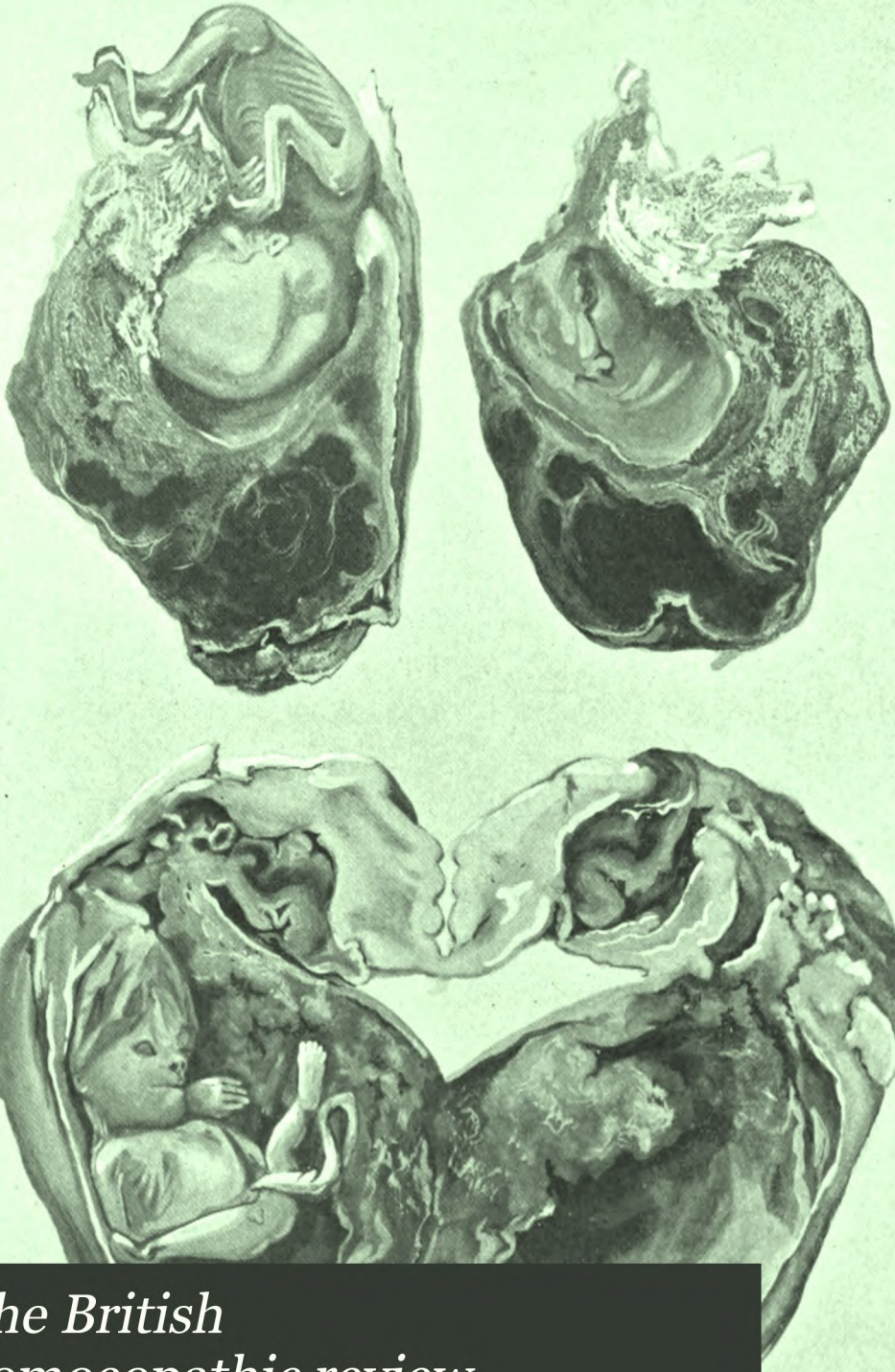

The British homoeopathic review

British Homoeopathic Association

1907-1909
6 vols

New Cent. Ref. Lib. 3
bound in 6 vols

10/6

THE BRITISH HOMŒOPATHIC REVIEW.

With which is incorporated

THE MONTHLY HOMŒOPATHIC REVIEW.

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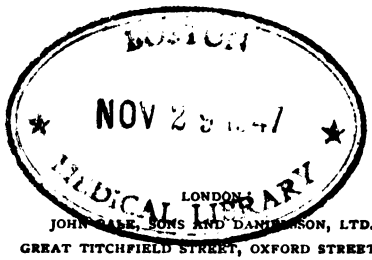
With a permanent staff of correspondents.

Volume I. New Series.

PUBLISHED FOR THE
BRITISH HOMŒOPATHIC ASSOCIATION
BY JOHN BALE, SONS & DANIELSSON, LTD.,
83-91, Great Titchfield Street, Oxford Street, London, W.



LONDON:
JOHN GALE, SONS AND DANIELSSON, LTD.
GREAT TITCHFIELD STREET, OXFORD STREET, W.

THE BRITISH HOMŒOPATHIC REVIEW.

MARCH, 1907.

INTRODUCTION TO THE NEW SERIES OF THE "REVIEW."

THE jubilee year of the "Monthly Homœopathic Review" has just terminated, and a profound debt of gratitude is due from British Homœopaths to the Editors and Publishers of this Magazine, for the half century of unflagging effort so splendidly made in the cause of Homœopathic journalism. From its earliest days the Review has appeared under the direction of some of the ablest workers in the Homœopathic field in Britain. Dr. Ozanne in 1856, Dr. Ryan in 1857, Dr. Pope in 1865, Dr. Bayes in the same year, Dr. H. R. Madden in 1867, Dr. Herbert Nankivell in 1874, Dr. Dyce Brown in 1876, Dr. E. A. Neatby in 1889, and Dr. C. J. Wilkinson in 1899—these have been the Editors bearing the heat and burden of the day, and the dates are those of their appointment. Dr. Pope and Dr. Dyce Brown have carried on their editorial work up to the present, and maintain the continuity of the Review as consulting Editors. Messrs. Henry Turner and Messrs. Gould and Son have published the Review without break since its commencement.

An opportunity for expansion has arisen, and the British Homœopathic Association, in taking over by invitation the responsibilities of the publication of the Review, will use every effort to maintain and develop the high standard of this Journal as the monthly professional organ of British Homœopathy. It is anticipated that the size of the Review will be further increased, and specificity has been given to the former

title, "Monthly Homœopathic Review," by the addition of the indicative term "British"—in brief, the "BRITISH HOMŒOPATHIC REVIEW."

