B. W. Richardson, there is pro-

duced first of all a stage of excitement. Is that stimulation? During this stage from a paralysing influence upon the vaso-motor nerves there is relaxation of blood-vessels with a determination of blood to the surface, a more rapid action of the heart, a higher *external* temperature, but a lower *internal*.

To call this stimulation seems something of a misnomer. Take again the following:—"A lady took a pill containing podophyllin and was seized with watery purging every two or three minutes, vomiting, coldness of the surface and great prostration." Were these symptoms the result of stimulation of certain organs and tissues of the body for which the drug has a specific affinity? and if so do they indicate a negative state on the part of the patient? and if this condition were met with as a natural disease, would it be a negative state the result of some dynamic influence producing stimulation, and would the true specific restorative in this case be podophyllin?

But just as in mechanics you have action and reaction, an upward and a downward swing of the pendulum, so you have on the introduction of some foreign substance into the system a revolt of the organism against it resulting in certain manifestations which we designate disease.

I can more readily understand the position assumed by Schüssler than that taken up by Bayes, because the former is administering one or other of the natural constituents of the body whose derangement he considers has brought about the disease in question, and, trusting to the elective affinity of the tissue cells for their own particular elements—like attracting like—he gives the remedy, and, if correct, according to him, the balance is restored and health results.

But unless we are to select our remedy from a wider *materia medica*, and upon the correspondence of the drug action with the totality of the patient's symptoms, it seems difficult to determine our action with any degree of certainty in the intermediate sphere of organopathy.

Of course, ultimately, whether we prescribe on the scale of a *materia medica* embracing twelve remedies, or one consisting of as many hundreds, the matter will resolve itself

into one of cell-selection and of the appropriation by the organs and tissues that are in a state of disease of that which is necessary for their recovery.

This power of the tissues in their minute structures to appropriate what is needful to their requirements, whether in health or disease, is at the root of all vital processes, whether they be physiological or pathological.

The Divine imprimatur given at the first has continued through all the varying manifestations of life and amid all the vicissitudes of the centuries, and will continue with that unerring power which indicates its source till time shall be no longer.

In his subtle analysis of Virchow's statement that "the common cause of all the phenomena in sickness as in health is life itself, and that the very essential difference between them consists only in their conditions," Grauvogl contends that this is erroneous.

"The assertion that life is the common cause of sick as well as of healthy phenomena would," he says, "be a proper expression, for in the space of the healthy life the diseased life develops in the course of time."

"Disease," he says, "expresses a quality of our organism which is only perceived by the senses, and which can be measured only by extensive quantities since it is itself an intensive quantity," and again, "every disease shows that the human type has undergone a change."

Virchow's statement that "pathology is physiology with hindrances" calls forth an angry protest from our author.

"His errors," he declares, "arise from the disregard of the difference between that which is constant and unchangeable in the life of the organism and that which is changeable.

"The *constant* and unchangeable are the laws of its specific forms, which forms we have in general learned in the cells and connective tissues, &c. These forms also spring from parents; the *changeable* are the chemical and physical properties of these constituents which its connection with the external world adds to it from beginning to end."

"There are two things which constitute disease—first,

'*the qualities of the organism,*' *i.e.*, the conditions for the disease; second, the external causes of the disease which do not immediately emanate from it."

"Disease," he again says, "is no reaction or passion, and its cause is no *action*. The *whole* cause of the phenomenon lies in the given form of reciprocal action in consequence of the connection of an external cause with the inner conditions of the organism, and *not* in the forces of the parts.

"In the forms of human individuals we find either a minus or a plus in relation to the never attained end of an artistic ideal. Health rests *upon a harmony of relations in which the parts of the organism stand on one side to each other and on the other to its whole.*"

This is what that master of English and ornament of our profession, Dr. John Brown, of Edinburgh, calls "that full measure of soundness, of wholeness, of consentaneous, harmonious action, of well-balanced, mutually concurring forces—that 'perfect diapason' which constitutes health or *wholth.*"

Grauvogl (proceeding) says: "The future *pathology* is not *cellular*, for I maintain, and have shown, that we can have only a *molecular pathology and therapeutics*, for the cells are not the ultimate elements of life; these we find in the *molecules* and *forces* which construct the cell with the help of the surrounding structures."

In other words, I suppose the protoplasm which is within the cell-wall and amongst whose molecules all vital processes take place as long as life lasts.

"Hence," he says, "we can never expect in therapeutics to act upon the cell and connective tissue forms as a whole, but only upon their molecules and their molecular forces."

Proportional oscillation seems to be what Grauvogl regards as the mathematical law underlying those conditions which we call health and disease.

"All phenomena," he says, "which we see connected with the laws of life, all self-activity from the molecular powers to the very motion of the earth itself, we observe in constant change of equipoise within determinate limits of accommodation.



“ Each individual being exists always in the midst of such oscillations only, as we observed in the functions of the adult, and even in its egg-cell, which constantly oscillates between life and death.”

I have given considerable prominence to these views because the writer was one of the subtlest thinkers and keenest intellects that ever adorned our profession.

You are all familiar with Hahnemann's views on this subject. According to the founder of our school “ by far the greater number of diseases are both of dynamic origin and dynamic nature, and their cause therefore not admitting of sensual discovery.”

According to this theory, then, we have nothing to do with the cause of disease, that being hidden from us, but only with its effects, as force or power of whatever kind can only be known to us by its effect, that is, by the *motion* which it produces in the body on which it acts.

“ The action that takes place in diseases manifests itself only by external symptoms that owe their origin to the primitive action of the disease and those which are occasioned by the reaction of the vital powers endeavouring to rescue themselves from danger.

“ Every malady presupposes some change in the interior of the human economy, but our understandings only permit us to form a vague and dark conception of this change from a view of the morbid symptoms, which are the sole guide we have to rely upon except in cases that are purely surgical. The immediate essence of this internal and concealed change is undiscoverable, nor have we any certain means of arriving at it.”

The statement contained in this last sentence is a great one to make. One wonders if Hahnemann were alive to-day whether, in view of the great advances in bacteriology, he would reaffirm it.

Would he say, “ Because you have discovered the bacillus of this and the bacillus of that you have not therefore reached the disease itself. These micro-organisms themselves presuppose a cause, for before they could have had being and assumed the definite shapes we know them to

possess, some deeper and more subtle influence has been at work, and this it is which, like electricity, manifests itself in various ways, but whose nature we are totally ignorant of."

"The invisible substance," he says, "that has undergone the morbid change in the interior of the body, and the perceptible change which exhibits itself externally (the symptoms), form together beneath the eye of an all-powerful Creator that which man calls disease."

"Is not this internal change the inaccessible and undiscoverable part of the malady, whereas that which exhibits itself by symptoms is the part that is manifest and accessible to the senses, and that which nature principally presents to us as the object of cure?"

I cannot help thinking that in the treatment of disease our eye is resting too much upon the essence and too little upon the manifestations. It is difficult for those of us who have practised for years according to the system in which we were instructed, to shake ourselves free from its deadening influence.

To have diseases labelled, and to have appropriate remedies attached to each, is no doubt a much easier way than going through all the drudgery of individualisation; whether it is in the end more or less successful is another and an entirely different matter.

That the grouping of certain symptoms under particular names is of great service in the study of disease all will admit—it seems to bring order out of what otherwise might be chaos—but the adaptation of remedies to these particular names, while the symptoms of the patient before us are ignored, will only result in failure and disappointment.

While welcoming every discovery that tends to throw light upon the nature of disease, and every element that adds to the sum of our knowledge, there will yet remain to the observant eye and the patient investigator those subjective and objective symptoms which in our school constitute the picture from the correspondence to which our drug selection must be made.

In his "Knowledge of the Physician," Dr. Richard Hughes says: "Life is a property belonging to matter in that peculiar state which we denote by terming it 'living.'"

The theory propounded by Brown, adopted by Fletcher and espoused by such great naturalists as Cuvier, Blumenbach and Bichat, and by Drysdale and Russell in our own school, is to this effect that "life is the result of the action of the natural stimuli—light, heat, oxygen, and so forth—on the irritability of the tissues."

I must say that this theory staggered me when I began to think of it, and Tennyson's noble lines kept ringing in my ears :—

Thine are these orbs of light and shade ;  
Thou madest life in man and brute.

"Life the result" (the consequence, the effect) "of the action of light, heat, oxygen and so forth," I kept repeating over and over to myself. If it had been "life is maintained" by the action of light, heat, oxygen, &c., I could more readily have grasped it, but as it stood it seemed so like putting these things in the place of the Almighty; however, on reading a little further I was greatly relieved to find that they were only secondary players after all, "for the great Musician who out of the diverse tones they elicit brings pure melody and perfect harmony is the Creator and Sustainer of all things."

I should just like here publicly to express my gratitude to Dr. Hughes, to whose writings I owe my conversion to homœopathy, and whose "Pharmacodynamics" made it possible for me, at a time when my mind was in doubt and perplexity, to understand in a scientific manner what might otherwise have remained a puzzle and enigma to me.

I do not think that I need pursue this matter of health and disease any farther. In bringing it to a conclusion perhaps I may be permitted to tabulate the views we have just been considering.

First, then, there is Schüssler's theory of disease, viz., disturbance of one or more of the chemical constituents of the body; second, that of Bayes, that it is a condition of debility in one or more organs of the body; third, Grauvogl's, that it is proportional oscillation; and fourth, Hahnemann's, that it is an alteration or aberration of the vital power by a spiritual or dynamic influence.

At this point it was my intention of passing to a consideration of the

*Physiologico-Chemical Data and General Action*

of these twelve tissue remedies in succession, and, under each, of placing before you such clinical experience as I had gained in those years during which this treatment had formed part of my practice; but when I came to tabulate the material at my disposal, and write out in detail the cases illustrative of the action of each of these drugs, I found the thing to be utterly impossible within the limits of any ordinary paper, and consequently it seemed to me better under the circumstances to deal rather more fully with one or two than furnish you with bare statements regarding ten or a dozen.

With this object in view I pass on now to the consideration of two of the most important of the tissue remedies of Schüssler, viz. :—

*Ferrum Phosphoricum and Kali Muriaticum.*

I name these together because while dealing with them to some extent separately, it is frequently necessary to supplement the action of the one with that of the other.

“The former is found,” as you are aware, “in the hæmoglobin or colouring matter of the red blood corpuscles. Schüssler also gives it a place as a constituent of the muscle-cells. A disturbance of the equilibrium of its molecules in muscular fibre causes relaxation. This occurring in the muscular coats of the vessels causes dilatation, accumulation of blood in the blood-vessels, congestion, increase of blood-pressure, rupture of the walls, and consequent hæmorrhage. From this relaxation in the intestinal villi diarrhœa results, and in the muscular walls of the intestines decrease of peristaltic action with tendency to constipation. Hyperæmia after injury also finds its remedy here. From its power of attracting oxygen it is beneficial in anæmia, chlorosis, and leucæmia.”

“Its field of action is,” therefore, “in all ailments of a hyperæmic or congestive nature, all febrile disturbances and inflammations at their onset, especially before exudation commences.” It is said to be especially useful in debility of children with failing appetite, who are listless and have lost weight and strength; also in many inflammatory, and some eruptive, fevers.

“The latter,” according to Schüssler, “stands in chemical relation to fibrin, disturbances in its molecular action causing fibrinous exudations. It is found in the blood corpuscles, muscles, nerve, and brain cells, as well as in the intercellular fluids. Disturbance results in exudation of fibrin, of white blood or lymph-corpuscles.

“It answers to croupous or diphtheritic exudations, and hence is useful in diphtheria, dysentery, croup, croupous pneumonia, fibrinous exudations in the interstitial connective tissues, lymphatic enlargements, infiltrated inflammations, cutaneous eruptions from bad vaccine virus, &c.” It is also of great service in catarrhal conditions of the ear.

My experience with these two remedies has been in diurnal enuresis, in epistaxis, in anæmia, in laryngeal catarrh, croup and diphtheria, in rheumatic fever, in erysipelas, erythema, eruptions after vaccination but not necessarily due to bad lymph, tonsilitis, scarlet fever, œdematous swellings, enlarged glands, catarrhal conditions of the middle ear, &c., &c.

I cured one case of diurnal enuresis with ferrum phos. in a boy between six and seven years of age. I am unable to give you the particulars, as I was unable to lay my hands on the case slip while writing this. My recollection of his case is that unless he could relieve himself the moment the desire came upon him he would wet his clothes. He was a boy of highly nervous temperament.

Ernest R., aged 9, with light blue eyes and flaxen hair, pale face, and of medium height and stoutness, was brought to me on Monday, October 28, 1895. Twelve months ago he began to wet the bed. According to his mother's account, he does so half-a-dozen to a dozen times in the night. He does not retain his water during the day, and when he cannot get out of school when

he wants to he wets himself. Ferrum phos. 5x trit., three times a day. Monday, November 25.—When he first took the medicine it seemed to have a magical effect, and for four nights he did not wet the bed. Since then he has done so pretty frequently, but, on the whole, he is decidedly better.

On July 24, 1893, I visited Gracie E., aged 5, fair, with grey eyes. Yesterday morning, about 9, she lay down; became very feverish; complained of pain in the back of the neck and a sensation as of a needle running into the stomach. She was very feverish last night, and her mother gave aconite. She says she fought the air, that her eyes had a wild glare about them, and the pupils were dilated. She points to the back of the neck as the seat of pain; complains also of headache. Pulse 120, temperature 101·8°. Ferr. phos. 5x, every two hours. Tuesday, 25.—Out in the garden this morning. Skin cool; head and neck better.

On Monday, November 13, I visited Mr. D. He complained that for three days he could not get his feet warm. This morning he was very pale, and looked as if he were going to die. He had a hot bath, and although the heat was great, he did not feel it. Now he is reported to be as red as a turkey cock. He had taken two stiff glasses of whisky before I saw him, to try to get a sweat, but the only effect produced was to cause him to burn. I found him in bed, complaining much of his left heel and left knee. Pulse 80, large and full; temperature 100·8°. If he pulled his leg up tightly against the thigh, it gave him ease, but on letting go again it began to pain. No pain in any joint of the upper extremities. Ferr. phos. 5x, every fifteen minutes till four doses are taken; then every one or two hours. Tuesday, 14.—Much easier to-day. Had slight perspiration during the night. Very little pain to-day in right knee and foot. Pulse 72, temperature 99·2°. Continue. Thursday, 16.—Pain gone; up and dressed.

Mrs. A., aged 30, dark hair, grey eyes; has suffered from cold for a few days. Saturday, November 25, 1893.—She shivered, her teeth chattered, and she could not keep away from the fire. About 10.30 p.m. a misty sensation came over her eyes, and one object looked like three. Her throat then became very bad, and she could scarcely sleep all night. Monday, 27.—Yesterday and to-day she has felt bad; every limb has ached. When she attempted to drink yesterday it ran out of her nose. She complains of great pain each side of the throat, smarting in char-

acter much increased by attempts at swallowing. The throat is brightly congested; the tonsils and surrounding structures looking very red. Ferr. phos., every fifteen minutes, half hour, and hour. Tuesday, 28.—Slept fairly well; feels much better to-day. Could swallow better very soon after beginning to take the medicine. Pulse 80, temperature 99°. Throat not so acutely congested as yesterday. Wednesday, 29.—Can swallow much better. Temperature, normal. Continue the medicine occasionally.

On Saturday, January 21, 1893, I was called to Jack H., 8 years old, with dark hair and eyes. I found him in bed; his face was flushed, his skin hot and burning, and his eyes glistening. Pulse 124, temperature 103.6°. He complained of severe pain in the back—lumbar region—and of great difficulty on attempting to turn. He had been working hard for an examination. Thursday was a holiday; went and played football; shivered afterwards; then became very feverish. Urine clear; no cough. Ferr. phos. 5x, every fifteen minutes, half hour, hour, and so on. Sunday, 22.—All right. Had wandered at night in sleep, but since then been himself. Perspired very freely. Could have wrung his hair, it was so wet with perspiration. Pulse 64, temperature normal. No pain.

Richard G., aged 5, fair, light grey eyes; began to vomit April 14, 1895, since which he has been sick quite ten times. He complains of pain, the situation of which is in front of right ear and up to the temple. He has had the pain in his head quite a week, but till the day previous to my seeing him had not vomited. Two or three weeks ago he received a blow on the head from a stone; it struck him, and cut him over the posterior part of right parietal bone; a swelling rose over the seat of injury like an egg. Ferr. phos. 5x. April 15.—Has not vomited since taking the first dose of medicine. Pulse 108, respiration 16, temperature 99.8°, slightly less than yesterday. I have no further note of this case, but if my memory serves me, he was soon all right.

I was consulted on August 16, 1894, by Alice W., aged 18, a stout, well-developed girl, with pale face, dark brown hair and eyes, and prominent nose. This is Monday, and she says that on Friday she experienced a severe, aching pain in the forehead, which became worse on Saturday. Yesterday she felt cold and shivery, and on the left cheek a reddish patch appeared, which spread towards evening. This afternoon I find an erythematous patch, extending from the side of the nose close to the eye, down

under the lower eyelid and on to the cheek. It extends slightly on to the nose at its upper part. There is also a slight blush under the left nostril, and a patch of red at upper and inner aspect of right side of bridge of nose. The nose itself is swollen. Pulse 116, temperature 99·4°. Ferr. phos. 5x, every two hours. Wednesday, August 18.—The redness and swelling are gone from the face, and she feels and looks all right. Pulse 88, temperature 97·4°.

Miss V., age uncertain (perhaps 60), stout, fair. March 15, 1893.—In bed; cheeks swollen and of a dusky red hue. There is some redness on the forehead; the nose is swollen; the eyes are partially closed. Pulse 100, temperature 102°. The swelling of the face began the night before last in right sub-maxillary gland, went up the right cheek, across bridge of nose, down left cheek to corresponding gland on left side; now extended to forehead. Rhus tox. 30 given every two hours. 10 p.m.—Pulse 104, temperature 104·6°. No delirium. Ferr. phos. 5x, every fifteen minutes, half hour, hour, &c. Thursday, 16.—Lying on her back; face less swollen. Pulse 95, temperature 102·4°. Complains of head feeling sore to touch and on lying. No wandering in the night, but felt her breathing short. Tongue moist. 10 p.m.—Condition very satisfactory. Pulse 90, intermitting about once in a minute, but better in character than it was. Temperature 101·2°. Tongue and skin moist. Head and face less tender to touch; redness of cheeks less intense; upper eyelids less oedematous, skin beginning to have a wrinkled appearance. Continue. Friday, 17.—Had a very good night. Temperature at 6 a.m. normal, and at 10 a.m. 98°. Feeling much better. Right cheek much less flushed and much less swollen; right eyelid ditto; left better. Complains of pain at the back of the neck. Pulse 74, no intermissions in a minute. Continue. Saturday, 18.—Doing splendidly. Pulse 60, regular, temperature 97·4°. In this case a drain was found choked leading from the sinkstone, and bad smells had been experienced by the servants for months, but they said nothing about them to their mistress, whose sense of smell, since an attack of influenza, had been perverted.