The Editors have and will use an entirely free hand in this Journal in furthering the cause of British Homœopathy. A Free Press is one of the sacred traditions of our cult; and truth is born out of the clash of varied opinions and the interaction of many minds. No niggardly interpretation and no limited purview of the detail of the great field of medical science will find encouragement in the free atmosphere of these pages. *Plato Amicus sed veritas Major* is our inspiring spirit, and the entire scope of medical work with its whole array of verified results we regard as our province.

The whole array of verified results in the cure of disease we view as concatenated by the Law of Similia as enunciated by Hahnemann. A consistent interpretation, direct in some and indirect in other instances, is afforded by this law of the therapeutic results of various workers in recent times, and of which Sir A. E. Wright's vaccines may be taken as the latest example. It is quite probable that the Homœopathic Law, like Newton's first Law of Motion, will receive amplification by collateral laws as investigation proceeds. At present the single Law of Similia is the only general law inductively established and deductively proved in Medical Science. There is now material accumulated in abundance for some latter-day *savant* to range the whole field of medical work and results, and educe those collateral laws which could not fail to be as epoch-making as their prototype.

Meanwhile the Similar Law will be maintained in these pages as the fundamental law of the Science of Medicine. Polemics, as well as scientific proof, has its fit and proper place in such maintenance, and we need as warrant for our polemics no more classical justification than that of John Milton: "I cannot praise a fugitive and cloistered virtue, unexercised and unbreathed, that never sallies out and sees her adversary, but slinks out of the race where that immortal garland is to be run for, not without dust and heat."

Editorial Notes and News.

Influenza up to Date.

INFLUENZA has now been with us for seventeen years, and continues every winter to scourge us with more or less severity. Previous epidemics are believed to have been played out in four or five years. It is doubtless due to our modern habit of incessant locomotion, and to increased commercial traffic, that the present plague continues; fresh germs are continually brought into each locality as those in possession exhaust their vitality. A medical contemporary has issued a number, consisting of 160 pages, entirely devoted to the fashionable disorder. Seventeen of the leading physicians of the day contribute their views and opinions thereon in the pages of that Journal. All that can be suggested in treatment by modern medical science (unenlightened, alas, by the genius of Hahnemann!) ought now to be pretty well known, and all is here set forth in order. There can be no doubt that far more rational treatment now prevails than in the early years of the epidemic. The antipyretics—responsible, indeed, for many a death from heart failure not so long ago—have now been discovered as dangerous and unreliable, and are generally tabooed. Even the salicylates—whose action has been equally disastrous when injudiciously used in acute rheumatism—are now treated with respect, and recommended to be given "guarded by caffeine"—whatever that may mean. Nevertheless, the sheet anchor of old-school treatment is still quinine in some form or another, both as a prophylactic and in the febrile stage of influenza. Gelsemium, certainly the most generally homœopathic remedy in simple cases, is recommended only by one or two writers. Oil of cinnamon, given internally in 10 ♏. doses, is highly spoken of by several and seems to be supplanting the eucalyptus oil so generally used a few years back. Altogether the papers are readable and interesting, except where medicinal treatment is concerned; in other respects they may be read with advantage and profit by the homœopathic practitioner. We consider the number to be a decided advance upon anything that has been issued before on the subject, and it shows a more intelligent and less risky usage of such drugs as are there spoken of.

Influenza as Treated Abroad.

In the same journal referred to above occur some "Notes on Influenza from Foreign Journals."[1] From these it appears that our Continental brethren have advanced further than their English colleagues in understanding the uses and dangers of drugs. The supposed prophylactic action of quinine is declared to be "exceedingly questionable," and this after experiments on a troop of Bonn Hussars for three weeks. Leichtenstern is stated to have found that "although quinine showed its antipyretic properties in the fever of influenza, and influenced some neuralgias in the convalescent stage, it did not exert the least effect upon the influenza process as such. Cases treated with large doses of quinine always felt worse (increased headache, &c.) than those not treated by quinine." This has always been the contention and belief of homœopaths, and the facts could not have been better or more forcibly stated. If, however, this sweeping condemnation of the favourite old-school remedy, as vaunted by Sir William Broadbent and other leading lights, had proceeded from the pen of a homœopath, it would have been attributed to ignorance and incapacity. Nevertheless, we have throughout the epidemic consistently pursued our duty as homœopathic practitioners, and few, if any, of us have found it necessary to give quinine in influenza. We have a better and a simpler way. The result having been that in the earlier years of the epidemic it was frequently reported that the homœopaths had no deaths from influenza, and this report gained not a few adherents to our cause. This would not have been so had we indulged in the use of quinine and antipyretics, or even in the methods at present advocated by the writers in our contemporary.

* * * *

A Happy Thought.

In the Influenza number of the *Practitioner*, Dr. West mentions a case in which "the sweating was profuse, and persisted for months, and caused the greatest distress by requiring frequent complete change of clothes both day and night. This case was most refractory. All drugs failed to

[1] *Practitioner*, January, 1907, p. 137.

control it until *a happy thought* suggested nitrite of amyl, which, strange to say, acted like a charm." In the same journal Dr. Clifford Allbutt refers to a case of Dr. Sheeby, "who *discovered almost accidentally, certainly contrary to our expectation*, that the sweats were controlled and cured by the nitrites. The form used in this case was amyl nitrite, of which $\frac{1}{50}$ of a minim was administered on sugar three or four times a day." It is curious how these "happy thoughts" and "almost accidents" occur to learned members of the orthodox branch of our profession whenever they do a little homœopathic prescribing. Were these gentlemen unaware that nitrite of amyl frequently produces profuse perspirations, or had they forgotten that Ringer, as long ago as 1878, called attention to this fact, and at the same time recommended this drug to avert the flushing and perspirations of the menopause?

* * * *

Influenza at Oxford.

THE prevalent form of influenza on this occasion has been the so-called "gastric" form, or rather gastro-intestinal form. One very marked feature has been "a feeling of weakness in, and loss of power of, the sphincter ani; a sense of insecurity in the rectum, as if the stool would escape when passing flatus or urine." There was also aggravation in the early morning and forenoon, say from 2 to 10 a.m., and after eating and drinking. Strong men in the prime of life had frequently to guard themselves with napkins, after the manner of infants, before going to bed to prevent mistakes during sleep. In many cases such "mistakes" did actually happen in spite of care; in others it was found impossible to retain the fæces long enough to effect the necessary strategic "change of base." In cases such as these the medicine was *aloes*. Sometimes the attack was ushered in by sudden vomiting; here *verat. alb.* was occasionally all sufficient. *Baptisia* did not seem to render much aid, though one thought it ought to; nor did *China* give material help, except afterwards to make up for the "loss of fluids." In cases where the sense of insecurity of the sphincter was wanting, with offensive, dark, very fluid stools, *Arsen. alb.* acted promptly and no other medicine was required.

Quinine in Influenza.

IN the Influenza number of the *Practitioner*, Sir William Broadbent gives a short note on the prophylactic virtues of quinine. It is also his "best remedy." For many years some of us have regarded such repressant and depressant drugs as quinine, salicylates, and aspirin, even though "guarded by caffeine," as main factors in the "excessive pulmonary death-rate" and the "tragic heart failures"; for only in this way it seemed to us could one explain the startling difference between the death-rate of the homœopathic practitioner and that of his allopathic colleague during the epidemics of influenza since 1890 onwards.

* * * *

Homœopathic and Allopathic Results.

FOR let homœopathy be what it may, and its practitioners and their clients what Sir Samuel Wilks appears to think they are, there is yet left this irreducible *fact* (so prominently seen in influenza epidemics of all varieties and grades), an almost negligible death-rate over all, and in the hands of the greater number of homœopathic practitioners no death-rate at all, either from influenza itself or its complications; indeed, it is a rare thing to meet with complications at all when the case is properly treated.

* * * *

Opsonic Treatment in Phthisis.

THE two papers recently read on this subject[1] by Dr. Ham, of the London Homœopathic Hospital, and Dr. Ord, of the Hahnemann Home, Bournemouth, have roused considerable interest. The remarkable confirmation of Hahnemann's methods and teachings obtained by this, the latest scientific discovery in tuberculosis, is an event of supreme importance for the progress of homœopathy. Dr. Ham's experiments had dealt chiefly with patients suffering from tubercular glands of neck and from joint disease. Dr. Ord's paper referred more especially to the use of opsonic treatment in the early stages of phthisis pulmonalis. In a general hospital few opportunities are given for investigations in the wards on such patients. But in the Hahnemann Conva-

[1] *Journal of the British Homœopathic Society*, January, 1907.

lescent Home at Bournemouth, which is almost entirely filled with consumptives—chiefly in the earlier stages of the disease—there exists plenty of valuable material. Until lately the difficulty and expense of obtaining opsonic examinations of the blood in provincial towns has prevented Dr. Ord from studying the subject in the manner suggested in his paper. Many important questions as to the behaviour of the opsonic index in phthisis under various conditions of treatment, both homœopathic and hygienic, remain to be solved. Also the effect of homœopathic remedies used in raising the tubercle-resisting power of the blood, should be thoroughly investigated. For these reasons we are very glad to hear that the British Homœopathic Association has generously consented to conduct the blood examinations necessary in our colleague's researches at the Hahnemann Home, and that Dr. Wheeler is superintending this essential part of the investigations on behalf of the Association. Original work of this kind is always worthy of encouragement, and we have great hopes that facts of value in the treatment of phthisis will be brought to light, and that the benefit of homœopathic treatment in this disease will be more than ever firmly established on the scientific basis of demonstrable experiment. To be able to see and measure the power of homœopathic remedies in the blood of a patient under a microscope, as can be done by the new opsonic methods, is an advance in science which Hahnemann himself could hardly have supposed would be possible in less than a century from his day.

* * * *

The Dudgeon Sphygmograph.

In the February number of the *Practitioner* is an able article on the "Interpretation of Sphygmograph Tracings," by Thomas Lewis, D.Sc., M.B., B.S. He first describes the forces acting on the pad of the sphygmograph and then considers the effect on the pulse tracing, of (1) complete and (2) partial occlusion of the brachial artery, and finally reviews the forces involved in the production of anacrotism. The article is illustrated by numerous pulse tracings. It is of too technical a nature to summarise satisfactorily, and those interested in the sphygmograph should read it in full. We notice that the instrument used in the investigation was Dudgeon's sphygmo-

graph, and that Dr. Lewis chose it, "not only because it is widely used for clinical purposes, but because, from my experience of it, I consider that it is an instrument of considerable delicacy and accuracy, and that it compares favourably with appliances of its kind." It is satisfactory that, after so many years, the instrument invented by our late esteemed *confrère* still holds the field.

* * * *

Report of the Royal Commission on Tuberculosis.

THE Royal Commission on Tuberculosis, appointed in 1901, have issued a second interim report which entirely disproves the statement made by Professor Koch, at the International Medical Congress held in London in 1900, that human and bovine tuberculosis are distinct affections, and that the bacillus of human tuberculosis is unable to give rise to tuberculosis in the ox, and *vice versâ*, that bovine tuberculosis cannot be the cause of tuberculosis in man. The Commission report that their experiments show that both these statements are erroneous, and that they have "wholly failed" to discover any essential difference between human and bovine tuberculosis, and that both are equally virulent and equally able to set up tuberculosis in bovine and other animals. They further report that tuberculosis in children is frequently caused by the ingestion into the alimentary canal of milk from tuberculous cows, and recommend more stringent measures to be taken to prevent the sale and consumption of such milk.

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British Homœopathic Congress.

THE annual British Homœopathic Congress will be held at Harrogate, on Thursday, September 19th, under the presidency of Dr. Wolston, of Edinburgh. Full details will be announced in a subsequent issue of the Review.

* * * *

London Homœopathic Hospital.

HIS MAJESTY THE KING has been graciously pleased to send a gift of old linen for the use of the patients in the London Homœopathic Hospital, Great Ormond Street, Bloomsbury, W.C.

The Earl Cawdor consented to preside at the Fifty-

seventh Annual Meeting of Governors and Subscribers of the London Homœopathic Hospital, Great Ormond Street, W.C., held on Tuesday, February 26th, at 3.30 p.m.

* * * *

The San Francisco Fund.

FIFTY-ONE pounds sterling have been transmitted to the authorities of the Homœopathic Hospital at San Francisco, from our sympathising English fraternity, as aid to the fund for the repair of this Hospital, damaged by the earthquake of last year. The subscribers were : Dr. Clarke, Dr. Byres Moir, Dr. Dyce Brown, Dr. Burford, Mr. Dudley Wright, Dr. Searson, J. P. Stilwell, Esq., C. A. Stewart, Esq., W. Willett, Esq., Dr. Hawkes, Dr. Cash Reed, Dr. E. B. Roche, Dr. Wm. Roche, Dr. Cooper, Dr. Roberson Day, Dr. James Johnstone, Dr. Ashton, Dr. Goldsbrough, Dr. C. J. Greig, Dr. Wheeler, and Dr. Stonham. This is a very practical method of cementing the *entente cordiale* between our American brethren and ourselves. May the Homœopathic Hospital in San Francisco ever prosper !