Saturday, September 14, 1895.—On Wednesday evening, Miss M. was at Chapel Hill, where she sat for a short time, then left and went round the Sea Road, and was seized with pain in the back which came suddenly across the loins. Began to shiver immediately after and on arriving home continued cold and



shivery all night. Next morning the pain was very bad ; she used some chili paste in the afternoon which did her good, but it came on again very badly last night. To-day it has been bad all morning and she has felt very cold. She complains now of burning across the back, " just as if someone were placing a red-hot iron there." " All my limbs ache : it is one continual pain. My head has been aching badly for two days and the back of my eyes." The pain is not made worse by movement. Urine the other day felt hot and scalding ; it is rather deep in colour now. Temperature 102°. Ferr. phos. 5x every hour or two. Sunday, 15, much better. Pulse 72, temperature 98·6°. She still complains of her back and of cold perspiration about the legs. Tuesday, September 17, letter received : " I am happy to tell you I am feeling very much better and the pain in my back is nearly gone, only I am feeling very weak and shall be glad if you would send me something to pull up my strength. I shall go down to the office for part of the day."

Thursday, October 17, 1895.—On Sunday morning, Miss V. awoke with burning heat over the entire body. When she got downstairs she felt cold and began to shiver, then a terrible throbbing headache came on. Her appetite failed suddenly, but she was very thirsty. Limbs began to ache—legs and knees—" in fact I ached all over worse than on Sunday. I was in a perspiration and was cold and burning from head to foot. In the night when I looked at my legs they were swollen and sore, red blotches had come out upon them. They were hot at night and I slept very little. Kept getting in and out of bed, was in so much pain didn't know what to do." Began to suffer from cough on Sunday morning, a short, hacking cough. The urine contains a light orange-coloured deposit. Pulse 88, respiration 18, temperature 101·4°. On examination I found a large number of red lumps on the anterior surface of the legs, some on the outer surface of the thighs, and on the buttocks, varying in size from a lentil to sixpence or rather larger. There are some also on the outer aspect of the forearm. They are elevated and tender to touch. There are also spots on the face and amongst the hair. Her head feels as if it were parting right on the top. She says her temperature varies very much, sometimes a degree in an hour. Ferr. phos. 5x. Saturday, 19, complains of gnawing, aching pain in the knee-joints, restless feeling in the legs—wants to keep moving them constantly. Right down the bone from the knees to the feet there is a scalding, burning feeling. She has a dry, rather loud-sounding cough. She has lots of red

blotches on her right cheek; they are elevated above the surrounding skin and have little vesicular heads that look as if they would become pustular. Right forearm is dotted all over with red, erythematous nodules varying in size and raised as the others; they are hot to the feel and hard. The right arm aches—a gnawing aching in the bones. The legs do not ache so much to-day as yesterday, nor does the head. Tongue red and rather raw. She keeps constantly moving her legs about. There is great pain in both knee-joints. Pulse 92, respiration 24, temperature 101.4°. On examining the legs I find them covered on their anterior aspect with red lumps, varying in size and exquisitely tender; there are also some on the thighs and one or two on the hips. Kali chlor. 6 in alternation with ferr. phos. Tuesday, October 22, letter received this morning in which her brother says, "The whole of Saturday she was in great pain in nearly all her joints; her head also ached very badly. Towards evening she began to get very hot, and after being some time in a burning heat she began to sweat violently, which continued about two hours. She had a little sleep during the night. Yesterday on awaking two red lumps appeared on the left wrist causing great pain; these lumps partially disappeared after taking a dose of the medicine (kali chlor.) which you sent yesterday. During last night she slept several hours quietly, and this morning feels somewhat better. The spots on the legs are fading and she is not in such intense pain. Her temperature on Saturday was as follows:—4.35 p.m., 102°; 7.20 p.m., 103.1°; 9.30 p.m., 101.3°. On Sunday, 3 a.m., 102°; 7 a.m., 100.4°; 11 a.m., 100.1°; 2 p.m., 102°; 5.15 p.m., 101.4°; 9 p.m., 102.1°. On Monday at 3.30 a.m., 100.3°; and at 8.30 a.m. the same." I visited her to-day, Monday, about noon; she was coughing a great deal—a loud, barking, brassy cough, and complained that it hurt her left side a good deal to do so. "My bones ache," she said, "a good deal, but I'm perfectly easy compared with what I was. I was bad the other day and *did* feel ill." Pulse 70, regular, respiration 18, temperature 99.4°. The erythematous lumps are fading from back of arms, front of legs, and side of thighs, and hips. Continue as before till fever is gone, then take kali chlor. 3x. October 26, much better. She gradually got well.

On Saturday, October 22, 1892, I was sent for late at night to see Mrs. L., whom I found in bed suffering from her back and throat. It came on yesterday. She felt stiff in the arms last Monday; that passed away. Yesterday her throat became affected, and she was unable to swallow anything. Has as much

difficulty in swallowing to-day. To-day it took her in her back, she says, so that she could not move. She was cold, and shivered, and wanted to sit over the fire. Has headache; also disagreeable taste in the mouth. Pulse 144, respiration 34, temperature 101.6°. On examining the throat I found the tonsils and adjacent structures greatly congested. On the left tonsil were a number of small mattery-looking spots, and on the right a dirty yellowy-grey patch, about the size of a threepenny-bit. Ferr. phos. 5x every two hours. Sunday, 23.—Got relief from the pain in about half an hour; can swallow rather better this morning. Kali chlor. 3x every two hours. Monday, 24.—Throat much better. The patches are nearly gone; the parts about are still much congested. Pulse 126, temperature 99.2°. Tuesday, 25.—Doing well; no pain whatever in the throat.

Miss P. was visited for the first time on Friday, November 24, 1893. She complained of her throat; had not been quite right for two or three days, being hot and cold by turns. She has much difficulty in swallowing, and her throat is very painful all round. Voice is nasal. Pulse 104, temperature 101°. Both tonsils much enlarged, and very congested; surrounding textures present a similar appearance. The right tonsil is studded on its inner aspect with numerous follicular ulcers. The left is not so dotted, but a streak of pus hangs down its inner aspect, close to the uvula, which is in contact with this tonsil. Ferr. phos. 5x every fifteen minutes, half hour, hour, and so on. Saturday, 25.—Did not sleep very well. Pulse 88, temperature 100.2°. Many of the ulcers are gone. The redness and swelling are less. Monday, 27.—Slept much better; voice less nasal; less swelling and redness than yesterday. Pulse 80, temperature normal.

I saw Miss N. on August 9, 1894. She is 25, above medium height, stout, has dark brown hair and grey eyes. On the 5th her throat felt as if swollen on the left side, had dreadful headache in the temples as if they would burst. Monday the 6th, was hot and cold alternately, felt light-headed and as if her strength were gone. Sunday afternoon had pain in the left side from the heart to the shoulder. On examination the throat was found to be greatly congested, both tonsils much swollen and congested with greyish-looking patches. These had very much the appearance of a diphtheritic membrane; and some of those cases of suppuration of the follicles, in which the pus has become matted so as to form a patch of greater or less extent on one or

other or both tonsils, are often difficult at first sight to determine the character of. In this case, on closer inspection, I was able to detect the individual points of suppuration, and often in a doubtful case by scraping a little of the purulent matter that has become caked on the surface aside we are helped to a true decision. There was considerable subsequent oedema, but under ferr. phos. and kali chlor. the swelling declined, the patches disappeared, and she was soon all right again.

In another case of follicular tonsilitis in a young woman, aged 21, there were the following symptoms: shivering, flushed face, sore throat, pain and stiffness in the nape, nasal tone of voice. Pulse 112, temperature 103°. Arms presented a rosy red appearance, but there was no rash on chest or legs. Her hands steamed when taken from under the bedclothes. Many follicles on both sides were in a state of suppuration. Ferr. phos. 5x. was given frequently, and on the 7th, the second day after I had first seen her, the pulse was 88, temperature 99·6°; after this she was soon all right.

I was called to Annie D., aged 9, on Thursday, March 21, 1895. She is fair with blue eyes and rosy complexion. On going to bed the previous night she was a little hoarse. She has a dry, brassy, ringing cough, and complains of pain over the larynx. Pulse 142, temperature 101·4°. Ferr. phos. 5x and kali chlor. 3x alternately every two hours.

Friday, 22.—Cough was very troublesome till 1 a.m. after which she coughed scarcely anything, and it is looser when she does so. Pulse 88, temperature 98·4°. Tongue moist, slightly coated with thin grey fur. Continue, but take kali chloricum more frequently than the other. Saturday, 23.—Slept well; cough rather troublesome last evening, since then has coughed little. Pulse 84. Temperature subnormal. Allowed up. Monday, 25.—Going on nicely.

I was called on Wednesday, March 20, 1895, to Percy C., aged 5, a stout little fellow, with light brown hair and grey eyes. On Sunday he was hot and burning all day, and had a hard, dry cough. The cough has continued since then and is now harsh, brassy and croupy in sound, but with a tendency to soften and a little phlegm to be dislodged, pulse 112, temperature 102°, respiration 40. Tongue covered except at tip with grey fur. Ferr. phos. 5x every two hours. In the evening his temperature was 103·2°, pulse 142. Coughing almost incessantly while I was in. Kali chlor. 3x in alternation with the other.

Thursday 21, at 10 p.m. he dropped off to sleep, and slept a nice long time without coughing. This morning he is much improved; has not coughed once during my visit. Pulse 92, respiration 36, temperature 98·8°. I am told, when he coughs, it is much softer in character. Continue. Saturday 23.—Doing well.

In a few instances I have used ferr. phos. with advantage in epistaxis; it is also of service in feverish conditions following blows upon the head.

Wednesday, November 21, 1894, I saw Jamie H., aged 5. A week ago yesterday, while playing about in the back premises, he fell down a flight of eight steps; he struck his head, it is thought, upon a barrow that was lying at the foot and made a clean cut down to the aponeurotic fascia, which was exposed, but as far as I could ascertain the bone was not bare. The parents seemed averse to its being stitched, and having already plastered the part up with ordinary sticking plaster I removed this, and endeavoured to bring the edges together as well as I could with strips of arnica plaster. He was also given *arn.* 3 internally. Next day things seemed to be going on satisfactorily, but in two or three days more it was not so. By this time very offensive pus was oozing from the wound and his face was swollen, the lower lids cedematous, and there were several red spots about the face and neck. Next day he was rather better. I bathed off the strips of plaster and applied glycerole of calendula. The day following I found him with a temperature of 102°, pulse 120; numerous red patches and an appearance as of vesicular erysipelas about the face; the left cheek was flushed, and it and the forehead were dotted over with little vesicles. Ferr. phos. was given every two hours. Yesterday morning his temperature was normal, by afternoon it was 102°. The wound was gaping, the edges red and irritable-looking, tongue rather dry with a red triangle at the tip, the rest was coated with whitish fur. He complained of pain in the umbilical region; no sickness. Continue the ferr. phos. Very restless last evening, muttering in his sleep; towards night, better. To-day at 2 p.m., temperature normal, pulse 100, wound looking better; tongue cleaner and more moist. Friday, 23.—All fever gone, bright and cheerful; the wound is converted into a granulating sore and looks much more healthy.

In a case of measles in which the rash came very imperfectly out, and which was complicated with croup and

alarming bleeding from the nose, I found ferr. phos. of the utmost service in controlling the epistaxis and mitigating the patient's condition. I gave acon. and spongia for the croup, and under these the stridor left the breathing and the cough softened. Just then his nose bled ten or twelve times, and when I saw the amount of blood he had lost (for his mother had preserved it in a vessel for me to see) I could scarcely think it possible that a little fellow of eight should lose so much blood and not be in a state of collapse. His pulse was very weak and compressible, and the following day it was 124, temperature 103·4°; there was also considerable muscular twitching. During the succeeding night he was very restless, and at times delirious. The rash had now come out well, pulse 124, respiration 28, temperature 101°. No return of the epistaxis. He was now troubled with retention of urine which was remedied by the application of a hot sponge; 10 p.m. pulse 118, temperature 100·4°. For two nights more he wandered a good deal, but the pulse decreased in frequency and the temperature steadily fell, and if your experience is similar to mine, delirium during the subsidence of acute diseases is nothing to be alarmed at.

Amongst other diseases that I have treated with these two remedies, are scarlet fever and diphtheria. Had time permitted, I should have liked to place before you a detailed account of some of these, but already I have trespassed too long both on your time and patience.

This is the first time that I have had the privilege of addressing this Society, although it is not the first time you have honoured me with the request to do so. I thank you for your kindness, and only wish that it had been in my power to traverse a wider area and give you something more uniform and consecutive than I have been able to do to-night.

However, such as my paper is, I leave it with you in the belief that as you pass judgment upon it it will be in that spirit of charity which is the finest trait in the character of the individual, and the grandest ornament of any profession.

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Dr. GALLEY BLACKLEY said, presuming that the recent book by Drs. Dewey and Boericke was the best modern account of the so-called tissue remedies, he would like to know whether Drs. Schüssler, Dewey and Boericke were practical physiologists. It was evident that they were interested in analytical chemistry, but he was afraid that the drift of all modern physiological work had been in the direction of showing that the body was not a mere chemical laboratory. At the very outset of our study of the twelve tissue remedies, one was struck by the fact that they were all substances which would be classed by chemists as "inorganic." One naturally asked why? They were simply the result of the crucible and the retort of the chemist. All organic constituents that had been in combination with them had been burnt out of them. That, to his mind, was a most fatal objection to the whole theory. If it were argued that those inorganic residua were the chief and the most important constituents of the body, then he thought a most vital and serious mistake was made, and all modern physiological research was opposed to it. The calcium phosphate, the sodium chloride and the potassium chloride, &c., &c., found in the body existed, not, in all probability, as such, but only in combination with other and equally important substances. But little work had been done of late in the way of elucidating those facts, but even as long ago as the early part of the century it was well known that scurvy depended upon the absence of potassium salts in the blood. Although that was true, a minute dose of potassium carbonate would not do very much good for the sailor sick with scurvy; a good large dose in the shape of lime juice must be given. In the same way it was known that in anæmia there was a deficiency of the hæmoglobin, the iron-containing element of the blood, but the experience of those who had experimented upon the subject was that a cure could not be effected by giving infinitesimal doses of iron. One of the very latest items as a contribution to the study of the chemical dependence of certain states upon the lack of certain inorganic constituents was Prof. Wright's experiments upon the coagulation of the blood, in which he had shown that this depended very largely upon the presence of an adequate amount of lime salts in the blood. Prof. Wright had gone further and cured a great many morbid conditions associated with defective coagulating power by giving lime steadily for weeks or months, but he did not give it in infinitesimal doses. He gave 15 or 20 grains, three times a day, of calcium chloride. There was no means of knowing

whether the tissue remedies existed as inorganic substances in the body, and it was very doubtful if in infinitesimal doses they could be trusted to act as dynamic remedies upon the tissues which contained them.

Dr. GOLDSBROUGH thought that some of Dr. Black's remarks with regard to the formation of tissues were not quite in accordance with the latest researches in biology. Dr. Black referred to granules combining together to form cells. That was regarded as an error, cells were formed by division or reproduction from other cells alone. In no sense of the word had it been observed that any inorganic substance had been transformed from an inorganic substance into a bioplast. The things were totally distinct, and had to be kept distinct in the mind in considering physiological questions. The next point was that the tissue drugs dealt with the formed material of the body and not with the bioplasts themselves. That was an important thing to be borne in mind. Hæmoglobin, for example, was a formed material, it was not bioplasm; so with certain parts of the nerve structures. It must be remembered that inorganic and organic substances went to form part of the formed material, which was the result of the action or was the effect of the bioplasm. Dr. Black had given a series of drugs which should be kept in mind, but which represented only a very small part of homœopathy, a real part, it was true, inasmuch as formed material constituted a very large amount of the human body. The field of homœopathy was as large as the law of bioplasm, which maintained its equilibrium by changes (metabolism) and increased itself by reproduction and by division.

Dr. ROBERSON DAY, in dealing with the more practical part of the paper, was glad to find that his experience, in some measure, coincided with that of Dr. Black. Ferum phosphoricum had proved invaluable in the treatment of several cases of enuresis in children.

Dr. BURFORD was interested in a side issue, viz., the intimation of the difficulties Dr. Black had had in canvassing the material theory of life, that life in its essence and manifestation was nothing more than the physico-chemical forces which were all expressed in physico-chemical processes. That was a view impressed upon thinkers years ago by the dominant genius of such men as Huxley and Tyndall. That bald view had now-a-days somewhat receded into the background, and a form of the old view of vitalism, somewhat rehabilitated, was found a necessary adjunct, as more in consonance with facts. That



doctrine implied that there was more in the manifestation of bioplasmic activity than could be expressed in physical and chemical terms. The bearing of that upon homœopathic practice was of prime importance, inasmuch as it allowed for a dynamic as well as physiological action of drugs. There was no way of explaining the dynamic action of remedies specifically selected for treatment of disease except by postulating a condition of things which neither chemical nor physiological influences would account for.

Dr. BLACK, in reply, did not wish it to be supposed that in practice he limited himself to the twelve tissue remedies of Schüssler; he should be very sorry indeed to do so. He agreed with Dr. Blackley that it was impossible to arrive at any definite conclusion as to what went on in the human body from what might transpire in a chemical laboratory.

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## AN ABSTRACT OF FORTY-SEVEN CASES OF ENTERIC FEVER, WITH REMARKS.

BY MAJOR H. E. DEANE, M.R.C.S., L.S.A.

*Of the Royal Army Medical Corps in India.<sup>1</sup>*

THE following letter from Major Deane to Dr. Byres Moir will explain the presentation of the following communication to the Society on this occasion.

BANGALORE.