* * * *

The Homœopathic Sanatorium at Davos.

IT may be news to some of our professional readers that a homœopathic sanatorium of a first-class type flourishes at Davos-Platz. It has, until recently, been under the sole direction of Dr. Nebel, formerly of Montreux, whose recent appearance at the British Homœopathic Society evoked considerable interest. Our colleague, Dr. B. Kranz, formerly of Homburg, who also is well known to our London brethren, has now taken on the supervision of this institution. Dr. Nebel's work here has been eminently successful, and we cordially commend the advantage of this Sanatorium to the homœopathic profession when need arises for such consideration.

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Our Foreign Contributors.

THE REVIEW, as the leading professional homœopathic monthly journal in Europe, has secured the collaboration of Dr. Paul Tessier, of Paris, Physician to the Hôpital St. Jacques, in its presentment of matters of homœopathic

interest transpiring in France. Dr. J. T. Wouters, of Arnhem, will keep us *au courant* with what of importance in our body occurs in Holland. Dr. Fr. Gisevius has undertaken the same duty for Berlin and part of the German Empire; while our well-known friend, Dr. B. Kranz, late of Homburg, and now at the Homœopathic Sanatorium at Davos, is our contributor for Switzerland and the other part of Germany. In this way we hope to affiliate homœopathic public interests all over Europe as far as the periodical Press can effect this, and thus present a unified European homœopathy.

* * * *

"Folia Therapeutica."

We have had sent to us a new journal with the above title, some extracts from the articles in which will be found among our "Digests." The justification offered by the editors for its issue is "that the number of new remedies being brought before the medical profession has become so great that it is an utter impossibility for the busy practitioner to keep pace with the advance of therapeutics or to learn authoritatively which novelties of pharmaceutical chemistry merit his attention, and which to discard as valueless." We fully endorse the statement as to the number of new pharmaceutical preparations; the shelves of our consulting rooms and our waste paper baskets bear witness to it. It seems that a selection of these remedies is to be made for us by preliminary experiments carried out on animals in university laboratories and subsequent trial at the sick bed in hospitals. We would suggest that the sick in the hospitals would be put to less inconvenience, not to say danger, and much more valuable information would be gained, if the drugs which have passed the test of the preliminary experiments on animals should be proved on themselves by some of the editorial staff before being given to the patients.

Original Articles.

SYMPTOMS AND DIAGNOSIS FROM THE HOMŒOPATHIC STANDPOINT.

By the SENIOR EDITOR.

THE human mind is so constituted that it cannot refrain from speculating. Some phenomenon is observed, and at once and spontaneously the question arises in consciousness, "Now, why is that?" or, "How did that happen?" Should the same phenomenon appear several times, this further question suggests itself, "Has it always the same cause?" This attitude of mind specially shows itself when we are dealing with an observational science such as the "Art of Medicine," where the interpretation of the signs and symptoms manifested by the sick form such a large part of our daily round and common task.

But what do we mean by "symptoms" or a symptom? For example, is "a pain" a symptom, or only the merest particle of a symptom? In all probability it would be dignified by the name of "symptom" by the dominant school. We shall refer to this point at a later stage. In reference to symptoms, we may very properly distinguish between *signs* and *symptoms*; the former are objective, and usually spoken of as *physical* signs, the latter are subjective, and can only be learned by listening to the patient's account of himself, or be elicited by questioning him. In any case, by whatever name these phenomena may be called, we must rely upon them as the chief means by which we are enabled to form a *diagnosis*. But is there only *one* kind of diagnosis, or is there more than one kind? Ah! that is another story.

The great point of difference, and the only one worth considering at present, between the two schools, is the mode in which, in a given case of disease, the presumed curative medicinal agent is chosen. At first sight this difference does not seem great: the *end* in both is the same—the healing of the sick; the *means* adopted alone differ. Can we say that the *end* justifies the *means* in all cases?

We may for our present purpose classify symptoms in their widest sense under three heads:—

(1) Physical signs.

(2) Symptoms detailed by the patients in their order and sequence.

(3) Hereditary influences.

For the purpose of what is usually called "diagnosis of the disease" these three groups are in order of descending value. The first two are the direct *results* of the disease, not the disease itself, but its footprints, as it were. The "symptoms" should be first in order of time, and if recognised and properly met, the physical signs may not appear at all, just as if some wideawake police officer recognised and arrested Mr. William Sikes on his way to commit a burglary, and thus prevented the development of the "physical signs" of burglary committed. The third head—hereditary influences—is, properly speaking, not a symptom, as it has rather to do with the *causes* of disease.

The "physical signs" are by far the most important for the diagnosis of the disease, according to the teaching and practice of the other school, *i.e.*, for the identification of the morbid anatomy, or the recognition of the pathological substratum through which the suffering organism brings to our notice the presence of *dis*-order or disease. We have, however, already seen that the signs and symptoms in no sense constitute this disorder, but are merely its results.

Now the physical signs of value in the "diagnosis of the disease" must be those only of *general* occurrence, *i.e.*, those that occur in *all* cases of the given "disease," mere individual and peculiar variations being of little or no use—being, indeed, more apt to confuse the diagnostician than to help in the diagnosis. The careful and observant "case-taker," however, will record them, were it only for the purpose of adding one other to his list of "curiosities" of medicine. The same is true of "symptoms" in the ordinary acceptation of that term; only symptoms of *general* and constant occurrence are of use in assisting to give the diseased condition a name. All individual, peculiar and uncommon symptoms are mere "curiosities," *e.g.*, the fanlike action ("rabbit action") of the alæ nasi, seen in certain diseased conditions, or the fact that an inflamed throat, while aggravated by empty swallowing, is relieved by swallowing solid food,

and this, too, sometimes in such a well-marked "disease" as diphtheria.

In diagnosis not only have we to recognise the presence of a disease, but we have to distinguish different diseases one from the other—in other words, diagnosis must be *differential.* Quain writes in regard to diagnosis: "It cannot be too often repeated that the application of a right remedy depends on an accurate diagnosis, and that the prevention and cure of disease are the aims and ultimate objects of our science." But as the diagnosis spoken of has been made only from *general* symptoms and from physical signs of *general* occurrence, the individual variations peculiar to the patient being ignored, because they are of no use in settling the name of the disease, or in helping us to diagnose the case, obviously the "right remedy" founded upon this method can only be one of general application to the *disease* in question—in other words, by this method the *disease* is treated, not the *patient.*

What, then, is the position of the homœopathic physician (or rather the physician who is a homœopath) in reference to this method of diagnosis? Is he to ignore and neglect it? Most certainly not! He is bound to be as careful and as expert a diagnostician as his brethren of the other school, were it for no other reason than for the purpose of being able to give a true prognosis, and as a guide to dietetic and general management during the illness. We are under obligations to make as exact a diagnosis as lies in our power and within our ability, to identify, not only the organ affected, but also the particular tissue of that organ involved, and, if possible, the nature of the disorder affecting the tissue in question.