*February 11, 1899.*

MY DEAR MOIR,—I am afraid this schedule is much too late for incorporation with others, but I could not help it. The cases were interrupted first in 1897 by plague duty in Bombay, and again the same year by active service; and I had hoped to have a complete fifty cases, but they were again broken into by plague duty here. These are the cases I have had under me since obtaining the schedule only. If you think they would

<sup>1</sup> Presented to the Section of General Medicine and Pathology, June 1, 1899. The abstract was prepared by Dr. Goldsbrough, Secretary to the Section, from the Schedule of cases sent to the Society by Major Deane for the purpose of collective investigation.

interest the Society, will you bring them up one evening; or do anything you like with these notes, if the schedule is too late to be of use for the collective investigation.

Owing to my unavoidably losing touch with them by absence, the charts of cases 2, 12, 15 and 39 have gone astray, leaving the details of the last case unrecorded beyond the fact that the patient recovered.

It occurs to me to make some remarks about the disease generally, based on my own experience and observation, as though they will be nothing new to you and other *confrères* they are at variance with what is frequently stated by men out here.

Yours sincerely,  
H. E. DEANE.

#### ABSTRACT OF CASES.

The following is an abstract of the cases :—

*Sex and occupation.*—The patients were all males, either in the army or employed in connection with it.

*Age.*—With the exception of two, the ages all ranged in the third decade of life—from 20 to 30. The two exceptions were a boy of 14 and a man of 37.

*Source of infection.*—This is reported as sporadic in one case, epidemic in forty-six.

*Temperature.*—The maximum temperature is shown on the schedules to be as follows :—

F. 102·3°	in	4	cases.
103·4°	„	15	„
104·5°	„	25	„
105°	„	2	„
107°	„	2	„
Unreported	„	1	„
—			
Total		47.	

*Eruption.*—A rash is reported in ten out of the forty-seven cases.

*Diarrhœa.*—Noted as occurring in twenty-two out of the forty-seven cases.

*Hæmorrhage.*—Occurred slightly in nine cases, and severely in two. Epistaxis occurred in two cases.

*Albuminuria* was observed as a trace in 1 case.

*Complications.*—Congestion of lungs is named as occurring in four cases ; congestion in two ; prostration in one. Convalescence was prolonged by malaria in one case, and by pyrexia in one case, lasting fourteen weeks.

*Relapses* occurred in two cases.

*Death* occurred in five cases.

*Duration.*—The duration is set down in weeks as follows :—

Two weeks	...	...	1 case	...	1 death.
Three	„	...	3 cases	...	2 deaths.
Four	„	...	5 „	...	1 death.
Five	„	...	5 „	...	1 „
Six	„	...	19 „	...	0 „
Seven	„	...	4 „	...	—
Nine	„	...	2 „	...	—
Ten	„	...	3 „	...	—
Fourteen	„	...	1 „	...	—
Unreported	...	...	4 „	...	—
Total			...	...	47 cases
					5 deaths.

*Cause of death.*—This is given after *post-mortem* examination as extensive ulceration down to peritoneum in one case, and perforation in two cases (one being undiagnosed during life, concerning which see remarks below). Congestion of lungs is a reported cause of death in two cases.

*Treatment.*—(a) *Diet.*—Liquid diet is named as being given in sixteen cases, milk in thirteen, beef-juice in one. (b) *Stimulants.*—No stimulants were given in nine cases, of which one died. Brandy was given in one case, champagne in fourteen cases, brandy and champagne in two cases. In the remainder the use of stimulants is unreported. (c) *Drugs.*—No drugs were administered in ten cases, one of which died. Baptisia was given in twenty cases, arsenicum in eleven cases, hyoscyamus in three, mercurius cor. in two, phosphorus in two, and hamamelis, digitalis, lachesis, rhus tox., and turpentine in one case each.

#### REMARKS BY MAJOR DEANE.

##### *Origin.*

I have put the causation in all cases as epidemic, but if I said endemic, it might be more accurate. The cases at times diminish, then increase ; and this year one such

decrease occurred after a well which supplied drinking-water—and in which the typhoid bacillus was said to have been found—was closed. A few weeks later, however, an increase occurred again, and I am told that the bacillus has been found in a vessel for drinking-water in barracks.

Case 36 contracted the disease when under treatment in hospital for venerea.

Case 35 was a sick orderly, mainly over typhoid cases in hospital, when he contracted it.

### *Diagnosis.*

As regards diagnosis, I have often heard the statement that temperatures out here are so apt to be modified by malaria and perhaps other climatic causes, that no inferences can be properly made from the temperature; and also that it is impossible to place any dependence on a rash, as it is impossible to distinguish it from sudamina. I am prepared to maintain that these statements are based on insufficient observation. A reference to these charts will exemplify the first, and there is no more difficulty in detecting a rash here than at home, where it requires careful observation, I imagine, as much as out here. The difficulties which occur in some cases are probably no greater than occur at home. For instance, take Case 35, which presented what were considered negative symptoms of typhoid, though personally I had little doubt in the diagnosis of it. However, I began feeding the patient, and up went his temperature with a typical course, and a rash which had been absent or not noticed before made its appearance.

A symptom to which I attach great significance is nose-bleeding, which sometimes occurs before the man's admission to hospital, and sometimes soon after. I am inclined to go so far as to say this symptom is absolutely diagnostic in any doubtful case. I mean, if a case be doubtful for the first two or three days, nose-bleeding will settle the question. In many cases the aspect of the patient is sufficiently diagnostic; the heavy, dusky appearance of the face is very

marked in many cases. In short, I find no difficulty out here in diagnosing typhoid that is not common to the question at home.

### *Symptoms.*

As regards symptoms it will be noted that constipation is common, and that albuminuria and lung symptoms are practically absent in this series. At other stations, though, the latter might show a different record. One word about this constipation—sometimes it is absolute, see Cases 35, 36, the latter never having a motion throughout, except by enema. In many cases, though, constipation does not exist, nor does diarrhoea, properly so-called. There may be one action of the bowels a day, or every two or three days, and the motions will be typical of typhoid.

It will be convenient here to remark on the treatment of the constipation. During the acute stage of the disease, say to the beginning of the third week, in the absence of indications to the contrary, I leave it alone—interference may be disastrous, and I refer to Case 18. The man may have died in any case, but I know that after he was given an enema on the thirteenth day, after five days' constipation, he at once got worse, and instead of any satisfactory result from the enema, he had severe tenesmus and passage of small quantities of liquid fæces for some hours, and I cannot help thinking the enema produced or hastened his downward course.

### *Treatment.*

A few words about treatment. Speaking in my own sphere of life, I have been much impressed with one fact, that typhoid cases can be and very often are over-fed and over-stimulated, and what perhaps is worse, over-diagnosed. If the patient is not being treated on some one's pet theory of the disease, he is drugged for each symptom, and it is a common thing to see a man dosed night after night with sleeping draughts which utterly fail to produce the desired result, but rarely fail to produce others undesirable. However, this need not be continued.

As regards this series of cases, in the acute stage three pints of milk were the allowance, increased by another pint of chicken broth according to judgment, and for stimulants I use mostly, as have been noted, champagne, and then only when the pulse was greatly dicrotic and tongue becoming dry. It was omitted as soon as these symptoms showed improvement. The drugs used were mostly baptisia and arsenic. I have had no experience of the abortive effect of baptisia, though I have thought at times it had such a tendency, but the cases have progressed more comfortably under that drug than under any other treatment I have seen. No patient ever vomited, which is common under the routine prescribing of rational (!) medicine.

The severe headache in some cases I have found subside after the first or second day in bed without anything specially for it. Sleep came naturally after a time, and I never directed treatment towards putting a man to sleep, and he was the better for it. Of course, with a complete armamentarium of homœopathic medicines at hand I should perhaps prescribe some suitable remedy.

#### *Treatment of Hæmorrhage.*

In the treatment of hæmorrhage I have given up the established method of ergot and turpentine, as I have seen no satisfaction from either of them either in my personal experience or in the experience of others' practice. I give now ten drops or even twenty of hamamelis every half hour or hour, according to the case. In Case 31, which was the worst I think I have seen recover, it acted well, and also in other cases.

I have remarked that slight hæmorrhages seem to be a favourable sign, and I had one case before I began this schedule where a severe hæmorrhage was followed by a fall of temperature to normal, and no further rise and a rapid convalescence.

#### *Relapses.*

As regards relapses and rises of temperature, I think they are mostly due to errors of diet or too much diet. There are

occasions out here when several typhoid cases and others, too, will get an evening rise, evidently due to some atmospheric condition, and the days have generally been sultry.

I must remark on Case 2, which was a case not diagnosed till a *post-mortem* was performed. The patient had been in hospital a few days and discharged as an ordinary case of fever, and his temperature had been normal several days. He was re-admitted a few days later, and came under me, and from the above facts I was rather put off typhoid. His temperature was only once 100°, but he complained of severe pain all over the abdomen, and when you went near him he flinched and cried out in an hysterical way. The abdominal muscles were rigid, and he would not allow the hand to rest, however lightly, on him. I was disposed to consider him in a hysterical state, although his pulse was always rapid. From his history and chart I was lamentably misled, though the issue could not have been prevented. He died, and a perforation was found through a typhoid ulcer. I regret the loss of the temperature chart in this case.

*Auto-infection ? Re-infection ?*

Some of these charts seem to me to indicate a re-infection of patches after commencing resolution of them. See Cases 13, 26, 27 for instance.

*Mortality.*

I doubt if the mortality out here can be brought much below 10 per cent. I send the mortality here for the last five years :—

			Cases.			Deaths.
1894	...	...	39	...	...	10
1895	...	...	18	...	...	2
1896	...	...	47	...	...	16
1897	...	...	67	...	...	12
1898	...	...	47	...	...	8

The mortality in my own series is five deaths in forty-seven cases. I feel sure many cases would recover if only their stomachs and nervous systems were given a chance.

Dr. DUDGEON said that high temperatures were very often met with in cases of Indian fever. He had seen a patient, newly arrived from India, and had been astonished to find the temperature was  $107^{\circ}$ . He thought the case was a very severe one, but after waiting for some time he found the temperature had gone down two or three degrees, and that it was very nearly normal next day, showing that Indian fever was apt to produce a higher temperature than doctors were in the habit of observing in fevers in England. From the case he had mentioned and several others he had seen he was not inclined to look upon a temperature as high as  $107^{\circ}$  as a very alarming feature in a case of Indian fever, though he had found it a fatal temperature in ordinary enteric fever of this country.

Dr. GALLEY BLACKLEY wished that a little more detail had been given with regard to treatment. Very little information as to the treatment of typhoid fever by means of homœopathy in India was obtainable, and it would have been very interesting to have seen how patients under homœopathy fared in a climate where everything was so much under the influence of malarial fever. There was no doubt that the malarial poison left its impress upon most other diseases. He had listened with considerable interest to what Major Deane had said about his experience of baptisia, viz., that it was helpful, but certainly did not appear to abort the fever. That, he thought, was the mature experience of most men who had really had the opportunity of putting the thing to the crucial test. A good many years ago he published some cases, half of which were treated with baptisia and half without; and those that were treated with baptisia did not appear to differ in any sensible degree from those that were treated with other remedies. With regard to hæmorrhage, his experience had been that of Major Deane, that a slight hæmorrhage seemed to be a salutary measure. He had always laid stress, in his teaching at the bedside, upon the value of the occurrence of epistaxis for diagnostic purposes. Where he learned it he could not actually say, but he suspected that it was from some of his teachers in the Manchester Royal Infirmary, probably from Sir William Roberts.

Dr. ROBBERSON DAY thought that constipation was a symptom of enteric fever more commonly met with than diarrhœa. In former years diarrhœa was almost always met with, but at the present time constipation appeared to be much more frequent than diarrhœa. Other diseases altered their character in the same way. It was an illustration of a change in the epidemic constitution.



Dr. STONHAM suggested that the difference in the symptoms was due not to the disease altering its character, but to the difference in the treatment. Milk diet had very much to do with the excess of constipation symptoms over those of diarrhoea. The use of baptisia in homœopathic practice also had something to do with the constipation, for he had found that baptisia was a constipating drug when given for other complaints. There was no doubt as to the value of baptisia in typhoid fever, though it did not act absolutely as an abortive or in any way neutralise the specific poison. Baptisia had great influence on the alimentary tract and acted by subduing the catarrhal condition which accompanied the typhoid ulcers, enabling the patient to take more food, to assimilate it better, and it had the effect of reducing diarrhoea and causing constipation.

Dr. PURDOM had used baptisia successfully for the last twenty-five years in cases of typhoid fever. As to hæmorrhage, in a very bad case he had a short time ago, great comfort was obtained by using an ice-bag and injecting ergotine.

Dr. GOLDSBROUGH said, as far as his recollection served him, a certain proportion of cases of typhoid always had a tendency to constipation. He remembered very distinctly one or two cases where the stools were always formed, and were pale probably because of the milk diet. Milk had always been given in typhoid as one of the articles of diet, so that it could hardly be credited with producing constipation. The cause of relapses had not been referred to. Major Deane said they were caused by over-feeding. He had a case last year where the patient had three relapses, really four attacks of fever. Two nurses took care of the patient, and he gave as much attention to the case as possibly could be given. In only one instance could the relapse be attributed to even an alteration in feeding. A little mutton broth had been given as a change from milk. Eventually he had the patient removed from the house in which she was living into another house not a great distance off. Forthwith she got better. That might be a coincidence, but he had been impressed by the fact. Although nothing could be found wrong with the drainage of the house in which the patient originally contracted the disease, it was not a healthy house, being damp in the basement. He considered the patient's recovery due to her removal from one house to the other.

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A CLINICAL AND PATHOLOGICAL STUDY OF  
DIPHTHERITIC PARALYSIS.<sup>1</sup>

BY J. HERVEY BODMAN, M.D., B.S.LOND., M.R.C.S., L.R.C.P.

MR. PRESIDENT AND GENTLEMEN,—When the Secretary of the Section of Medicine and Pathology honoured me with the request that I would read a paper during the present session, I chose the subject of diphtheritic paralysis, because it was one which specially aroused my interest during my term of residence in the hospital; and some cases which we had gave me the opportunity of making a few observations on the disease, both in its clinical and pathological aspects. These observations were, however, on too small a scale, and of insufficient importance, to form by themselves the subject of a communication of this kind; I shall, therefore, simply incorporate them in what will be at the best but a rough sketch of what is at present known about this interesting form of nervous disease, making no attempt at an exhaustive presentation of the subject. I must, therefore, request your indulgence in submitting to your consideration an effort which will bear on the face of it the marks of being the work of a beginner.

*Ætiology.*

The paralysis which follows diphtheria has such a definite and characteristic symptomatology that it can usually be certainly diagnosed without reference to the recent history of the case, that is, without knowing that the patient has recently had an attack of diphtheria. In fact, in many cases it is impossible to obtain a definite history of an attack of diphtheria; but in spite of this it is probably safe to assert that in every case where this form of paralysis develops there has previously been some form of local diphtheritic infection, either obvious or latent.

<sup>1</sup> Presented to the Section of General Medicine and Pathology, June 1, 1899.

The importance of latent diphtheria is becoming increasingly recognised, and in a special section devoted to it in Allbutt's System of Medicine, Gee<sup>1</sup> describes faucial, nasal, and laryngeal varieties; and there can be little doubt that in one or other of these forms of latent diphtheria is to be found the explanation of those cases of this type of paralysis which appear to have occurred as a primary affection, or as the result of some non-diphtheritic malady.

The frequency with which diphtheria is followed by paralysis is very variously stated by different authors:—Osler<sup>2</sup> thinks the proportion of cases in which it occurs varies between 10 and 20 per cent., but Gowers<sup>3</sup> believes that “on an average one-fourth of those who do not die of the primary disease subsequently suffer from paralysis.” This seems a high figure, but there is no doubt that many slight cases pass unrecognised. Among the thirty cases of diphtheria which were treated in this hospital during my year of office as house physician, only two subsequently developed paralysis.<sup>4</sup>

The liability to suffer from paralysis is not proportionate to the severity of the primary disease; in fact R. W. Parker<sup>5</sup> has observed it to follow mild attacks of diphtheria more often than severe ones, and he suggests in explanation that this may be due to their being less effectually treated, and points to the analogy of scarlatinal nephritis, which is more liable to follow slight attacks, owing, it is supposed, to less care being taken of the cases during convalescence.

The paralysis may follow a diphtheritic process involving any part of the body. Gayton<sup>6</sup> has recorded a typical case in a child following diphtheria limited to the vulva; and Griesinger, the celebrated authority on mental diseases, succumbed to paralysis following diphtheria of the wound produced in opening a perityphlitic abscess.

In view of the striking effect of antitoxin treatment in reducing the rate of mortality from diphtheria, it is only natural to ask what has been its effect on the occurrence of diphtheritic paralysis. Goodall,<sup>7</sup> of the Eastern Fever Hospital, says that since the introduction of antitoxin treatment the number of cases of paralysis has increased, and he attri-

butes this to the fact that numbers of cases that would otherwise have died in a few days, and before there was time for paralysis to develop, now either recover or live longer. The number of fatal cases of paralysis has, it is satisfactory to learn, greatly diminished. In cases where it was possible to commence the antitoxin treatment early, the liability to paralysis was distinctly reduced.

In connection with the ætiology of diphtheritic paralysis, mention may be made of certain anomalous cases in which the paralysis preceded instead of followed the throat affection. Several cases of this kind were observed by Boissarie<sup>8</sup> in connection with an epidemic of diphtheria in Paris; and Mr. Frank Watkins once told me of a similar case which he had met with in New Zealand. It is difficult to explain the occurrence of such cases; possibly the paralysis was preceded by some unrecognised diphtheritic infection, the subsequent throat affection being of the nature of a relapse.

### *Symptomatology.*

The first symptoms of diphtheritic paralysis occasionally occur during the course of the primary disease, but not as a rule until after an interval of variable length. The most common time for the onset of paralytic symptoms is two or three weeks after the subsidence of the primary attack, but it may be as late as eight or ten weeks after. Generally speaking, the earlier the paralysis develops the more likely it is to be severe.

The earliest symptoms to attract notice are usually those due to paralysis of the soft palate, viz., nasal voice and regurgitation of fluids through the nose during swallowing; but sometimes other symptoms appear before these, *e.g.*, weakness of the legs, squint, or facial paralysis. When looked for paralysis of accommodation is found to be an early and almost constant symptom; but in children, unless specially sought for, it generally passes unnoticed. The paralysis is usually gradual in its onset and progress, but it varies greatly in severity. In some cases the palatal paralysis is the only prominent feature of the disease, and is only

of brief duration. "In others," to quote from Gowers,<sup>9</sup> "region after region is successively attacked; the parts which suffer first, as the palate and the eye, may recover before the limbs are involved; and when these are improving and a speedy convalescence is hoped for, paralysis of the trunk and respiratory muscles may come on and throw the patient into extreme danger. Irregular waves of palsy seem to flow through the body, sometimes quickly, sometimes slowly; and determined as it is by influences that we cannot discern, its course can never be foretold."