Let me remind you of a saying of one whom we all revere: "When we have to do with an art whose end is the saving of human life, any neglect to make ourselves thorough masters of it becomes a crime." But some one may say, "The form of diagnosis given above can have no relation to, and is not included in, the above quotation." Are you sure? In any case, it need do no harm to be *capable* of making a correct diagnosis of the above type, and the faculty is not difficult to carry about. A British workman who knows nothing about the composition of gunpowder, and

cares less, may be able to handle it perfectly for the purpose of blasting rocks, better even, perhaps, than a professor of chemistry at any of our universities. At the same time, were *I* that British workman, I would take every means I could to find out what gunpowder was, and how and why it did its work, and if that did not help me to use it better, it would at least educate my mental powers, and in that way would make me a more *intelligent* and better workman.

Take, for example, pain in the abdomen. We have to ask ourselves here whether we have to do with hyperalgesia of the gastro-intestinal mucosa, spasm of the muscular tissue (*i.e.*, disorderly peristalsis), or inflammation of the peritoneum. To know this will at least help us to answer the question, "What is it, doctor?" And when we have to answer such a question it is better, surely, to give a true than a haphazard answer.

Take, again, a child affected with sudden attacks of screaming, say in sleep, or during the night. Is it of no importance to know whether such screaming fits are due to fright induced by nightmare, or emotional disturbance caused by punishment before going to bed, or irritation of the posterior pair of the corpora quadrigemina from tubercular deposit in the brain itself, or tubercular or other inflammation of the brain and its membranes; or due to dosing (secondary effect) with bromide of potassium, or, lastly, due to acute middle ear disease?

Once more, a child has "chewing motions" of the mouth, rolls its head, with or without moaning or other noises; or it bangs its head with its fist, or bores it into the pillow. Is it of no importance to have some definite idea whether any or all of these symptoms are associated with, or due to, inflammation of the middle ear, dentition, or meningitis, or whether they occur during the course of other diseases not directly connected with the head, as dysentery, the specific infective fevers, including pneumonia? The "head rolling" may be due not only to middle ear disease, dentition, or meningitis, but also to pains in the cranial bones due to rickets or congenital syphilis; also to inflammatory or other irritation of the upper part of the spinal cord conveyed through the great and the small occipital nerves to their terminal twigs in the skin, and the rubbing of the occiput against the pillow seems to relieve

this. It is possible also that the irrritation produced by ear affections may be conveyed through the auricular branches of the same nerves to the same area. In this connection it is interesting to observe that horses with meningitis bang their heads furiously against the wall, for they cannot bang it with their fist. It is quite true that the medicines for all or most of these conditions will mostly be found in the following short list: *apis*, *bell.*, *bry.*, *hell.*, *podo.*, *zinc.*, at least, so long as the case is in an acute stage; nevertheless, were I attending such a case, or if the case was my own child, I would not be happy until I could differentiate the special part affected, and as far as possible the nature of the affection.

We are just as much bound as others to train the *tactus expertus*, and cultivate the *tactus eruditus* to the fullest possible extent, the one to feel and discriminate, and the other to interpret what is felt and discriminated. We must make as exact a diagnosis of what is called in the other school "the disease," even were it for no other reason than that there are such things as "coroner's inquests," in England, at any rate. It cannot be too frequently insisted upon, however, that the symptoms and physical signs are *not* the disease, but only the *results* of the disease; the morbid anatomy is only the pathological substratum through which the signs and symptoms are made manifest to our senses. But they are at best merely the outward and visible signs of an inward and invisible change, a picture thrown from behind upon a veil of flesh, from whence and by whose hand we know not: the wind blowing where it listeth, and we only hear the sound, but cannot *see* it or grasp it with our hands.

It is our duty, then, to make an exact diagnosis in the ordinary acceptation of the term, but we must not stop there. To the allopath it is practically the end, for all their talk about the "right remedy" and its relation to a correct diagnosis amounts to but very little, when closely examined. To us, however, it is but the beginning, for we have a further and more important diagnosis to make, viz., the diagnosis of the remedy, a diagnosis of a different order and built upon a different foundation. With the other school it is called "treatment," and this treatment is founded upon the diagnosis—a sandy foundation indeed. I detest the word "treatment":

any fool, qualified or unqualified, can "*treat*," diagnosis or no diagnosis.

For the homœopath to attempt to found his diagnosis of the specific remedy on such a foundation must, we believe, be very unsatisfactory, and was not the method followed by the giants of the old brigade. We have already seen *why* such a method must be unsatisfactory: the physical signs and subjective symptoms used for the diagnosis of the "disease" are only those of *general* character, the individual characteristics of the particular patient are ignored as being, to all intents and purposes, useless so far as the diagnosis is concerned. It seems to me, therefore, impossible to find the "right remedy" by a study of the morbid anatomy. It may, it is true, be found in spite of it, but not because of it. By such a method every case of pneumonia and every case of peritonitis would get the same remedial treatment, as the disease in each case is the same. Hence, while it is our duty to make an exact diagnosis of the disease for reasons previously stated, there is one thing we must *not* do (unless nothing better is possible), and that is to make it the basis of our therapeutics. The symptoms and physical signs can be used in a legitimate or in an illegitimate manner. If, for example, in cases of disease showing a high temperature, the result of our thermometry is a hurried and panic-stricken attempt to get the temperature reduced at all costs, quite irrespective of the other manifestations of the disease; if this is to be the result, I say, it is a pity that the thermometer was ever invented. This is to use physical signs in an illegitimate manner, and a use likely to lead to disaster. To arbitrarily choose one symptom out of a totality as the one deserving of our special attention is symptom-treating in its most malignant and fatal—for the patient—form. The thermometer is a most valuable instrument when used with brains, but not otherwise, for fever, or "pyrexia," is an essential and beneficent reaction of the organism to changes induced by the disease. To treat the temperature is even worse than treating "the disease"; and again, to treat a disease is a very different thing from treating a patient suffering from a disease. This latter is the aim of every true physician, but to none save those who adopt, consciously or unconsciously, the principle enunciated by Hahnemann, is such a thing

possible in any real sense. For I do not believe that any *cure* worth the name has ever been effected under any other principle from the first of time until now, or ever will be. In making this statement, I distinguish between acute diseases, which are self-limited and tend to natural recovery, and chronic diseases which show no such tendency, as well as between *cure* in the proper sense on the one hand, and natural recovery on the other. It is utterly unthinkable that Nature could have *two* laws of cure diametrically opposed to each other. If it were so, then would we be face to face with a *direct* antinomy—a contradiction of the most insoluble character; if it were so, then the "Science of Therapeutics" would be quite out of line with all other sciences and could never by any possibility be anything else. But we claim that homœopathy *is* the Science of Therapeutics, and that, too, on evidence of the same order of certainty as obtains in other sciences, such as Physics and Chemistry.