I will now endeavour to describe in some detail the clinical features of these severe cases, two of the cases which I shall presently narrate having been of this description. The patient—usually a child—lies in a condition of marked listlessness and apathy, showing disinclination for the slightest exertion, and refraining, as far as possible, even from speaking or crying; when he does speak the voice is often husky, or there may be complete aphonia from laryngeal paralysis; but if this is not present the voice will probably have the nasal character imparted to it by paralysis of the soft palate. The swallowing of fluids is usually followed by the regurgitation of a portion through the nose, and, in some cases, by an attack of coughing owing to imperfect descent of the epiglottis during swallowing permitting the passage of some of the fluid into the larynx. There is often severe anorexia, and occasionally the pharynx is paralysed and deglutition is impossible. The breathing is quiet, and sometimes slow and sighing or irregular. In many cases there is evidence of weak action of the diaphragm in weakness or absence of the respiratory movements of the upper part of the abdomen; and in those cases where the diaphragm is completely paralysed, the normal respiratory movements of the abdomen are reversed, the epigastric region receding during inspiration and rising again during expiration. This weakness or paralysis of the diaphragm is generally accompanied by exaggerated respiratory movements of the lower ribs, which should perhaps be regarded as an effort at compensation, though it may be simply due to the diminution of the inward traction of the diaphragm

upon the lower ribs during inspiration. There is often a characteristic weak ineffectual cough, due partly to imperfect closure of the glottis, from laryngeal paresis, and partly to the weakness of the diaphragm. The pulse is usually weak and irregular; its frequency may be either diminished or increased, the retardation being most commonly observed in the earlier, and the acceleration in the later stages of the disease. There is always more or less loss of power in the extremities; and the knee-jerks are almost invariably absent, though their disappearance is occasionally preceded by temporary exaggeration. In some cases, if walking is permitted, there is a peculiar gait, the legs being moved as if they were limp and heavy; in others the gait is distinctly ataxic, like that of locomotor ataxy. The principal muscles of the trunk or neck may be paralysed, so that the child is unable to sit up or to hold the head erect. Other manifestations of the paralysis which may be present are strabismus, ptosis, facial paralysis and incontinence of urine. In many cases there is no impairment of sensation; when present it usually affects the distal parts of the extremities; but it may also, as Bristowe<sup>10</sup> has pointed out, involve districts situated in the middle line of the body, such as the lips, the tip of the tongue, the point of the chin, the back of the neck, &c. The senses of taste and smell are occasionally impaired or lost.

Besides the above symptoms, which are usually of gradual onset, these cases are liable to sudden and alarming attacks, in which the symptoms are chiefly cardiac or respiratory, or both. Leonard Guthrie<sup>11</sup> has appropriately named these attacks "bulbar crises," for there is good reason to believe that they are due to "sudden and severe functional disturbances of the vital centres in the medulla." In describing these crises I shall follow somewhat closely Guthrie's account of them as published in the *Lancet*, 1891, vol. i., as his description was fully corroborated by the cases we had in the hospital. The symptoms in a case of diphtheritic paralysis which should be looked upon as premonitory of these attacks, are: (1) marked listlessness and apathy; (2) weak, hoarse, and nasal voice; (3) weak, noiseless

cough; (4) irregular and sighing respiration; (5) rapid pulse; (6) vomiting. A crisis may be brought on by emotional excitement or physical exertion. The attacks consist to a large extent of a sudden exacerbation of pre-existing symptoms, though fresh symptoms also frequently make their appearance at the same time. Occasional dysphagia is replaced by absolute paralysis of deglutition; a weak, hoarse voice gives place to complete aphonia; instead of slightly embarrassed respiration there is sudden and alarming dyspnoea, and sometimes respiration becomes very slow. The pulse becomes rapid, weak, and often irregular. In some cases the temperature rises to 102° or 103°. There is no loss of consciousness, unless from syncope or a severe degree of asphyxia. In some cases the respiratory symptoms are the most prominent, the dyspnoea becomes increasingly severe, and the respiration more and more irregular and sobbing in character, the inspirations being sudden and forcible and the expirations feeble; mucus accumulates in the air passages, causing râles all over the chest; expectoration is impossible owing to the weakness of the muscles of respiration; cyanosis and profuse sweating ensue, and the child dies of asphyxia, suffocated by the unexpelled mucus in the bronchial tubes. It is not difficult to understand that cases of this kind in children are sometimes mistaken for capillary bronchitis. In other cases the cardiac symptoms are the most conspicuous; a sudden attack of syncope occurs, from which the patient may or may not rally, the pulse runs up to 140 or 150, or even 200, being at the same time very weak or imperceptible at the wrist. Vomiting often occurs in association with these respiratory and cardiac crises, and like them is probably of bulbar origin, and thus analagous to the gastric crises of locomotor ataxy.

The majority of the cases in which bulbar crises occur prove fatal. In a series of 64 cases of diphtheritic paralysis treated as in-patients at the North-Eastern Hospital for Children, and recorded by Pasteur,<sup>12</sup> 22 had crises, and of these 17 died, a mortality of over 75 per cent. But these bulbar crises are not the only cause of death in diphtheritic paralysis; a fatal result may also be due to respiratory

paralysis of gradual onset, to exhaustion from inability to take food owing to paralysis of the pharynx or extreme anorexia, or to aspiration pneumonia from the escape of food into the air passages during swallowing.

I will now read some notes of three cases which came under my observation in the hospital, and for kind permission to do this I am indebted to Dr. Moir, under whom the cases were admitted.

CASE I.—Joseph E., aged 3½ years. Admitted October 12, 1896.

*History of illness.*—When admitted his father and mother said he had not recently had a sore throat, nor any acute illness; and that no one else in the house had had anything of the kind; but when questioned again about a fortnight later, they admitted that five others in the house had had diphtheria several weeks before, and that one had died of it. Five weeks ago after suffering from symptoms of a feverish cold, the patient was found one morning paralysed in both legs, there having previously been no weakness in them; since that time, also, his voice is said to have been hoarse. There was no convulsion; and no change in the colour or temperature of the limbs was noticed. Since the same time he has seemed weak in the back.

*Present condition.*—Both lower extremities are paralysed; there is considerable wasting below the knees, less above the knees. Lies with feet in the position of talipes varus; the knees sometimes get drawn up, but he has no power to extend them again. No abnormality of sensation. Knee-jerks and plantar reflexes absent; no ankle-clonus. No paralysis of palate or accommodation. Urine—acid, clear, no albumen.

On October 19, conium  $\phi$ ,  $\eta$ ii. t.d.s., was prescribed.

*Progress of case.*—October 27. On one occasion during the last two or three days some milk regurgitated through the nose, but apart from this he has always swallowed every kind of food well.

October 31.—No improvement in condition of legs. No reaction to faradic current in muscles of lower extremities.

November 1.—Whilst sitting up in bed eating his dinner to-day gave a peculiar cry with a choking sound, and fell forwards helpless; his face was very pale, and the pulse could not be felt for a few minutes. He rallied from this attack in a short time, but has been more helpless since. The movements of the thorax are now exaggerated; but the epigastric region is sucked



in and becomes concave during inspiration, and is distended during expiration (thus showing that the diaphragm is paralysed). He is unable to cough; when he attempts to do so he only makes a short expiratory effort without any force.

November 2.—Breathing very laboured all day; no action of the diaphragm. In the evening the breathing became increasingly choky, and once there was a prolonged period of apnoea, preceded by a cry and accompanied by intense redness of the face—symptoms apparently due to temporary failure of the respiratory and vaso-motor centres. Bell.  $\phi$ ,  $\text{m}$ i. t.d.s.

November 3.—The lungs became more and more choked with mucus and he died at 4.45 a.m. At 1 a.m. some temporary relief was obtained by making him lie with the head low, the hips being raised on a pillow. Faradisation of the phrenic nerves was tried but without any appreciable result.

*Remarks.*—In this case there was not a definite history of an attack of diphtheria, but the child was said to have had a feverish cold at about the same time as five other members of the household were suffering from diphtheria; and as this was followed by paralysis, it is practically certain that he had a slight attack of diphtheria, possibly only nasal. The mode of onset of the paralysis was quite unusual, for if the father's account is to be relied upon it came on very rapidly, if not suddenly; and the legs were involved to a severe degree weeks before the paralysis of the palate developed. The case was at first considered to be one of infantile paralysis—*i.e.*, acute anterior poliomyelitis—which was not unnatural considering that there was no history of diphtheria or sore throat, and that at that time the boy's father denied that there had been cases of either in the house; besides which the paralysis was described as having come on suddenly, and there was no sign of paralysis of the palate. But that the case was really one of diphtheritic paralysis was subsequently made clear by the development of paralysis of the palate and the occurrence of a bulbar crisis; whilst the boy's father eventually admitted the recent occurrence of several cases of diphtheria in the house. The attack which occurred on November 1 was a typical bulbar crisis; the cardiac symptoms were the most prominent at the time, but the attack was followed by complete paralysis of the diaphragm from which he never recovered.

CASE II.—Ellen T., aged 4½ years; admitted August 6, 1897. This was a malignant case of faucial and nasal diphtheria, with a distinctly hæmorrhagic tendency, and complicated by nephritis. Antitoxin was used, but not until the fifth day of the disease; its employment was, however, speedily followed by improvement. Nasal feeding had to be employed for a few days, owing to refusal of food.

I will just extract from the notes of the case those parts which bear on the occurrence of paralysis.

August 13.—Pulse 120, fairly strong, but irregular; bell.  $\phi$ ,  $\eta$ i. 4<sup>th</sup> horis.

August 16.—Pulse regular to-day.

August 21.—Patient remains in a listless apathetic condition; is occasionally sick. No difficulty in swallowing (taking ars. alb. 3).

August 31.—For some time has had a slight, weak, high-pitched cough; during the last few days fluids have occasionally returned through the nose while swallowing. Knee-jerks absent. Caust. 6,  $\eta$ ii. 2<sup>th</sup> horis.

September 4.—No more regurgitation of fluids through nose since last note; has seemed rather brighter for a day or two.

September 15.—Much better; knee-jerks absent (taking strychn. phos. 1 in 200,  $\eta$ i. t.d.s.).

September 17.—Last evening, about 7.30, whilst asleep, was noticed to sob occasionally; this gradually increased, and became more frequent, and continued whilst the child was awake. At 11 p.m. the irregular sobbing character of the respiration was much more marked; there seemed to be some difficulty in swallowing, for the child swallowed very slowly, but there was no regurgitation of fluids through the nose. There was, after about 10 p.m., an occasional croupy cough, and the air, in passing in and out of the larynx, produced a slight stridulous sound, but there was no serious laryngeal obstruction; inspiration and expiration were both unimpeded; there was no retraction at the epigastrium, and no sign of weakness or paralysis of the diaphragm. On examination of the fauces, the most noticeable feature was the relaxed condition of the soft palate, the arch lying so low that it was scarcely possible to see the back of the pharynx between it and the base of the tongue. The pulse was regular and good, but quicker than it had been—about 120. There was no vomiting. From 11 p.m. till 4 a.m. causticum 6 was given every hour, but the disturbance of respiration continued to increase, so from 4.30 a.m. bell. 1x,  $\eta$ i. was given

every hour, and from that time the breathing gradually improved in character; there is now no sobbing, but the breathing is not quite regular. Respirations 22, pulse 120, regular. There is now no difficulty in swallowing, but there is still an occasional croupy cough. Voice not lost, but husky.

September 18.—Breathing quite normal; seems bright and well again. Bell. 1x., 4<sup>th</sup> horis.

September 26.—Last night, about 12 o'clock, whilst sound asleep, began to have slight sobbing respiration again; the respiration was distinctly irregular in depth and rhythm. At the same time there were occasional movements of the eyelids up and down; these movements seemed to occur at the same time as the deep sobbing respirations; less frequently there were slight momentary contractions of some of the facial muscles, producing a slight "risus sardonicus." The pulse was strong and regular. After this bell. 1x was given every hour again, and the sobbing respiration ceased at 3.30 a.m.

September 29.—Seems bright and well since last note. No further irregularity of respiration.

October 9.—Knee-jerks still absent.

October 26.—Discharged well and strong.

*Remarks.*—This was a severe malignant case of diphtheria, and there seemed to be little doubt that life was saved by the use of antitoxin. The symptoms of paralysis of the palate developed between three and four weeks after the onset of the primary disease, and appeared to be immediately benefited by the administration of causticum 6. More than a fortnight later symptoms of bulbar origin appeared; paralysis of the respiratory centre appeared to be impending; tachycardia, and laryngeal symptoms, probably due to abductor paralysis of the vocal cords, indicated impairment of the cardiac and laryngeal functions of the vagus. These symptoms were distinctly relieved by bell. 1x after the failure of caust. 6. There was a slight return of the disturbance of respiration nine days later, but it again rapidly passed off under the frequent administration of bell. 1x.

CASE III.—Ernest C., aged 6. Admitted November 18, 1896.

*History of illness.*—Was in the hospital from October 12 till November 4 with a moderately severe attack of faucial diph-

theria. There was no cardiac disturbance during convalescence. For several days the voice has been noticed to have a nasal twang.

*Present condition.*—The voice has a decided nasal twang; no difficulty in swallowing now, but he had before he came into the hospital. There has been no regurgitation of fluids through the nose. No loss of power in the limbs. Incontinence of urine every night. Frequently sick. The palate is raised in phonation. Knee-jerks absent. Pupils react to light and to accommodation. Bell. 1x., miii. t.d.s.

*Progress of case.*—November 25. Condition of palate much the same; voice still has a decided nasal twang. No difficulty in swallowing; and no loss of power in the limbs. No nocturnal enuresis except on the first and third nights after admission.

November 28.—Still has nasal voice. Palate not drawn up on phonation; palate reflex absent. Knee-jerks absent. Eyes normal. No sickness.

The case ultimately made a complete recovery.

*Remarks.*—This was a slight case of diphtheritic paralysis; the first symptoms appeared about four weeks after the onset of the primary attack. The case is of interest because of the occurrence of nocturnal incontinence of urine as a symptom, this being apparently a very uncommon result of the disease; at any rate I have never seen it mentioned in the course of my reading on the subject. Gowers<sup>18</sup> says, "the bladder is affected only in very severe cases," and speaks of retention and simple incontinence as occasional symptoms, but does not refer to the nocturnal form of incontinence. In this case it ceased in a day or two whilst taking bell. 1x.

### *Diagnosis.*

In the majority of cases of diphtheritic paralysis the diagnosis presents no difficulty; a mistake is not likely to occur unless the primary disease has escaped recognition. Case I. shows that for a time it is possible to mistake a case for acute poliomyelitis; but whereas diphtheritic paralysis usually develops gradually, this disease always has a sudden onset, and it does not tend to spread from the part first attacked to other parts as diphtheritic paralysis does; it is

further distinguished by the fact that paralysis of the palate, bulbar crises, and anæsthesia are never caused by it.

In some cases of diphtheritic paralysis the ataxia is one of the most striking features, and in the case of an adult, this, taken in conjunction with the absence of the knee-jerks, may at first lead to a diagnosis of locomotor ataxy; but the history of the case would show that the disease had developed much more rapidly than is customary with the latter malady, and further observation of the case would certainly reveal distinctive features.

In cases where the weakness of the legs is the most prominent feature spinal paraplegia might be thought of, but in this condition the knee-jerks are usually increased and there is a spastic condition of the lower extremities.

Mention has been made of the fact that during a bulbar crisis cases have been mistaken for capillary bronchitis, but careful enquiry into the history of the case, when possible, would obviate an error of this kind.

### *Prognosis.*

Most of the standard text-books on medicine speak as though diphtheritic paralysis was of little importance as a source of danger to life, and would lead one to infer that a fatal result is an occurrence of some rarity. It is only necessary to refer to the published results of two series of cases to disprove this. In a series of sixty-four cases treated as in-patients at the North-Eastern Hospital for Children, and reported by Pasteur,<sup>10</sup> death resulted in nineteen—a mortality of 29·6 per cent. ; and in a series of twenty-nine cases at the Paddington Green Hospital for Children, reported by Guthrie,<sup>11</sup> there were eight deaths—a mortality of 27·4 per cent. These results correspond very closely, and may be looked upon as giving a fair idea of the mortality of hospital cases of diphtheritic paralysis; but as a large number of the slight cases do not find their way into hospitals, this is doubtless considerably in excess of the true mortality of the disease; none the less, the results referred to show that

diphtheritic paralysis is not to be regarded so lightly as appears to have been customary.

The prognosis should be guarded if the paralysis commences very soon after the primary disease; also if the case presents any of the symptoms referred to as premonitory of a bulbar crisis. The outlook is also serious in young children when there is paralysis of the pharynx or very marked anorexia, on account of the difficulty of efficiently carrying on artificial feeding for any length of time.

When the palate and eye are the only parts involved, recovery will usually occur in a few weeks; but when the extremities are paralysed the duration of the disease has usually to be reckoned in months. Recovery is, however, nearly always complete, even in the most protracted cases; it is quite rare for any permanent result to be left by an attack of diphtheritic paralysis.

#### *Pathology and Pathological Anatomy.*

The first point to be dealt with in this connection is the nature of the relationship between diphtheritic paralysis and the primary disease. Much light has been thrown on this subject by the investigations of Sidney Martin;<sup>14</sup> he has shown that a toxic substance may be isolated from cultures of the bacillus diphtheriæ, which, when injected into rabbits, causes symptoms and nerve lesions corresponding with those observed in diphtheritic paralysis in man. This proves that whilst the local symptoms of diphtheria are due to the immediate presence of the bacilli in the part affected, the paralysis is due to a poison produced by the bacilli at the seat of the local disease, and carried thence by the blood to the nervous system, the tissues of which appear to have a special susceptibility to its action. This is precisely analogous to what has been proved to take place in the case of tetanus, the specific micro-organism multiplying in the wound, and its products being carried in the blood to the nervous system, but producing in this case increased, instead of diminished, irritability, and consequently convulsive, instead of paralytic, symptoms.





FIG. 1. *Normal Anterior Cornu* (low power). A number of large multipolar nerve-cells are visible.



FIG. 2. *Degenerated Anterior Cornu* (low power). The degeneration is advanced. All the multipolar nerve-cells have disappeared, and there is an abnormal development of blood-vessels in the part.



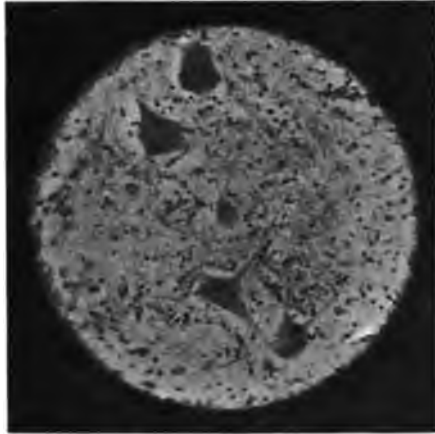


FIG. 3. *Normal Anterior Cornu* (high power). Four normal multipolar nerve-cells are seen. Their processes are well marked, and there are faint indications of the position of the nuclei. The nerve-cells are surrounded by a dense felt-work of fine fibrils.

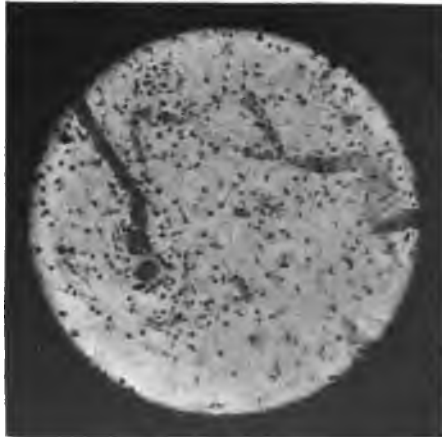


FIG. 4. *Degenerated Anterior Cornu* (high power). The blood-vessels are abnormally large and numerous. There is an excess of free leucocytes in the neighbourhood of the blood-vessels. The felt-work of fibrils is much less dense than in fig. 3.



What is the exact nature of the toxic substance produced by the diphtheria bacilli is still uncertain; Martin thought it was an albumose produced by the action on proteids of an enzyme secreted by the bacilli; but Uschinsky and Buchner<sup>15</sup> found that the toxin was still produced when the diphtheria bacilli were cultivated in a non-albuminous medium, from which they conclude that the poison is a direct product of the cell plasma of the bacilli. They obtained similar results in the case of tetanus.

Admitting that the paralysis is due to the action of a specific toxin which reaches the nervous system by the blood, it is necessary further to ascertain in what way this substance affects the various elements of the nervous system. Martin considers that the action of the poison is limited to the peripheral nerves, and that the disease is essentially a multiple neuritis; and in some of the most widely-read text-books on medicine this statement is reproduced without qualification, as if it was one of the most unquestionable facts of medicine. This is, however, far from being the case, as I shall hope to show. This question needs to be examined from two points of view: first, from that of pathological anatomy; and, secondly, from that of symptomatology. As to the pathological anatomy of this disease there has been considerable difference of opinion among different observers. Some have found parenchymatous degeneration of the peripheral nerves, but have failed to find any changes in the nerve cells of the central nervous system: among these are Martin,<sup>16</sup> J. J. Thomas,<sup>17</sup> and Batten.<sup>18</sup> Others have found distinct changes in the cells of the anterior cornua of the spinal cord; for instance, Abercrombie<sup>19</sup> examined the spinal cord in nine fatal cases at the Hospital for Sick Children, and in seven he found the following changes:— Many of the cells of the anterior cornua were swollen and ill-defined; their processes had mostly disappeared; their contents were granular; in many no nucleus could be seen. Some of the cells were shrunken. These changes occurred in very limited areas, attacking groups of cells. Dejerine<sup>20</sup> described similar changes in three cases examined by him.

The case which I had the opportunity of investigating—Case I., related just now—was one of those in which marked changes in the grey matter of the anterior cornua were found. I will therefore describe the condition of the parts of the nervous system which were examined. The phrenic nerve was treated with osmic acid and examined in the recent state; it showed advanced degenerative changes in many of its fibres—the segmentation of the myelin sheath being very marked. These changes are of special interest, because the immediate cause of death in this case was paralysis of the diaphragm. Three or four nerves from the extremities were hardened and examined in transverse and longitudinal section, but no marked changes were revealed by this method. In the lumbar region of the spinal cord there was a lesion which was visible even to the naked eye; it presented itself on transverse section of the hardened cord as a gelatinous-looking spot occupying the position of the left anterior cornu; it looked darker and less opaque than the remainder of the grey matter, and it was of softer consistence. There was no change visible to the naked eye in any other part of the cord. Sections of the lumbar cord through the lesion referred to show that the normal structure of the left anterior cornu is replaced by what appears to be newly-formed connective tissue; it consists of a meshwork of fine fibrils containing connective tissue cells and leucocytes, but is absolutely devoid of the large multipolar nerve cells which normally occupy this position, and it contains a number of abnormally conspicuous blood-vessels. This condition corresponds exactly to what Ziegler<sup>21</sup> calls “grey gelatinous degeneration,” and which he describes as resulting from acute poliomyelitis. There is a picture of this condition in his work on pathological anatomy which might well have been drawn from this specimen, so exact is the correspondence. In the other anterior cornu in the lumbar region there are a number of normal multipolar nerve cells; but there are also a few which are shrunken and devoid of processes. In no other part of the cord are the changes so marked as in the lumbar region; but in sections both of the dorsal

and cervical regions degenerated nerve cells are here and there to be seen. No changes were observed in the white matter of the cord. The medulla was not examined microscopically, but there were no changes in it visible to the naked eye.

There can therefore be no doubt that in some cases of diphtheritic paralysis, at any rate, there are well marked lesions of the grey matter of the spinal cord, as well as of the peripheral nerves. In other words, pathological anatomy does not support the contention of Martin and others, that only the peripheral portions of the nervous system succumb to the influence of the diphtheria toxin; but neither does clinical observation. The functions of the diaphragm, for instance, may be for a time only slightly impaired and subsequently become suddenly arrested, and then again be resumed. Again, the symptoms constituting a bulbar crisis appear suddenly, and may in a few minutes disappear as suddenly. We cannot conceive of these changes as being due to lesions of the peripheral nerve fibres; they must be due to disturbances of the functions of the cells of the nerve centres. Other evidence could be brought forward to support the contention that the nerve cells are involved in this disease, but it seems to me that the facts adduced are sufficient to prove it.

A question now arises as to what explanation is to be given of those cases in which there is degeneration of the peripheral nerve fibres, but no visible changes in the nerve cells. Whilst insisting on the view that the diphtherial poison has a direct action on the nerve cells, I do not contend that it has not also a direct action on the peripheral portions of the nerve fibres; it is quite possible that it acts simultaneously on both extremities of the neuron; in fact, this is the view which finds favour with Gowers,<sup>22</sup> Bristowe,<sup>10</sup> and Mott.<sup>23</sup> But it is not necessary to assume any direct action of the poison on the peripheral nerve fibres, for as Gowers<sup>22</sup> says, "Transient and slight lesions of the cells often causes a greater degeneration in the fibres;" so that the changes found in the nerves may be the result of interference with the function of the cells. Sims Woodhead<sup>24</sup>

contends for this view in a paper on Diphtheritic Paralysis, read before the last Annual Meeting of the British Medical Association; he points out that the lesions in the nerve cells are easily overlooked, because the changes are transient, except in those which degenerate and disintegrate completely. In his opinion the toxin acts primarily on the nerve cells, which either degenerate or recover at an early date; and later on the nerves for which these cells acted as trophic centres show secondary degenerative changes. Striking confirmation of this view is found in the results of experiments on rabbits related by Crocq.<sup>25</sup> When the animals were killed within the first two weeks after the injection of diphtheria toxin the changes found were in the nerve cells; but if four or five weeks elapsed after the injection the principal changes were found in the peripheral nerves.

The conclusion to be drawn from the foregoing considerations is that in the causation of diphtheritic paralysis the central changes are in all probability of more importance than the peripheral, and whilst they occasionally are of sufficient intensity to be described as acute poliomyelitis, in the majority of the cases the changes are slight and transient, causing temporary loss of function, but leaving no permanent effect.

The special liability of the soft palate to be involved in the paralysis is not, as is often assumed, due to the local effect of the diphtherial poison, for it has been observed as the first symptom of paralysis following diphtheria of wounds and of the vulva, where there has been no throat affection. Gayton<sup>6</sup> has recorded a good example of this:—A child, aged 4, had extensive vulvar diphtheria, but no throat affection at any time; the local affection got practically well, but five or six weeks after its onset paralysis developed; it began with paralysis of the palate, regurgitation of fluids, irritating noiseless cough and marked strabismus; the paralysis became general, deglutition became paralysed, and death took place in fourteen days as the result, apparently, of the direct action of the toxin on the bulbar centres.

*Treatment.*

All writers who have devoted special attention to this subject insist on the prime importance of absolute rest for these cases. Guthrie<sup>11</sup> says the patient should rest in bed for six weeks from the onset of the paralysis, and he further remarks :—" Were patients during the first few weeks of diphtheritic paralysis treated as those whose lives are in a balance, fatalities might be less common ; whilst the knowledge that they may occur would render the minor symptoms of diphtheritic paralysis less liable to escape recognition." C. M. Hibbard,<sup>28</sup> who has specially studied the question of heart complications during and after diphtheria, says :—" All diphtheria patients who have tachycardia, bradycardia, irregular or weak pulse, systolic murmur, vomiting or any paralysis—especially palatal—must be kept in bed." It seems that the toxin of diphtheria has a far more harmful action on the nerve-cells when they are in a state of functional activity than when at rest.

Another very important element in the treatment of these cases is a liberal supply of nutritious food ; when the palate is paralysed pulpy foods are swallowed much more easily than liquids. In those cases when deglutition is paralysed, or when there is complete anorexia, an abundant supply of liquid nourishment must be administered at regular intervals—say, every eight hours—by the nasal tube. Rectal alimentation is usually unsatisfactory in these cases.

The application of a slowly interrupted voltaic current to the paralysed muscles is advantageous if it can be done without causing fright to the child ; if it cannot it will do more harm than good. When there is paralysis of the diaphragm or intercostal muscles occasional artificial respiration is considered useful, and an occasional application of the faradic current to the affected muscles is also advised.

The question of drug treatment now comes up for consideration, and at the outset it is of the utmost importance to recognise the fact that in the great majority of cases of diphtheritic paralysis complete recovery will ensue without the use of any drugs whatsoever. This makes it very difficult

to determine the effect of drugs on the course of the disease, and we cannot safely assume that a drug has had a distinctly beneficial effect unless its administration is speedily followed by the relief or removal of symptoms which had been present for some time, or which are usually of considerable duration. The mere fact that under the use of a certain drug all the symptoms ultimately disappear does not prove that the drug has had any influence over the disease. Far-*rington*<sup>27</sup> describes a severe case of diphtheritic paralysis which recovered under the use of gelsemium, but as he says nothing about the duration of the case, it does not carry conviction as to the value of the drug in this particular instance.

I am sorry to say that I have but little to offer from actual experience as to the effect of drugs in the treatment of this disease, but my great hope is that in the discussion which is to follow, this subject will receive special attention from those who are far better qualified to deal with it than I am. There are, however, two or three conclusions as to treatment which it seems fair to draw from the cases I have related. In Case II. symptoms of paralysis of the palate, which had existed for some days, ceased from the moment that caust. 6 was given. Subsequently in the course of the same case symptoms appeared—irregular sobbing respiration, rapid pulse, &c.—which indicated impending failure of the bulbar centres, and as caust. appeared to have removed the earlier manifestation of the paralysis it was tried again, but this time without effect. Bell. 1x, however, gave immediate relief, both on this occasion and subsequently when there was a slight return of the symptoms. In Case III. nocturnal enuresis and vomiting ceased under the use of bell. 1x, but the paralysis of the palate and loss of knee-jerks remained uninfluenced.

The experience of these cases has suggested to me that for purposes of treatment it may be helpful to divide the symptoms of diphtheritic paralysis into splanchnic or visceral, and somatic or peripheral; the splanchnic symptoms would include the respiratory and cardiac disturbances and vomiting and bladder symptoms, while the somatic group



would include the paralysis of the palate, ocular muscles, limbs, &c. My reason for suggesting this classification is that belladonna appeared to be beneficial in all the symptoms of the splanchnic group, but useless in the others; whereas, in the latter, other drugs, such as causticum, &c., seem to find their special sphere of usefulness. I only throw this out as a suggestion, for it is based on such a limited experience, but I shall be interested to hear it criticised by those whose clinical experience and knowledge of the *materia medica* would enable them to express a more decided opinion than it is possible for me to do.

Besides the drugs already mentioned gelsemium, conium, cocculus, and argentum nitricum should be thought of as promising remedies in diphtheritic paralysis, for there are many striking resemblances in the pathogenesis of each to the clinical features of this disease.

An interesting case of what was undoubtedly diphtheritic paralysis, although it did not appear to have been diagnosed, is quoted in the April number of the *Monthly Homœopathic Review*,<sup>28</sup> from the *Calcutta Journal of Medicine*, under the title "Paralysis of Muscles of the Neck cured by Lycopodium." The patient, a child of four, after a febrile illness, began to suffer from nasal voice and regurgitation of fluids through the nose. Paralysis of the muscles of the neck occurred during the course of treatment, so that the child could not hold his head erect. Lycopodium 30 was given on the strength of a symptom in the "Chronic Diseases" indicating weakness of the muscles of the neck, and in two days there was marked improvement, and in a few days more the paralysis of the cervical muscles was well. Paralysis of the cervical muscles in diphtheritic paralysis is not usually of such brief duration as this, so that it is probable that the remedy is rightly credited with having had a beneficial effect.

In conclusion, allow me, gentlemen, to thank you most sincerely for having listened to my paper with such long-suffering attention.

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Dr. PRITCHARD said that out of about forty-five cases of diphtheria he had seen in the hospital there had not been more than six or eight cases of paralysis, and those were mostly light. Only one case was at all severe. In that case the kneejerks were absent for several weeks. The other cases rapidly recovered under strict rest and belladonna, which was used more than any other drug. He was very pleased that Dr. Bodman had laid stress on the wonderful results obtained since anti-toxin had been introduced. The cases in which antitoxin was used at the hospital had progressed splendidly, and three or four cases undoubtedly would have come to tracheotomy had the antitoxin not been given. The death rate in the forty-five cases named was about 10 per cent.

Dr. GALLEY BLACKLEY was disappointed that so few drugs had been mentioned for the treatment of diphtheritic paralysis.

Those which had been spoken of were well known in the treatment of neuritis, and there is strong reason for thinking that diphtheritic paralysis was a neuritis—an affection of the peripheral nerve fibres without preceding affection of the trophic cells. The three drugs which he had seen used with striking effect were bi-sulphide of carbon, nitrate of silver, and carbonate of lead, all drugs whose effects closely simulated neuritis, and whose therapeutic action covered few except the purely neuritic symptoms. Belladonna, of course, was a drug which covered an immense field. In the *Hospital Reports* for 1895-96 he published some cases of peripheral neuritis, and among them were several severe cases of post-diphtheritic paralysis which did uncommonly well under the three drugs he had mentioned. The specimens exhibited on the table were most striking and instructive.

Dr. ROBERSON DAY said the exceedingly mild cases of diphtheria sometimes met with were those where paralysis often occurred and proved fatal. He remembered attending a child in whom the initial attack was entirely overlooked, and the paralysis was the first symptom noticed and eventually proved fatal through cardiac syncope. A doctor friend of his had found himself unable to mount the step into his carriage. This was the first intimation he had of the disease. It was eventually discovered that he had post-diphtheritic paralysis. Had there been any characteristic initial lesion he surely would have noticed it. The first case Dr. Day had treated with anti-toxin—using it on the second day of the disease—developed paralysis, and the same thing happened in another case. There did not seem to be any direct relation between the severity of the case and the paralysis, or whether anti-toxin had or had not been used. With reference to pathology, the relationship to infantile paralysis was very striking. If the patient lived long enough recovery was invariable and complete in diphtheritic paralysis, but in infantile paralysis recovery was a thing to be hoped for in favourable cases only. Therefore, there must be a great difference in the two diseases, although the large cells in the anterior cornua seemed to be involved in both cases. There would seem to remain much yet to be elucidated in the pathology of post-diphtheritic paralysis.

Dr. STONHAM was interested in the pathology of the subject. Dr. Bodman had taken up the question as to whether the primary effect was in the cells in the anterior cornua, or in the muscles, and he inclined to the belief, and put reasons forward

for it, that the poison primarily affected the cell body, that it gave the cell body a shock, which later was shown by a secondary degeneration in the nerve, but the cell itself usually recovered its balance. He was interested in that, because he thought the way in which diphtheritic paralysis behaved to electrical testing supported that view. In a primary neuritis, like alcoholic neuritis, paralysis was obtained and a reaction of degeneration if the muscle was thoroughly paralysed. But that was not obtained in diphtheritic paralysis, where the reaction of the muscles was very uncertain, and one could not depend upon getting a reaction of degeneration. The reason, he thought, was as accounted for by the view of the pathology of the case which Dr. Bodman indicated. Each muscle was supplied by nerves, each of which had its origin, not in one segment of the cord, but probably in two or three segments. In diphtheritic paralysis one level seemed to be affected, so that not all the nerve fibres of one muscle were affected, but they were scattered and spread over several muscles. The consequence was as a rule that in no muscle did they get all the nerve fibres completely affected, as would be the case if the affection were primary neuritis. Electrical results favoured the suggestion that the cells in the anterior cornua were primarily affected by the disease.

Dr. GOLDSBROUGH considered the paper read would stand as an original contribution to the pathology of diphtheritic paralysis. With regard to symptoms, a very slow pulse was not an uncommon thing in cases of diphtheria as they were getting better. Should not that be regarded as a symptom of paralysis affecting the ganglia of the heart rather than the vagus nerves? Trouble might be saved if that symptom were recognised as a symptom of paralysis, because it so often occurred when the temperature fell and the membrane cleared. With regard to pathology, it seemed to him that they had not yet come to finality in the pathology of multiple neuritis. If the neuron was regarded as the functional unit of the nervous system, any mischief occurring in any part of that unit must have some relationship to the unit as a whole; and that, he thought, was the argument which Dr. Bodman had used in relation to the pathology of diphtheritic paralysis. Dr. Bodman had suggested that although it could not be proved that the cell itself was affected with degeneration, yet it must be affected in some degree if the axon of the neuron was affected. That, it seemed to him, was a suggestion which would have to be applied to the pathology of multiple neuritis.