(*To be continued.*)

THE PROGRESS OF HOMŒOPATHY IN ENGLAND.

By Dr. W. T. ORD.

I. The Metropolis—A Sketch and a Retrospect.[1]

It is always of interest to observe the gradual advancement of a great discovery, as in the teeth of opposition and ignorance its truth slowly gains ground and receives wider and fuller recognition. In the progress of Homœopathy, since its first admission into England nearly a century ago, there have been periods of ebb and flow, with here an increase, there an apparent decrease in development, but the total result has been a steady and permanent advance. To a superficial observer this may not be self-evident; nevertheless, it is a fact not difficult of demonstration. The many directions in which advance may occur—slowly and imperceptibly in some, rapidly in others—tend to confuse the observer. For example, in locality we have three areas to consider, the metropolis, the provincial towns and the country districts. Again, there may

[1] To be followed by a second paper on "Homœopathy in the Provinces."

be great progress in hospital and dispensary work, without any increase in the number of the profession practising homœopathically elsewhere. Finally, there may be much amateur dabbling in homœopathy, which is not to be despised, but has accomplished much good in the past, with diminished interest in the subject on the part of professional men. Consequently these several lines of advance are not all occupied at one time. Hence, by those that look at only one or two factors, we are often told that homœopathy is declining, whereas a notable advance in other directions is actually taking place, unobserved by the careless onlooker.

It may be of interest to briefly notice the most conspicuous events that have occurred in the history of homœopathy in England, each of which has played a prominent part in its progress. Soon after the late Dr. Quin brought the value of the law of similars as propounded by Hahnemann (then but just dead) to the notice of the profession, and whilst many, admitting its value in minor ailments, exclaimed against its use in dangerous maladies, like a thunder-clap the terrible cholera epidemic of 1854 burst upon this country. The extraordinary success with which the severest cases of this awesome disease were treated in the then but recently opened London Homœopathic Hospital, is a matter of history. This, with the Government Medical Inspector's observations in his Report, has been happily brought forward afresh in the booklet just issued by the British Homœopathic Asssociation.[1] It is well thus to remind the rising, and too sceptical, generation of these and other equally striking statistics of homœopathic treatment, which have there been admirably and forcibly stated. The publicity given to these facts after the cholera had subsided caused many thoughtful men, both doctors and laity, to consider the subject, and few, very few, who did this with care remained unconvinced of the truth of Hahnemann's teachings. From this resulted a great demand for homœopathic treatment in provincial towns, and numbers of medical men commenced to practice as homœopaths in places which had hitherto been unrepresented.

For many years the effect of this movement in favour of

[1] "What Homœopathy is, and What it Does," to be obtained gratis at the office of the Association, 233A, Regent Street, W.

homœopathy remained evident, indeed, until a new generation arose, which knew nothing of cholera. Then there appeared an ebb in the tide of progress, and for a brief period but few signs of advance were evident. From this, however, a rapid awakening ensued, showing that homœopathy was very much alive; this chiefly originated through the correspondence in the *Times* newspaper. This excited widespread interest, and, in spite of every effort on the part of those of the other opinion, resulted in a great revival of interest in Hahnemann's methods, the homœopaths, it being generally acknowledged, having much the best of the discussion.

About this time Pasteur and Lister's researches, resulting in the general adoption of antiseptics, led to the modern great advances in surgery. At the London Homœopathic Hospital surgery had until then been but little practised, it having been rightly thought that one object of homœopathy was to minimise the necessity of surgical interference in disease, and that there lay one great argument in its favour. Nevertheless, it was made apparent by the enormous advance in successful surgical procedure that now took place, and by the clear demarcation between medicinally curable diseases and those that could only be cured by surgery (now rendered evident by the growing science of pathology), that antiseptic surgery must occupy a place in the practice of the principal homœopathic hospital in England.

All honour is due to those who, thorough homœopaths as they were, had the wisdom to perceive this necessity, and, laying aside the older traditions of their order, to welcome the new surgical handicraft as a valued aid to those conditions in which the law of similars alone could not effect a cure. Hence arose the modern advance in the interest and spread of homœopathy that has for the past fifteen years been centred in and spread around the metropolis from the London Homœopathic Hospital.

In the old days homœopathy was looked upon as the enemy of surgery, and for a homœopath to call in a surgeon was as if he had denied his faith. Such reproaches could no longer be launched against Hahnemann's disciples in England; surgery had now become the valued handmaiden to homœopathic practice, occupying, it is true, a subordinate position,

but one, nevertheless, of honour and confidence. For it yet remains true, although great advances have been made in allopathic medicinal practice (largely through the annexing of homœopathic remedies and methods), that the number of cases passed on from homœopathic hands to the surgeon is far less in proportion than those proceeding from other sources, and so it must ever remain until the law of similars receives general recognition in the profession.

Coincident with the fresh vigour imparted into homœopathy by this forward movement, occurred a desire to reorganise the forces of the British Homœopathic Society. For some years previously the members of this body had been few, and but little vitality had characterised their proceedings. Many men practising homœopathically declined to belong to the Society, and the *British Journal of Homœopathy* had ceased to exist, the proceedings of the British Homœopathic Society being published in the pages of the *Monthly Homœopathic Review*. Under the energetic secretaryship of Mr. Knox Shaw a rapid change came over the scene. With a very few exceptions, all the representatives of homœopathy in provincial towns as well as the metropolis joined the Society, and the present Journal, in its new form, as it appeared fifteen years ago, presented the proceedings of the British Homœopathic Society for the first time in a manner commensurate with its dignity and importance.

At this period a movement for the rebuilding of the London Homœopathic Hospital proved the interest excited by recent events in the homœopathic world, and resulted in so large a sum of money being contributed that the present splendid block of buildings sprang into being. For the first time a Homœopathic Hospital, fit for comparison in everything except size with the best-equipped London hospitals, graced the metropolis, exhibiting a striking contradiction to the vain ignorance of a leading physician, who, about that time, publicly sneered at homœopathy as a mere ghost. Coincident with this, a further development in homœopathic practice resulted in the adoption of specialism in surgery and medicine by several of the homœopathic leaders in the events referred to. This coincided with the example set by the traditional school, under compulsion of the vast increase in medical knowledge of the preceding decade.