The body of the cell was the strongest part of the unit, the most resisting part. Although the axis cylinder might be observed to succumb to a poison and the cell apparently remain intact, they could not but believe that if the axis cylinder was affected the cell must be affected, because it was its trophic centre. That opened up quite a new field for investigation, as far as the pathology of neuritis or diphtheritic paralysis was concerned. He would suggest, in regard to Dr. Stonham's remarks, that in alcoholic neuritis the cases were usually of the chronic variety, whereas in diphtheritic paralysis they were usually acute, and corresponded far more to acute poliomyelitis than to alcoholic neuritis. In proportion as the case was acute, if the patient could be placed under conditions of recovery, regeneration was likely to take place quickly and the electrical reaction was observed, in that case irregularly differing from multiple neuritis, especially of the alcoholic type, where the toxæmia was of a very chronic character. He had nothing to say with regard to drugs, except to demur to the running down of strychnine. He did not advocate the use of strychnine in serious cases, but it was a good drug to give in cases that were recovering. Theoretically it would be indicated as a tonic or stimulant to the nerve cells, and in several cases he had found it of practical value.

Dr. JONES asked if it was a fact that antitoxin increased the tendency to diphtheritic paralysis. He understood it did not do so.

Dr. REED said that heart failure in the early stage of the disease was fairly common. Following hospital statistics, it would be found that paralysis was noticed in only a very small percentage of cases. He was convinced that the more closely the cases were studied, a larger number of paralytic cases would be found, even up to 25 per cent. In the early heart cases he found belladonna most satisfactory. In later cases he relied on arsenic in fairly considerable doses, perhaps  $\frac{1}{10}$ th to  $\frac{1}{50}$ th of a grain in solution, more than any other drug.

Dr. BODMAN, in reply, said he had been specially interested in the acquiescence that had been accorded to the view he had taken of the pathology of the disease, because it was not at all in accordance with what was usually found in the medical literature on the subject. Dr. Blackley contended that the disease was essentially a peripheral neuritis. There was no doubt that peripheral neuritis was a factor in the pathology of diphtheritic paralysis, but it seemed to him quite impossible to believe that it constituted the whole process. It might form a part of it, but some of the symptoms referred to, especially those due to

the disturbance of the bulbar centres, were not such as one could conceive to be the result of peripheral neuritis alone; indeed, the changes shown under the microscope that evening were sufficient to prove that the changes were not wholly peripheral. If it was a fact that paralysis often followed slight cases, what was the reason? It seemed to him quite possible the difference was in the fact that the severe cases obtained a prolonged period of rest after the acute disease, and therefore their nerve-cells were in a condition in which the poison had a less deleterious effect upon them; whereas the slight cases were often unrecognised and obtained no special rest at all, and therefore in these cases the nerve-cells were in a much more vulnerable condition. A question had been raised by Dr. Jones, and also touched upon by Dr. Day, as to the influence of antitoxin treatment upon diphtheritic paralysis. The actual number of cases of diphtheritic paralysis in the Eastern Fever Hospital had been larger since the use of antitoxin, but that was fully explained by the fact that very many more cases now recovered, and since more cases recovered there were more patients in whom paralysis was liable to ensue. It had been found, on the other hand, that in cases where the antitoxin treatment could be adopted early the number of cases of paralysis was distinctly diminished. Dr. Stonham's remarks on electrical reactions were very interesting. It certainly seemed that the electrical reactions supported the theory that the principal action of the (?) poison was upon the cells. There was a close analogy in that case to the electrical reactions in progressive muscular atrophy. Here a similar condition was found, some of the fibres of a muscle showing reaction of degeneration and others not. In that disease it was well known that it was the cells of the anterior cornua in which the changes were found. As to early heart failure, he had not laid much stress upon that in his paper, because it seemed to him not very clear whether it was really a part of diphtheritic paralysis or due to the direct effect of the poison on the heart, such as occurred in many other diseases. He thought it was not at all unlikely however, as had been suggested, that early heart failure was due to an early effect of the poison on the centres controlling the movements of the heart. He understood Dr. Goldsbrough to say that in every case where the peripheral nerves were affected there must necessarily be an affection of the cells. In diphtheritic paralysis he thought that was probably the case. He thanked the members very cordially for the reception accorded to him.

CLINICAL EVENING; <sup>1</sup> CASES EXHIBITED.*Mycosis Fungoides with Microscopic Preparation of Blood from the same.*<sup>2</sup>

The disease began four years ago with a rash resembling lichen planus on the flexor surface of arms and legs; followed after a lapse of twelve months by a similar rash on thighs and legs, with some enlargement of axillary glands. Nodules first appeared on the nape of the neck and forehead eighteen months ago. Eight small tumours have been removed by the knife, and patient has had courses of iodide of potassium and arsenic both in full doses, without visible effect in retarding the progress of the disease.

The *microscopic preparation* of the stained blood corpuscles shows excess of lymphocytes and myelocytes.

*Aneurism of the Arch of the Aorta.*<sup>3</sup>

Albert Johnson, aged 41 years, printer.

*History.*—Has had attacks of cardiac pain since January, 1899. Attacks last from half an hour to two hours. Pain is chiefly below upper part of sternum, and down the left arm. The fingers tingle. Sometimes there is pain in the left elbow alone.

*Physical Condition.*—Well-marked expansile pulsation can be seen and felt in episternal notch and beneath right sternomastoid. Apex beat, long and heaving, is in sixth space, 4½ inches from mid-sternum. *Dulness* as in tracing. *Auscultation.* *Mitral*, 1st sound long, low and booming; followed by a short systolic murmur; 2nd sound followed by a blowing diastolic murmur, propagated from aortic area. *Aortic Area.*—A rough systolic murmur and a loud blowing diastolic, the latter heard all over precordia, and specially traceable down the sternum. Both murmurs traceable into vessels of neck.

*Since admission* patient has had several attacks as above, more or less severe. The pain is usually controllable in a short time by amyl nitrite, and sometimes by hot water.

<sup>1</sup> A Clinical Evening was held on Wednesday, July 5, 1899, under the auspices of the Section of Surgery and Gynæcology, the first evening of the annual assembly.

<sup>2</sup> Exhibited by Dr. BYRES MOIR.

<sup>3</sup> Exhibited by Dr. J. GALLEY BLACKLEY.

*Cerebral Lesion.—Tubercular.*<sup>1</sup>

Miss A. B., aged 21 years. Very anæmic for months.

On December 6, 1898, was seized with sudden abdominal pain and collapse as if from ruptured gastric ulcer, which proved the beginning of tubercular peritonitis. On December 12 developed left sided pleurisy; December 14, symptoms of acute tubercular meningitis with convulsions, double optic neuritis, blindness, strabismus, &c., from which she made a slow recovery, chiefly under bry.; calc. carb.; bell.; tuberculinum.

*Present Condition.*—Discs normal; contracture of right flexor muscles of hand and arm; slight internal strabismus of right eye; lately two to three epileptiform convulsions of right side.

*A Case of Cerebellar Ataxy.*<sup>2</sup>

P. P., male, aged 48 years, married, of no occupation, has been ill four years.

The symptoms began with loss of control of walking on excitement and have increased up to the present time. He denies syphilis; has always been a well conducted man. He feels his memory weak. Used to lose consciousness occasionally at the beginning of his illness.

The most marked symptom is the ataxic gait, there is a swaying of the trunk, and a planting of the limbs as if the patient were reeling. He can stand with the eyes shut, but in attempting to walk the ataxia is more marked. There are no special ocular symptoms; the optic discs are rather indistinct, with the vessels small. There is deafness on the left side. Superficial reflexes diminished or absent. Knee-jerks exaggerated. Ankle clonus on both sides, worse on the right.

*A Case of Bilateral Paresis of the Deltoids, Abductors of the Thumbs, and Flexors of the Fingers, with Excessive Deposits of Fat and Double Cataract.*<sup>2</sup>

A. F., single, female, aged 27 years. Duration of illness eleven years.

A history of diabetes and cataract in the family. At 16, began to lose power in the hands. She could not hold things

<sup>1</sup> Exhibited by Dr. MADDEN, of Bromley.

<sup>2</sup> Exhibited by Dr. GOLDSBROUGH.



properly, and could only carry them on her wrist. Ankles became weak; she used to fall down when by herself.

The aspect of the patient is dull and she speaks in a low voice; she complains of general headache, worse in the forehead and temples; often has vertigo. General sensation is dull, but there is no obvious localised defect. There is loss of power to raise or rotate the shoulders; patient raises her arms largely by the help of the pectorals. There is inability to close the hands, and the thumbs remain in an adducted condition. There is flaccidity and hyper-extension of the fingers. The knee-jerks are absent, there is slight ankle clonus on the left side. There are no superficial reflexes except the plantar. There is shrinking of all the affected muscles.

Electrical examination indicates a reaction to both currents, but diminished especially in the deltoids and abductors of thumb.

There are enormous deposits of fat about the arms, trunk, and thighs. Patient has soft cataract in both eyes, worse in the left. An examination of the optic discs is impossible.

Urine has specific gravity 1024; acid. No albumen or sugar, phosphates are increased.

#### *Abdominal Tumour; Sarcoma (?)*.<sup>1</sup>

E. B., aged 45 years. First seen July, 1894.

In 1893 patient was operated on in Birmingham; the tumour was diagnosed, when the abdomen was opened, as a soft multiple uterine myoma, but the operation was abandoned. From July, 1894, the tumour increased in size, caused swelling of feet, dyspnœa, &c.

In May, 1895, the abdomen was opened, and the tumour found to be almost universally adherent and apparently continuous with the uterus. The mass was removed except small portions adherent to different viscera. The microscope showed the growth to be a spindle-celled sarcoma. Menstruation returned in August. In September, 1895, recurrence of tumour was observed, beginning in the right renal region, and by the beginning of 1896 it had extended across to left side and become cystic.

*During the last year* no increase in size has been observed; the girth at umbilicus is thirty-four inches; it was thirty-five inches before the removal of growth.

Both before and since operation the tumour varies in size,

<sup>1</sup> Exhibited by Dr. E. A. NEATBY.

being largest just before menstruation appears; the circumference of abdomen varies four inches. The feet and legs swell more at this time and urination is scanty. Taking *calcareæ iodat.*

The tumour and microscopic section were on view.

### *Syphilitic Ulceration of Labium Majus.*<sup>1</sup>

Mrs. B., aged 27 years, married two and a-half years. One child.

In March, 1899, vulvitis came on followed by sore throat, alopecia, and copper-coloured maculæ over body; much "leucorrhœa," no offensive odour. Contagion history unobtainable.

The left labium majus is hypertrophied and the edge of it is fretted with a superficial serpiginous ulceration.

The glands in both groins are swollen, hard and discrete.

### *Venereal Pudendal Sores for Comparison with Foregoing.*<sup>1</sup>

E. P., aged 38 years, widow; first seen June 7, 1899; had five soft sores on labia.

*Contagion History.*—Contact one month before sores were first noticed; nothing beyond slight irritation between.

June 21.—Sores have enlarged, edges raised, hard but not undermined; centre depressed and slightly oozing. Glands in groin enlarged and matted. No constitutional symptoms.

### *Lupus Vulgaris of Foot and Leg.*<sup>2</sup>

K. N., aged 27 years. Suffered from tuberculosis since ten years old.

*Family history.*—Patient's parents were each of a family of twelve, she herself is the fifth child of a family of seven. The father was probably tuberculous, as he suffered from cough for seven years and had wasting, night-sweats and hæmoptysis. The mother was never strong and has several scars on the neck from suppurating glands.

*Past history.*—At 10 years of age patient was operated on by Mr. John Marshall, at University College Hospital, for tuberculous abscesses near the ankle. From this time she suffered from tuberculous disease of the foot and leg. The two photographs taken in 1894 illustrate the condition of the foot at that

<sup>1</sup> Exhibited by Dr. E. A. NEATBY.

<sup>2</sup> Exhibited by Dr. EPPS.

period, when she first came under my notice. She had then been advised by two medical men to have the leg amputated, and, not agreeing to this, came under my care for three months; this has extended to five years. Besides the lupus on the foot, there were extensive patches of the same disease on the leg and thigh and an abscess on the thigh three inches below Poupart's ligament.

The treatment has consisted principally of the iodides of arsenic and mercury, in the form of ars. iod., merc. iod. and biniod., and the combination of the two in Donovan's solution; and occasional doses of tuberculin. For the last year she has taken ars. iod. almost continuously. Locally, at first creolin ointment was of use; later, an ointment of salicylic acid 1 in 6, or Unna's plasters of ac. salic. 40 per cent. and kreasote 60 per cent., were used, and lastly, an occasional application of the acid salicyl. ointment and continuously a powder of aristol (iodide of thymol) 1 part and starch 3 or 4 parts.

The improvement in the case during this long period is clearly visible by comparing the condition as seen in the photo. of 1894, and the condition of the foot at the present time.

### *Cystic Enlargement of the Gall-Bladder.*<sup>1</sup>

For about four years this patient had been conscious of a tumour in the right hypochondrium. Her attention was first directed to this as the outcome of an acute attack of local pain, with vomiting and jaundice. She is 53 years of age, married, and two years past the climacteric. After the first onset, the patient suffered at intervals of three or four weeks with bilious attacks, attended with jaundice.

On coming under our care in October, 1897, the gall-bladder was found much distended, nearly below the umbilicus, and occupying a space over the abdominal area equivalent to that of the open hand. She was at once put upon berberis  $\phi$   $\eta$  v. t.d.s., and this has been continued at frequent intervals since. Also, merc. sol., nux, hydrastis and chelidonium have been given, but in each instance we had again to recur to the berberis. The tumour now is much smaller, scarcely palpable at times, insensitive. The crises of pain and jaundice are rare: her general health has greatly improved, and she is able to attend diligently to her household duties.

<sup>1</sup> Exhibited by Dr. BURFORD.

*Case of Uterine Fibroid with Accompanying Melancholia.*<sup>1</sup>

This was a single woman of 44, whose aspect when she came into Hospital was striking. A constant expression of acute anxiety, a restlessness which was also persistent, and an averted look, at once stamped her as the subject of considerable nervous tension. Her history was that she had for some months suffered with religious melancholia, which latterly had taken suicidal form. She was exceedingly taciturn, her sleep was very scant, and her memory defective.

Physical examination showed the presence of a uterine fibroid about the size of a cocoa-nut, which of late had caused menorrhagia. On consultation the view was held that the psychical symptoms might probably be the outcome of the pelvic lesion, and total removal of the uterus and appendages was advised.

This was accordingly performed; the patient had an excellent convalescence, and from the first few days after operation, the psychical symptoms have been continuously improving until now; her personality has undergone material change. Her suicidal tendencies have vanished, she is relatively cheerful, sleeps well, and is full of thanks for her bodily and mental amelioration.

*Huge Fibroid of the Uterus.*<sup>1</sup>

This patient is 42 years of age, married, but with no family. Eight years ago she first noticed an abdominal swelling, which has since then increased very considerably, until now it appears to occupy the whole abdomen. Its surface is irregular, full of knobs and bosses; pelvic examination shows it to be continuous with a large outgrowth from the uterus. It is a uterine fibroid.

The bladder is adherent to the mass, and its upper limit reaches nearly to the umbilicus. When distended, it bulges anteriorly in the form of an elliptical cyst, which cannot be completely evacuated voluntarily by the patient, although a long catheter readily causes the collapse of the vesical protuberance.

The menstrual period lasts nearly a week, and is copious.

But, strangely, in spite of the wholesale dislocation engendered by the fibroid mass, the patient has few pressure symptoms. The tongue is clean, there is only occasional flatulence or palpitation, no constipation, a trace only of albumen in the urine.

<sup>1</sup> Exhibited by Dr. BURFORD.

She has of late lost her hair, and the finger-nails are undergoing a process of atrophy.

(Operation was afterwards performed; the severity of the procedure required transfusion for shock. The patient made a good recovery. G. B.)

### *Cirsoid Aneurism of Dorsum of Hand.*<sup>1</sup>

Woman, aged 48 years. At twelve years of age had a swelling on the back of the hand due to a sprain. This went away under treatment. About fifteen years ago again sprained the hand and another swelling formed, which her medical man tried to disperse by means of a smart blow. Immediately after this was done pulsation was noticed in the site of the tumour, and the veins in its neighbourhood began to swell. This pulsating swelling has increased up to the present time, but only lowly.

### *Lymphangioma.*<sup>2</sup>

Gladys F., aged 8 years. Existed since three months old. Has been under treatment four years, and had silica 3, thuja 12, kali mur. 3, sulph. 3, apis 3. Also electrolysis. Condition varies very little. The superficial vesicles alter in distribution and are at times blood-stained.

### *Congenital Syphilis.*<sup>3</sup>

Child, aged 3 years. First and only evidence of the disease consists of a large mucous tubercle extending from the anus on to the right buttock. When first seen was  $1\frac{1}{2}$  in. long by  $\frac{3}{4}$  in. broad.

This is evidence of a mild attack of the disease.

### *Abdominal Case. Ascites v. Pelvic Cyst. For Diagnosis.*<sup>3</sup>

B. E., aged 36 years, beadworker, unmarried, has menstruated since the age of 14 every six to eight weeks for four days. At 21 years she missed her periods for eleven months. Last menstruation twenty months ago, when she had a period lasting one day. Has noticed for the last few months that while she is getting

<sup>1</sup> Exhibited by Mr. DUDLEY WRIGHT.

<sup>2</sup> Exhibited by Dr. ROBERSON DAY.

<sup>3</sup> Exhibited by Mr. JOHNSTONE.

thinner in the body, the abdomen has been swelling, more particularly the last few weeks. There is dulness all over lower part of abdomen in both flanks and reaching above the umbilicus: resonant slightly between right flank and umbilicus. Dulness is due to fluid in the abdomen except at lower part in both groins, where solid masses are to be felt rising out of the pelvis.

Examination, *per vaginam*, shows an oedematous uterine cervix; sound passes  $2\frac{1}{2}$  inches in normal direction. Nothing else abnormal. When examined on June 21 there was a difficulty in diagnosis between ascites and cyst of pelvic origin. The classical signs of neither were distinctive.

### *Enormous Bone Tumour growing from Left Innominate Bone.*<sup>1</sup>

W. R., cabdriver. Noticed six years ago a small growth proceeding from the left hip bone. It has increased in size gradually till the last two years when its progress has been rapid. At first he says it was entirely bony. Now it consists of bony, fleshy and fluid elements, and has a cystic feel in places. The mass has grown to an enormous size, which must be seen to be realised. It involves the whole of the left iliac bone with ischium and sacrum. The patient up to the present follows his occupation, being on the box about ten hours a day. Twelve months ago he began to experience pain, and has lost flesh somewhat lately. The circulation of the left leg is being interfered with.

### *Cerebellar Lesion (from a blow).*<sup>2</sup>

N. L., aged 5 years. Two sisters died, one from cerebral tumour, the other from nervous shock. Patient had a blow on occiput shortly before Christmas 1898, since which she had gradually developed symptoms of cerebral tumour, with headache, vomiting, double optic neuritis, spastic paresis, retraction of head.

Has been having bell. 3, cal. carb. 30, tuberculinum 6 and 30, without result.

### *Rheumatoid Arthritis.*<sup>3</sup>

E. T., woman, aged 52 years.

This case is shown on account of the benefit received after the exhibition of actæa and colchicum.

<sup>1</sup> Exhibited by Mr. JOHNSTONE.

<sup>2</sup> Exhibited by Dr. H. WYNNE THOMAS, of Bromley.

<sup>3</sup> Exhibited by Dr. LEO ROWSE.

Bryonia, eupatorium, sodæ salicyl., and other drugs had been used, but without any success. Under actæa and colchicum, however, her pains were almost at once lessened, the joints became smaller and suppleness is more marked.

### *Pulmonary and Cardiac Disease.*<sup>1</sup>

R. E., married woman, aged 29 years, five children.

For twelve months has complained of frequently feeling giddy, with attacks of vomiting, not necessarily after food. The attacks are at irregular intervals—from two to four weeks, and are not associated with menstruation. Has also dysuria and leucorrhœa; no marked pelvic lesion.

Has slight lateral spinal curvature, with dulness and loss of respiratory murmur at base of left lung; also mitral systolic bruit.

Loss of flesh for some months, and rapidly for the last four weeks. No history of cough, pain, or serious illness.

*Query.*—Is the lung condition due to the curved spine or to the more recent disease? What is the cause of the vomiting?

## MICROSCOPIC SPECIMENS EXHIBITED.

### *Sputa from a Case of Phthisis.*<sup>2</sup>

THIS specimen was from the second stage, showing *Bacillus tuberculosis* in abundance.

### *Sputa from Gouty Bronchial Catarrh, with Lobular Pneumonia.*<sup>3</sup>

In this specimen enormous quantities of eosinophile leucocytes were shown (stained with eosin and methylin blue).

### *Sputa from a Case of Epidemic Tracheitis.*<sup>3</sup>

In this specimen, removed during the first twelve hours of the disease, were seen diplococcus, tetracoccus, and sarcina in quantity.

<sup>1</sup> Exhibited by Dr. SPENCER COX.

<sup>2</sup> Exhibited by Dr. J. GALLEY BLACKLEY, July 6, 1899.

*Pellet from a Case of Acute Amygdalitis.*<sup>1</sup>

In this specimen streptococcus, staphylococcus, and tetracoccus were seen in great abundance.

*Scirrhus Carcinoma of Axillary Gland.*<sup>2</sup>

In 1888 the right breast of this patient was removed for carcinoma. In 1896 a small, hard gland was removed from the right axilla. The centre of the specimen is occupied by dense fibroid material, but at the periphery there is a narrow zone of typical scirrhus carcinoma. The extreme degree of fibrosis in the gland is very interesting. The patient is now alive and quite well. This specimen should be compared with the next specimen, a fibroid breast with scirrhus.

*Fibroid Breast and Scirrhus.*<sup>2</sup>

This section is shown to compare with the preceding. It is a typical specimen of advanced fibrosis of the breast, with scirrhus invasion.

*Tuberculosis of the Lid.*<sup>2</sup>

Section of a small nodular growth, removed from the upper eyelid of a man, aged 48, the subject of chronic laryngeal and pulmonary tuberculosis. The growth had existed nine months. The section shows groups of grey tubercles in the subcutaneous tissue of the eyelid. It somewhat resembles lupus verrucosus.

*Rodent Ulcer.*<sup>2</sup>

A section from a patient, aged 80, showing tubes of epithelial cells penetrating into the subcutaneous tissue. The cells are smaller than the normal epithelial cells, and are not arranged in "birds'-nests," as in epithelioma.

*Cavernous Angioma.*<sup>2</sup>

This specimen was removed from among the muscles of the forearm of a young girl. It shows fibrous trabeculæ, in which are many nuclei, surrounding cavernous sinuses. Some of the cavities contain blood corpuscles. In parts of the specimen are sections of striped muscular fibre.

<sup>1</sup> Exhibited by Dr. J. GALLEY BLACKLEY, July 6, 1899.

<sup>2</sup> Exhibited by Mr. C. KNOX SHAW, July 6, 1899.



*Medullary Carcinoma of Testis.*<sup>1</sup>

This specimen, removed from an enormous, rapidly-growing tumour of the testicle, shows delicate connective tissue stroma, with alveoli containing cells of an epithelial type. The cells are arranged irregularly in groups and in columns.

*Sarcoma in a Fowl.*<sup>2</sup>

One specimen showed the occurrence of the new growth in the wing bones, and it had been of rapid growth. Another specimen was taken from the peritoneal cavity, where disseminated nodules had been found.

## REPORT OF THE COUNCIL OF THE BRITISH HOMŒOPATHIC SOCIETY, 1898-9.<sup>3</sup>

THE membership of the Society remains about the same in numbers. During the session there have been six *Membership* deaths, viz., Dr. Burns, of Margate; the Hon. Allan Campbell, of Adelaide; Dr. Churchill, of Folkestone; Dr. Kyngdon, of Sydney; Dr. Morrison, of Clapham; and Dr. Powell, of Anerley. One corresponding member has recently departed, Dr. Ludlam, of Chicago.

One member has resigned, and there have been five additions to the list of active members.

We have had to welcome twenty-one visitors during the session.

The work of the year at the monthly meetings has been carried out on the lines so ably laid down by our *Work of the* late secretary, Mr. Knox Shaw. The work of the *Session* Council and Secretary in collecting the material for each meeting has been entirely taken over by the Sections. This year there has been a plethora of material, and there has been no difficulty in getting members to read papers—a satisfactory indication, we take it, of the health of the Society.

<sup>1</sup> Exhibited by Mr. C. KNOX SHAW, July 6, 1899.

<sup>2</sup> Exhibited by Mr. JOHNSTONE, July 6, 1899.

<sup>3</sup> Presented at the Annual Assembly, July 6, 1899.

Sixteen papers have been read and discussed, many of which have been of high merit and are valuable contributions to the knowledge of disease and its cure. The discussions throughout the session have been taken part in by a large number of the members, and have usually been animated, thoughtful, and interesting. Pathological specimens and exhibits were shown to the number of forty-five. At the concluding meeting, twenty-three clinical cases of the greatest interest and instruction were inspected and discussed, till a late hour, by the Society.

Of the other undertakings of the Society, more or less of a literary nature, reports are presented. *Inter alia*, the Council are gratified to know that the indexing of British homœopathic literature is in such an advanced state as to be ready for the printer and the necessary payment. The newest undertaking of the Society, viz., the compilation by many workers of a new *Materia Medica*, has made decided progress, under the active and zealous direction of Dr. Theophilus Ord, of Bournemouth. A specimen drug was issued to the Society during the session; its form was approved of, and all that now remains is to find willing and capable workers to provide MS. and financial support to allow it to go to press.

Though no special report is presented from the Library Committee, a communication has been received from the librarian stating that the library is now in effective working order. Its volumes are now of easy access, thanks to the catalogue so admirably prepared by our energetic librarian, Dr. Neatby. Having so far finished his labours and set his house in order, Dr. Neatby now thinks it a fitting time to quit his post, and he has therefore placed his resignation in our hands. While reluctantly accepting Dr. Neatby's resignation, the Council is deeply conscious of all the hard work done and unremitting attention given to the interests of the library, and they therefore suggest that a special resolution be passed by the Society, setting forth its appreciation of Dr. Neatby's services, and conveying their hearty thanks for the same.

In the matter of the Journal of the Society, there has been an important departure, namely, the appointment of an assistant editor, to which post Dr. Giles Goldsbrough has been appointed, and already you may have noticed the result of his activity in the columns of the Journal. We are glad to announce that the revenue from the Journal is yearly lessening the drain on the funds of the Society.

A noteworthy incident in the annals of the Society has been the inclusion in its roll of the name of a lady  
*Admission of a* medical practitioner. The existing laws of the  
*Lady Member* Society did not preclude lady practitioners, but we were none the less glad to welcome, without official difficulties, the admission of Miss Neild to our Society.

The Council has been extremely fortunate in having the guidance and co-operation of one of the veterans  
*The Retiring* of British Homœopathy, in our President, Dr. A.  
*President* C. Clifton, of Northampton. Though living at a distance and full of years, he has been most regular in his attendance at Council and Society meetings. His zeal is unabated; his youth-like enthusiasm is ever stimulating, while his matured and judicious counsel has ever been sought and acted on by your Council. They wish him many years yet of health and happiness.

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# BRITISH HOMOEOPATHIC SOCIETY.

## BALANCE SHEET, SESSION 1898-99.<sup>1</sup>

RECEIPTS.	£ s. d.	EXPENDITURE.	£ s. d.
To Balance in hand .. .. .	38 16 0	By Printing (less advertising) .. .. .	122 16 4
" Subscriptions .. .. .	190 1 0	" Reporting .. .. .	18 18 0
" Sale of Publications .. .. .	2 11 0	" Postage and Stationery .. .. .	6 12 9
" Dividends upon £199 4s. 8d. 2½ per cent. Consols .. .. .	5 6 0	" Honorarium to Editor .. .. .	10 10 0
" Half cost of Plates .. .. .	1 7 6	" Rent .. .. .	25 0 0
" Fellowship Fee .. .. .	1 1 0	" Refreshments .. .. .	5 10 0
" Subscriptions paid in Error .. .. .	2 2 0	" Library .. .. .	11 10 8
		" Petty Cash .. .. .	2 10 9
		" Subscription to Hospital .. .. .	10 10 0
		" Subscriptions returned .. .. .	8 8 0
		" Sundries .. .. .	0 5 0
		Balance .. .. .	£317 6 6
	<u>£241 4 6</u>	Balance .. .. .	98 18 0
			<u>£241 4 6</u>

Audited and found correct, EDWIN A. NEATBY.

JNO. G. BLACKLEY, Treasurer.

<sup>1</sup> Presented at the Annual Assembly, July 6, 1899.

REPORT  
OF THE "HOMŒOPATHIC LITERATURE  
INDEXING COMMITTEE," 1898-99.<sup>1</sup>

THE Committee is glad to report that substantial progress has been made during the last twelve months in the compilation of the manuscript of the "Index," and its preparation in a fitting form for the printer.

Early after re-election the Committee met, and on due deliberation decided on the general plan of distribution of the detail, with a view to make the work of maximum service.

The whole proceeding was of the most laborious and painstaking character. Every single item has had to be cut from the abstracts furnished by the compilers and allotted its proper place in the printer's MS. During this procedure every precaution was taken by the workers not to lose a single one of the thousands of references, and at night the material was amply protected against fire.

The greater proportion of the references have been thus dealt with, and the printer's MS. is fast approaching completion.

All connected with the construction of the work—the abstractors, the Committee, and the distributors of the detail—have spared no pains to make the work accurate and complete, and the Committee believe that the finished work, as the embodiment of all the published clinical work in British Homœopathic Journals, will rank high among the issues of the century.

The Committee ask for a re-affirmation of the grant made last year, to wit, that a sum not at present exceeding sixty pounds should be allocated, from the Society's funds, toward the expenses of preparation and printing.

Your Committee also ask for a renewal of their appointment for the ensuing year, to ensure continuity in the production of this very important work.

R. E. DUDGEON.  
WASHINGTON EPPS.  
GEORGE BURFORD.

<sup>1</sup> Presented at the Annual Assembly, July 6, 1899.

## REPORT OF THE COMMITTEE FOR A NEW MATERIA MEDICA AND NEW PROVINGS.<sup>1</sup>

Your Committee report—That in pursuance of your resolution of December 6, 1898, Dr. Ord, on behalf of your Committee, presented a brochure upon Kali Bichromicum as a specimen of the working of the proposed method for a new Materia Medica upon February 2, 1899. This having been approved by your Society, it was then resolved that the work should be proceeded with in manuscript.

Dr. Ord has been appointed Editor and Dr. Hughes honorary adviser to the Committee.

Estimates for printing the proposed work, varying from £900 to £750, have been received. The Committee recommend that of Messrs. Harrison at the lower figure, proposing that the work shall be issued in eight fasciculi at 5s. to members subscribing originally for a complete set and 7s. 6d. to non-members for each fasciculus, and that a circular calling for the names of subscribers be issued before the printing of Part I. is commenced. In this way the Society will be advised of the amount of its liability before it is incurred, and the expense (if any) will be spread over a considerable period.

The following members are at present engaged in the work :—  
Drs. Black, Hervey Bodman, McNish, Neatby, Ord, and Stonham, and Mr. Wilkinson.

Sufficient work has not yet been done to justify a forecast of the probable date when the first fasciculus will be ready for the printer. It is intended that it shall embrace all drugs with the initial "A."

ARTHUR C. CLIFTON, *Chairman.*

GILES F. GOLDSBROUGH.

JAMES JOHNSTONE.

EDWD. M. MADDEN.

EDWIN A. NEATBY.

T. G. STONHAM.

C. J. WILKINSON, *Hon. Sec.*

<sup>1</sup> Presented at the Annual Assembly, July 6, 1899.

THE PRESIDENT'S RETIRING ADDRESS.<sup>1</sup>

WE have come now nearly to the end of the session of this Society, 1898-9. It only remains for me to make a very few remarks and then vacate the chair, which I have but seldom filled during the year, but which has been most ably occupied by the gentlemen whom you kindly elected as vice-presidents to help me, and to whom I tender my hearty thanks.

Although I have but seldom been present, I have had an opportunity of seeing the papers and reading the discussions which have taken place upon them, and of comparing them with others of former years, and I have no hesitation in saying they cannot be equalled—for thoroughness of conception, width, and depth of thought, and practical usefulness in various aspects of medical and surgical knowledge. The quantity and quality are alike good. It would be invidious to single any out for commendation and remark upon: I would rather urge upon you all to read diligently those same papers in your Journal, by which means you will get greater good than from anything I can say about them.

So pleased have I been in relation to the papers that were it possible I think it would be greatly to the advantage of our cause to have a few extra copies in relation to the nature of the subjects discussed and the work of the Society printed for such gentlemen as desired them to send to some of their orthodox *friends*, so that they might know the character of our proceedings.

There have been thirteen papers read and discussed. In relation to our work as physicians and surgeons, the papers being of the character I have described, I think I was justified in taking as the text of my presidential address "The *raison d'être*" of this Society, "The Growing of Souls," which, I feel sure, will have been largely promoted by the work of this session.

I am particularly pleased to see that, as the older members pass away, instead of the fathers the sons of some of them have read papers during the session; for example, Drs. C. E. Wheeler and Hervey Bodman. To-night also as visitors the two sons of my deceased relative and your hearty colleague, Henry Harris, are with us, and will, I trust, soon become members of our Society.

<sup>1</sup> Read by Dr. A. C. Clifton at the Annual Assembly, July 6, 1899.

If I am not out of order at this stage, I would suggest that our colleague, Major Herbert Deane, Royal Army Medical Corps in India, who has furnished us with a valuable paper, an abstract of forty-seven cases of enteric fever, with remarks, should by reason of his enforced absence receive a cordial vote of thanks from this Society.

As President of this Society, now about to end my life in that capacity, but in which I have played so small a part, I beg to thank you for what you have all done, and urge that you will still press forward to those things which are before—that the younger members particularly will take their full share of work, will demand to be allowed to do so, not waiting for an invitation, for so far as they do that they will not only further the cause of homœopathy, but promote their growth of soul in relation to their profession. Finally, I thank you all for allowing me to do so little and have so much honour.

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## SOCIETY NEWS.

At the Annual Assembly, Harold Wynne Thomas, M.R.C.S. Eng., L.R.C.P.Lond., of Bromley, Member since 1891, was elected a Fellow of the Society.

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At the Annual Assembly, F. G. Stacey, M.R.C.S.Eng., L.R.C.P.Lond., of the London Homœopathic Hospital, was elected a Member of the Society.

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At the Annual Assembly, the following Fellows and Members were elected as Office-Bearers for the Session 1899-1900 :—

*President* : Dr. Epps.

*Vice-Presidents* : Drs. Burford and Cash Reed.

*Treasurer* : Dr. Galley Blackley.

*Council* : (with the foregoing) Dr. A. C. Clifton (retiring President *ex-officio*). Fellows : Dr. Byres Moir, Dr. E. A. Neatby, Mr. Knox Shaw, and Mr. Dudley Wright. Members : Mr. C. J. Wilkinson and Dr. Macnish.

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Members of the various Sections were re-elected as in the present Session.

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## LIVERPOOL BRANCH.

The following Office-Bearers have been elected for the Session 1899-1900 :—

*President* : Dr. Douglas Moir.

*Vice-President* : Dr. Theodore Green.

*Hon. Secretary and Treasurer* : Dr. James Watson.

*Representative on Council* : Dr. A. E. Hawkes.

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## SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

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

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JUNE—AUGUST, 1899.

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### PHARMACODYNAMICS.

**Acidum oxalicum.**—Dr. E. T. Burch relates an instructive case of oxalic acid poisoning which came under his care for the after-effects. In the acute attack the symptoms were those of irritant poisoning, with sense of cold and heat alternately in the abdomen, general coldness, and numbness of the feet. There was no purging, but rather constipation, which persisted afterwards. The sequelæ were (besides this) "hearing impaired, but smell and taste unusually acute; appetite ravenous—hunger day and night; craves sweets to eat, but sour drinks only; complains especially of a sensation of numbness behind each ear, especially the right. Sensation in the tongue was lessened, notwithstanding the acuteness of taste."—*Med. Century*, August.

**Anacardium.**—Dr. Hulbert finds that this remedy, if given in 5 drop doses of the mother-tincture, will often clear away those conditions of mental hebetude, irritability, and delusion which come on in advancing age and make one suspect softening of the brain. Drs. Taylor and McCracken, from alienist experience, confirm his praise of the drug, the former giving it when any change appears in the delusions of patients. Dr. E. M. Bruce praises it in nervous dyspepsia and the irritability of brain-workers.—*The Clinique*, July.