Although this step has been regretted by some of Hahnemann's older followers, there can be no doubt that in the main it has worked out well for the advancement of homœopathy. And our knowledge of the best treatment of diseases of special organs, in accordance with the law of similars, has notably progressed through the labours and experience of homœopathic specialists in the various departments of medicine. We can have no doubt that the necessity for this specialism would have appealed to the great Hahnemann himself, could he have foreseen modern developments in scientific medicine.

From these very notable events in London, homœopathy at this time received a tremendous impetus, and progressed with a vigour that had probably not been equalled since after the cholera epidemic of 1854. Many young medicals have been attracted to the new hospital, and after occupying posts as resident medical officers, have started in homœopathic practice in the metropolis and its suburbs. From these and other circumstances a great increase in the number of men practising according to the teachings of Hahnemann has resulted, and London was certainly never so well supplied with homœopathic practitioners as at the present day. It is equally true that never before was there so large, influential and enthusiastic a body of laymen and believers in the system as now permeate the population of this city.

Space forbids our enlarging further on this subject. The facts are well known to most of our readers. With the rise and progress of the British Homœopathic Association we shall not deal at present. Its work is now before the public, professional and lay. But as regards the progress of homœopathy in the provinces, to be treated in a second paper, we shall endeavour to show the need of great and united effort on the part of all homœopaths, that the same impetus may be there applied, and as successfully, as has so recently advanced our cause in the metropolis.

TWO NATRUM MURIATICUM CASES.

By T. G. STONHAM, M.D.

CASE 1.—The following two cases may prove interesting both for themselves and for what they suggest.

Mrs. L. S., aged about 50, past climacteric, had been feeling very unwell for several weeks past. She complained of a constant feeling of coldness, especially down the back of the head and spine, it felt, she said, as if jugs of cold water were being poured down her back, and no amount of clothing made any difference. She had a sallow appearance, and the skin was dry and shrivelled. She had become much thinner, and had but little appetite. There was much thirst, which was incessant all day; she said "she felt she could drink gallons." Obstinate constipation, pains in the legs and arms, weariness and tenderness; also pain in the small of the back was very troublesome, especially on walking about; it was relieved by lying down. Fluid coryza from the nose and eyes, and a dry tickling in the throat with paroxysms of cough. She was very depressed, shed tears freely, but disliked to be sympathised with; she wept most while alone. There was an irritating papular rash, the principal seat of which was at the back of the neck, and mostly at the margin of the hair in the nape, but there was also some on the face, hands and fingers.

These symptoms gave such a perfect picture of natrum muriaticum, that as soon as I had elicited them from her I said to her, "You have taken a great deal of salt lately, have you not?" She replied that she had always been very fond of salt and habitually took a great deal with her meat, she also liked her soup strongly flavoured with salt, and took much with vegetables, was fond of salt fish, of salt butter, and had recently taken a great many onions baked with salt. It was evident that she was suffering from salt poisoning. I told her she must moderate her use of salt, but need not give it up entirely, and prescribed *natrum muriaticum* 30 pil ii., night and morning, and an ointment consisting of *natrum muriaticum* 6x and *spermaceti*, to be applied to the rash at the back of the neck during nights.

I saw her again a week later, when she told me that the ointment had been so irritating that she had left it off after

three days, but that since then the rash had been much better. She also felt better in herself, especially with regard to the pain in the back, and was less low spirited. The rash looked fainter in colour and the papules were less numerous. The *natrum muriaticum* was continued night and morning.

She returned in another week with the rash nearly gone and no longer troubling her. She was in good spirits, much more vigorous, much less constipated, and the coryza from the eyes and nose had gone with the cough. There were no pains in the arms or legs and the backache had ceased. Repeat. After another week she was quite well and was putting on flesh, the bowels were regular, the rash quite gone, in fact, none of her symptoms were left. She had continued to take a moderate amount of salt with her food.

CASE 2.—Another case showing the influence of salt on the system is the following.

Mrs. C., aged 60, came on May 23rd, 1906, complaining of trigeminal neuralgia of the right side, which had lasted ten days and was getting worse. All branches of the right trigeminal were affected. The attacks came on daily about 9.30 a.m, and gradually attained great severity in a climax lasting from 11 a.m. to 2 p.m., after which amelioration occurred and all pain was gone by 4 p.m. In the attacks the eyes watered and the face became a bright scarlet colour. The pain was tearing, and was aggravated by movement and by stooping. The right eye streamed with water, and the head throbbed with the pain. There was nausea, a crack in the right corner of the mouth, and from time to time she had had ulcers on the tongue. There were also cold sensations in the sacrum and thighs. She felt depressed and irritable, and inclined to weep. For some time past she had been working long hours and had stood much, and on account of a prolapse of the uterus had worn a pessary.

The symptoms suggested natrum muriaticum, especially the forenoon aggravation and the profuse lachrymation, as also did the mental condition and the state of the mouth and tongue.

She was accordingly given *natrum muriaticum* 30 pil. ii., t.d.s. On June 13th (three weeks later) she came again, and said that the second day after beginning the medicine the

neuralgia lessened, and by the end of the week it had quite gone. There had been no return. I then elicited from her an interesting piece of information. She had been wearing a ring pessary for over twelve months to counteract a prolapse of the uterus, and I had ordered her to use a cleansing douche daily of warm water with common salt dissolved in it, in the proportion of a teaspoonful to the pint. On questioning her about this, I found that she had made the solution six or eight times stronger of salt than I had ordered.

It appeared to me that her symptoms had been caused by absorption of salt from the vagina, and that this second case, like the first one, was an involuntary proving of natrum muriaticum. Cases like this raise a question of great interest with regard to the effect of potentisation on drugs. In both these cases symptoms produced by the crude drug were antidoted by the thirtieth dilution of the same. It may be objected to this in the first case, that the patient having been ordered to moderate her use of salt, the system rapidly got rid of the excess which was causing the symptoms, and health was restored without any influence being exerted by the potency.

This is quite a valid argument, though from the rapidity with which the long-continued and deep-seated constitutional symptoms were recovered from, I think the medicine had much to do with the result.

But whatever may be thought of Case 1, this objection does not hold in Case 2. There the excess of salt in the douches was not discovered till the neuralgia had been cured, and was going on all the time the patient was taking the potency, which acted with remarkable rapidity as an antidote.