**Antitoxin.**—The controversy as to the value of this antiphtheritic still rages. Dr. J. Edward Herman, in the *Medical*

*Record* for May 27, challenges the statistics which have been adduced, showing that the decline in the mortality of diphtheria of late years is paralleled by that which has obtained in most other diseases of similar kind, for which, nevertheless, no antitoxin has been supposed to be discovered. He also cites abundant evidence of the injurious influence of the serum.—*Hom. Recorder*, July.

An old school American journal (the *Medical Brief*) puts in a strong indictment against antitoxin. Its bad effects are enumerated as—sudden death; more frequent nephritis and paralysis; destruction of red corpuscles; fever, with eruptions and rheumatic symptoms.—*Amer. Homœopathist*, August 15.

In the *North American Journal of Homœopathy* for August Dr. George B. Rice puts the other side of the case with much effect.

**Arsenicum.**—Dr. Balfour, of Edinburgh, in his book on “The Senile Heart” says of arsenic: “Most excellent results, indeed, occasionally follow the prolonged use of almost infinitesimal doses. I well remember one old gentleman, exceedingly sensitive to the action of infinitesimal doses, to whom gr.  $\frac{1}{50}$  of arsenious acid was quite poisonous, but who could tolerate gr.  $\frac{1}{100}$  without difficulty. After taking this minute dose for two or three weeks, and nothing else, for a dilated and hypertrophied heart beginning to fail, he said to me: ‘I don’t know what benefit you expected from the treatment, but I know what I have received. I can go upstairs much easier than I used to do.’”—*Hahn. Monthly*, June, p. 411.

A patient, after taking Fowler’s solution for upwards of a year, presented a general bronzing of the skin just like that of Addison’s disease. On the suspension of the drug the coloration became sensibly less.—*Journ. Belge d’Homœopathie*, July-August, p. 167.

**Berberis.**—One of those obscure cases of pain in the sole of the foot on treading is recorded in the *Homœopathie Physician* for May (p. 218). It speedily recovered under berberis vulgaris 200.

**Chelidonium.**—The expectations from chelidonium in cancer have failed of realisation. The last published case, however, seems to show some power over the disease—at least in the form of the alkaloid, chelidonine. Dr. Ivanoff, of Gjatsch, in Russia, had a patient of 52 with cancer of the stomach. She was in a state of extreme marasmus, and suffered from violent pains

localised in the region of the stomach, vomiting everything that she ate, so that it was necessary to feed her *per rectum*. The vomit resembled coffee-grounds; the liver was enlarged, and its left lobe presented a prominence which was very sensitive to pressure. The existence of a malignant neoplasm was not to be doubted. It was probably a cancer of the pylorus, with a metastasis to the liver, or adhesions between this organ and the stomach. Under the influence of the sulphate of chelidonine, in cachets, 10-15 centigr. twice daily, the condition of the patient rapidly ameliorated. The vomiting ceased, the enlargement decreased; she was soon able to feed herself by the mouth, and got up.—*Hahn. Monthly*, June, p. 415.

**Chininum arsenicosum.**—Dr. Schier, of Mainz, having to work up this drug for the new German *Materia Medica*, found it (as he supposed) to have received hitherto only one, involuntary, proving—that of Dr. Muhr, published in vol. 88 of the *A. h. Z.* He thereupon set to work to enrich its pathogenesis, and has given us, in this journal for April, provings made on six persons with dilutions from the 12x to the 2x, and with the crude salt. [If Dr. Schier had consulted the “*Cyclopædia of Drug Pathogenesis*,” he would have found there no fewer than ten provings of *chininum arsenicosum*. It was a *felix culpa*, however, which has resulted in his own excellent experiments.—Ed.]—*Hom. Recorder*, June.

**Echinacea.**—So much has been said of late about the medicinal virtues of this plant, that the chairman of the *Materia Medica* Section of the American Institute of Homœopathy thought it well to institute a proving, and the results were presented at the recent meeting of that body. They are printed in the *Medical Counselor* for July. The prostration induced by the drug was very marked.

**Glonoin.**—An old-school practitioner recommends nitro-glycerine for giving speedy relief to spasmodic croup. He gives “from one ten-hundredth to one six-hundredth of a grain,” *i.e.*, about 1 or 2 drops of our 3x dil.—*American Homœopathist*, June 15, p. 190.

**Hydrastis.**—In the *British Medical Journal* of April 8 is recorded a case in which *hydrastis*, given in full doses for bronchorrhœa, caused a severe paroxysm of dyspnœa, with livid face. The patient recovered under stimulants. From the symptomata the

observer thinks the dyspnoea to have been of cardiac origin.—*Hom. World*, July.

**Iodine.**—A Russian physician communicates to *La Semaine Médicale* of June 28 two cases of severe scurvy, in which—after the failure in one of the usual dietetic measures—4 or 5 drops of the tincture of iodine, three times daily, induced a complete cure.—*L'Art Médical*, July.

Dr. Laidlaw, in an article on the therapeutics of pulmonary tuberculosis, reckons iodine “the closest approach to a specific that is offered by the mineral kingdom,” and prefers to use it in the form of hydriodic acid, with which, he says, he has seen phthisis cured in the early stages, its use being long continued.—*Med. Era*, August.

Dr. Larrien has come forward to endorse the experience of Guillemin and Zeissl with simple tincture of iodine in the treatment of syphilis. Like them, he finds small doses—3 to 4 drops daily—sufficient.—*Journ. Belge d'Homœopathie*, July-August, p. 223.

**Iodoform.**—In an article on “Tuberculosis in Infancy and Childhood,” Dr. Sigmund Raue writes:—“Iodoform (3x to 12x trit.) has given me such promising results in all tuberculous conditions, notably in the presence of glandular enlargements, and in chronic diarrhoea of greenish, watery, undigested stools, a symptom which I have frequently developed in provings upon children, the diarrhoea being accompanied by an irritability of temper, that I give this remedy the preference above all others in such cases.”—*N. A. Jour. of Hom.*, June, p. 350.

**Kali bichromicum.**—Dr. McHardy has published, in the *Scottish Medical and Surgical Reporter*, a case of gastric ulcer of twenty years' standing cured by bichromate of potash. He gave first  $\frac{1}{15}$  and then  $\frac{1}{12}$  gr. every four hours, and admits the (needless) aggravations produced by such large doses.—*Pacific Coast Journal of Homœopathy*, August.

In the *New England Medical Gazette* for August will be found two cases of duodenal and one of gastric ulcer having the same happy termination without these accidents by the way.

**Kali iodatum.**—A case is recorded in which a severe and persistent ptyalism, but without any other symptom of iodism, set in after a three weeks' course of iodide of potassium.—*L'Art Médical*, June, p. 442.

Another case appears in the *British Medical Journal* of December 17, in which the coryza of the iodide was complicated with deafness, and the affected ear presented all the symptoms of serous catarrh.—*Monthly Hom. Review*, August.

**Mezereum.**—The *North American Journal of Homœopathy* for July gives a "Symposium," entitled "A Study of Mezereum." It will repay reading, though it labours under the common fallacy of assuming that all the symptoms ascribed to the drug in Hering's "Guiding Symptoms" have been induced by it on the healthy.

**Natrum phosphoricum.**—Dr. Niederkorn records his experience with this salt. It is, he says, the main remedy for acidity when there is a creamy yellow coating of the tongue. In scores of cases he has seen one powder of the 3x trit. produce large biliary evacuation of the bowels.—*Amer. Homœopathist*, August 15.

**Phosphorus.**—Dr. Goullon calls attention to a troublesome dryness of throat and windpipe apt to accompany or follow influenza, and says it finds its specific remedy in phosphorus.—*Hom. Recorder*, July.

**Quinine.**—The amblyopia resulting from quinine poisoning has been studied experimentally in dogs by Holden. He finds no histological change in the retinal blood-vessels, but a narrowing of their calibre, followed by a highly albuminous serous exudation into the nerve-fibre layer, and a degeneration of the ganglion cells, together with their axis cylinder processes which become the centripetal fibres of the optic nerve. These changes were not prevented by the exhibition of nitrite of sodium.—*Calcutta Journ. of Medicine*, April.

**Sanguinaria.**—This drug is the subject of Dr. Sands Mills' fourth paper of "Desultory Notes on the Homœopathic Materia Medica." His practical experience has been limited almost exclusively to its use in one-sided headaches. Here he esteems it—generally in the 1st cent. dil.—very highly.—*N. A. Journ. of Hom.*, p. 357.

**Thyroidin.**—The theory that exophthalmic goitre is due to an excessive secretion from the thyroid gland, as myxœdema is to a depression of the same, has been substantiated by an observation in which thyroidin tablets, taken for a length of time for obesity,

brought on the exophthalmos, the palpitations, and the enlarged neck of Graves' disease, together with the essential symptoms of diabetes and a marked tremor of the tongue. All subsided on discontinuance of the medication.—*L'Art Médical*, July.

A case of psoriasis diffusa cured with this substance, reported by Dr. C. D. Collins, shows that large doses are unnecessary for the purpose, the 2x trit. alone effecting the recovery in six weeks.—*The Clinique*, July.

## THERAPEUTICS.

**Amaurosis.**—Dr. Douglass relates one case, and refers to another, of sudden blindness occurring in connection with the albuminuria of pregnancy. This is rarely remediable; but both cases recovered under kali phosphoricum 6x.—*Amer. Med. Monthly*, August.

**Aortitis.**—Dr. Goullon relates a case, treated by correspondence, in which anginous symptoms had been diagnosed by a distinguished old-school physician as dependent on aortitis. He sent aurum 6x, which was continued for three months with progressive improvement; and at the end of this time all symptoms had disappeared, and the physician—ignorant of what had been taken—expressed his astonishment, and said there were merely some traces remaining of the lesion.—*Hom. Recorder*, July.

**Appendicitis.**—An interesting discussion on this disease at the Société Française d'Homœopathie is recorded in the *Revue Homœopathique Française* for July-September. Dr. Jousset regards its prevalence and severity of late years as due to influenza. He expresses much confidence in the medical treatment of the affection, especially with belladonna and bryonia, and is echoed herein by his colleagues.

**Capillary Bronchitis.**—Dr. M. T. Laird writes an instructive article on the homœopathic treatment of this malady as occurring in children. He advocates selection from a wider range of medicines than those commonly employed, laying special stress on the value of belladonna, cina, and stibium arsenicosum, when indicated.—*N. Am. Journ. of Hom.*, July.

**Diphtheria.**—In a discussion on the treatment of this disease, Dr. Ruggles stated that his sheet-anchor was bichloride of mer-

cury, given in the heroic dosage of gr.  $\frac{1}{10}$  frequently repeated. "The virus of the disease apparently antidoted the poison of the remedy, and thus rendered this massive dose harmless." He had on his case-book a series of seventy consecutive cases, in all of which the clinical diagnosis was confirmed by bacteriological tests, and many of them of a malignant form, and he had yet to lose a case.—*Ibid.*, June, p. 396.

**Glaucoma.**—Upon the generally accepted hypothesis of the connection of glaucoma with gout, Dr. O. Walter, of Odessa, has essayed treatment of the eye affection by piperazine. Giving one grain daily in carbonated water, he has seen all the glaucomatous symptoms disappear in two cases in the space of two or three weeks.—*Hahn. Monthly*, July, p. 474.

**Headache.**—Mr. H., railway station-master, aged 49, sent to me on February 28 on account of severe pains in head. He had suffered for some months from vertigo and confusion of head, and for three weeks from violent headaches. He had been treated by the railway doctor with various remedies, then by a specialist, who tried many things, but without any good result. At last they assured him that it must be some serious cerebral affection, and prescribed patience. I was asked to send him something to relieve him in the night. I was told that the violent pains had lasted three weeks, that they commenced in the occiput, and radiated thence to the crown. Heat relieved them. I chose silica, which I prescribed in the 200th dilution, a dose every three hours. When I saw him next day I found him with his head enveloped in fur and flannel in a very warm room. The symptoms remained the same, but he had slept for a few hours, which he had not done for weeks. I then gave silica 10, and told him to take a dose every two hours. In a few days the patient visited me, and he was quite well.—*Sulzer, Zeitsch. d. Berliner Vereins*, xviii., 220.

Mrs. W., aged 60, had been under my care for years for slight symptoms of fatty heart, emphysema, and frequent bronchial catarrh. One day she complained to me of pains in head with pressure in head, the exact seat of which she could not describe. They only came on at night, and ceased when she sat up. I prescribed stannum 14, and she was rapidly cured.—*Ibid.*, p. 227.

Mrs. v. L. wrote to me that she suffered from constant headache, that compelled her to lie down and unfitted her for all work. Ordinary remedies did no good, and antipyrin produced



very great suffering. As she was the daughter of a distinguished allopathic physician, I was anxious to relieve her quickly. In the letter she sent me, after describing the horrible pains, she mentioned that the blood rose to her head, and made it feel as big as a house. I sent her gelsemium 3x in globules. After a few days she wrote to tell me that the medicine reached her at the commencement of a severe attack; she took a dose every half hour. By noon all the pain was gone. She now has always resort to the medicine when an attack is threatened, and a few globules promptly cure her.—*Ibid.*

Mrs. M. Sch., aged 35, had suffered for ten years from pains in head. As she had been affected with syphilis by her husband, she had been much dosed with mercury and iodide of potassium, which had brought on the headaches. The pain came on at night, was violent boring, and flat doughy elevations could be felt on the scalp—evidently dolores osteocopi and tophi. Aur. mur. 4x, 4 drops three times a day, cured the headache quickly and perfectly. The syphilitic symptoms required a longer treatment.—*Ibid.*, p. 228.

**Hepatitis.**—Mrs. H., aged 74, had been annoyed for many years with a very troublesome cough, without expectoration. She was suddenly taken ill with a very acute pain in the right hypochondrium. The hepatic dulness increased considerably, and jaundice developed. Patient was unable to lie on the right side, and the slightest exertion produced intense pain. Deep breathing caused cutting pains through the liver. The temperature was above normal, and she had periods of profuse sweating, while the slightest current of air would produce chilly sensations over the entire body. After several remedies had been given to no purpose, merc. sol., 3rd trit., was given every hour, and the acute symptoms threatening abscess speedily subsided.—*Amer. Med. Monthly*, June, p. 85.

**Locomotor ataxy.**—Dr. T. F. Allen reports iodide of lead, 3rd dil., as giving “magical relief” to the intense fulminating pains (making the patient fall) of an acute aggravation of a chronic case of ataxy. He made his attenuations with boiling water.—*North Amer. Journ. of Hom.*, August, p. 527.

**Menorrhagia.**—Under the title of “The Medical Treatment of Menorrhagia,” Dr. Stillman Bailey communicates to the *Clinique* for August a series of cases of this affection, each cured (or practically so) by the persistent use of a single medicine,

generally in the 3x dil. Belladonna, china, pulsatilla, phosphorus and platina were the remedies employed—each according to its usual indications.

**Papilloma of bladder.**—Having seen three or four times multiple papillomata of the surface disappear under the action of arsenic, Dr. Mason was led to try it in a case of papilloma of the bladder, revealed by the usual hæmorrhage and villous tufts. He gave two drops of Fowler's solution twice daily, and complete cure resulted.—*Monthly Hom. Review*, August.

**Plague.**—Dr. Majumdar's experience with the cases of plague that have come under his notice in Calcutta has been eminently satisfactory. He has had to make no new departure in the way of medicines or attenuations, and has found rhus most frequently indicated.—*Indian Hom. Review*, June.

**Pyelo-nephritis.**—In the *American Medical Monthly* for July Dr. Mifflin relates his experience in the treatment of pyelo-nephritis. While he cannot boast of cure, the improvement he has been able to obtain is practically equivalent. Sandal wood and sabal serrulata in their crude form, and in one case croctalus 3, have been his medicines, to which he adds the free use of certain mineral waters—"Hothorn" or "White Sulphur Springs."

**Ringworm.**—We are in much need of a harmless parasiticide for this obstinate complaint, and Dr. Perkins thinks he has found it in chloride of sodium. He powders the salt finely, and mixes it with a little vaseline to make an ointment. This—the affected part having been shaved—is well rubbed in night and morning until the place is sore, which takes place in two to four days. Some healing salve should then be substituted, and when well from the sores, the hair will be found growing healthily.—*Hom. Journ. of Obstetrics, &c.*

**Tic douloureux.**—Mrs. H., aged 83, widow, in very poor circumstances, was subject to attacks of tic, which had its seat in the right infra-orbitalis, but which darted through the whole right side of the face, mouth, tongue, &c., and caused great distortion of the features. Aconitin 4 did no good, nor yet phosphorus. I learnt from the patient that the pain was most violent at night, and was attended by sweat and ptyalism. Thuja did some good, but the pain still continued, and was aggravated by pressure, movement, and draughts of air, and attended by spasmodic ten-

sion of the chewing and facial muscles. *Verbascum 3x* was of great service. In the following years she had recurrences of the pain, which speedily yielded to *verbascum*.—Sulzer, *Zeitsch. d. Berliner Vereins*, xviii., p. 228.

**Tremor.**—Dr. Laidlaw makes a suggestion towards the treatment of the so-called “intentional tremor” of disseminated sclerosis of the cord. The lesion here is in the myelin sheath of the nerve-fibres—the “white substance of Schwann” of the older physiologists. According to the thyroid therapeutics so dominant at the present day, myelin should be remedial here; and the yolk of egg contains a large amount of a substance chemically identical with that of the medullary sheath. He ordered eggs to be boiled for half an hour, and four to six yolks to be eaten daily. The patient whose case suggested this treatment recovered, and Dr. Laidlaw has found it effective in other cases of intentional tremor.—*North Amer. Journ. of Hom.*, August.

**Warts.**—A housemaid, aged 16, consulted me on May 15, 1898. Her hands were covered with innumerable warts. They had begun to appear a year ago. Some were very large, and they bled easily when at her work. Each hand had several dozen warts of various sizes. As they bled so readily she was like to lose her situation. I prescribed *natr. carb.* 10 three times a day. After this the warts ceased to bleed, but they continued to increase in number, and when I saw her four months later she had several also on her face; otherwise she was in good health. On September 19 I prescribed *calc. carb.* 10x, four drops twice a day. I saw her again in November, and was surprised to find all the warts gone. Those on the face had disappeared after a few days, and by the time she had finished the bottle (5 grammes) those on the hands were also completely gone.—Sulzer, *Zeitsch. d. Berl. Ver.*, xviii., 234.

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