Natrum muriaticum is not the only drug whose crude effects are antidoted by its potencies. The same has been shown to be true of several others. Tobacco, for instance, to name only one; and possibly it may be the case that it occurs with all drugs. When this occurs, something must have happened to the crude drug in the process of potentisation to alter in some manner its constitution. It is not quite the same substance as it was before, and though it is sufficiently like it to select the same tissues, it must act on them in a slightly different way. It must have changed from an "idem" to a "simillimum." That it is possible for substances

to undergo changes of this kind, we know from the instance afforded by radium, which undergoes such a variety of transformations into matter unseen and imponderable but potent. And just as the radium transformations have to be studied by their effects on the conductivity of gases, and their action on the photographic plate, not by any grosser means, so the alteration in a drug produced by potentising requires for its demonstration the equally fine method of the physiological and therapeutic reaction of living cells.

AURAL VERTIGO AND TINNITUS, WITH ILLUSTRATIVE CASES.

By A. SPEIRS ALEXANDER, M.D., C.M.

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THE above title does not imply that the subject of these ailments necessarily suffers from any organic disease of the ear, or even from deafness. It does imply that patients so affected refer their symptoms to the ear, and that this organ is implicated in the production of these symptoms is beyond doubt.

(1) Vertigo and tinnitus may, and often do, occur together, and when thus associated they depend on aural conditions for their causation.

(2) They may also occur independently of each other. When vertigo occurs alone it is usually due to a non-aural cause, such as gastric disturbances, cardiac affections and nervous exhaustion. It may, in graver cases, be due to the pressure of endo-cranial tumours on the auditory nerve. Except in this latter case, hearing is rarely, and not necessarily, impaired.

(3) Tinnitus may likewise occur without any vertigo, but in this case the converse of the foregoing obtains, that is, that deafness is generally the rule.

The conditions that give rise to tinnitus and deafness without vertigo are accumulations of cerumen, perforations of

the tympanic membrane, and sclerosis of the middle ear and its contents.

The noises in the first case are due to the pressure of wax on the membrana tympani; in the second, to the vibration of the ruptured membrane; and the third is often combined with atheromatous changes in the vascular system. The last form is usually accompanied by the condition known to aurists as Paracusis Willisii, or deafness where the patient hears better in a train or carriage, or in other noisy surroundings. Such cases are, as far as our present knowledge goes, hopelessly incurable. The two first forms, happily, are much more tractable, and can be cured by the removal of their respective causes.

What this paper is more immediately concerned with, however, are the associated symptoms of vertigo and tinnitus. Such cases may be accompanied by deafness, but they often occur without any impairment of the aural function.

The simplest form in which this congeries of symptoms may be observed is that caused by pressure of wax on the tympanic membrane, and here deafness is generally present. (It has already been stated that cerumen may give rise to tinnitus and deafness without vertigo, yet in some cases the latter symptom also occurs.) Here pressure is conducted by the ossicular chain to the labyrinth, resulting in an alteration of tension in the fluid contained therein. It is well known to physiologists that the sense of equilibrium is largely under the control of the semi-circular canals, and hence it can easily be understood that any change, permanent or transient, in the endo-labyrinthine tension must interfere with the function of co-ordinated movement. Needless to say that the removal of the cause, namely, the wax, is sufficient to cure uncomplicated cases of this kind.

Another and much graver variety is Menière's disease, but here not only is the condition due to a definite lesion, that is, hæmorrhage into the labyrinth, but the symptomatology is different. In addition to vertigo and tinnitus vomiting takes place, and the subjective noises are of a different kind, for, as well as buzzing, roaring and wheezing, there are intermittent sounds, described as resembling the report of a pistol, heard by the subject of it. While true Menière's disease is

rare, there is a paroxysmal form of vertigo and tinnitus which simulates but is not to be confounded with it. Here, the labyrinthine lesion is absent, there is no structural change in the ear, and hearing is unimpaired. Cases of this kind may sometimes be complicated with the presence of cerumen, but its occurrence is to be regarded as accidental rather than causative, since its removal does not cure radically.

The form of paroxysmal vertigo and tinnitus under consideration seems to be connected, as far as the writer's observation has gone, with two conditions, namely, cardiac asthenia and neurasthenia. Both are fortunately amenable to treatment, and a hopeful prognosis may therefore be given when such cases are met with. Their treatment, too, in accordance with the rule of similars, affords a striking example of that principle of therapeutics. And, in this connection, what is of paramount interest to the homœopathic practitioner is that vertigo and tinnitus can be produced by certain drugs, which, in turn, become themselves available as a means of cure. These are, as is well known, *quinine*, the *salicylates* and *nitrite of amyl*. The two former are thought by some to produce their effects by contracting the cerebral and aural vessels, while the last does so, *per contra*, by dilating them. Be this as it may, the first two, at all events, are a valuable aid in treatment from our point of view.

CASE I.—The sphere of action of the first of the foregoing drugs may be illustrated by the following case. Some years ago a lady, aged about 60, presented herself with a history of recurring attacks of paroxysmal aural vertigo, with all the attendant symptoms usually attributable to Menière's disease. These were, in addition to vertigo, vomiting, roaring in the ears, and also noises like pistol shots from time to time. The paroxysms were severe, protracted and prostrating. The remedy prescribed was *salicylate of soda* 3x, and its effect was rapid and striking. The attacks became not only less frequent, but much less pronounced, till at length they occurred only once in a few months, and when last seen the patient had not been troubled with them for a long time. Whether a true labyrinthine lesion was present in this case or not was hardly possible to determine. As to the action of the drug there could be no question, and it afforded an example of what the

practitioner of homœopathy often experiences—that the symptomatology of a case may guide to its curative treatment, even when the pathology is doubtful or obscure.

CASE 2.—One etiological factor that has been referred to in relation to paroxysmal vertigo is cardiac asthenia. Of this variety the case now reported presents an example. Mrs. W., aged 65, was seen on February 16th, 1903, and complained of severe attacks of giddiness, accompanied by buzzing noises in the ears, and by faintness. The attacks sometimes occurred in the open air, so that she staggered in walking, and had even fallen down in the street, a condition sufficiently distressing to the patient from every point of view. There was no sickness, and hearing was normal. The prescription in this case was *quin. sulph.* 3, t.d.s., and on March 12th the patient reported a marked improvement in the whole condition. The medicine was continued, and on May 5th the vertigo had disappeared, and there had been no more falling down, either in or out of doors. The noises were also much better, but were still heard a little when in bed. She now complained of much shortness of breath, especially when going up hill or upstairs. No valvular lesion of the heart could be detected, but the cardiac sounds were feeble, and the pulse soft and easily compressible, though the rate was about normal. The dilution of the quinine was now altered to 4x, and *ars. iod.* 3x given after each meal. On June 12th the noises had become more pronounced, but there was no return of giddiness. The breathing was still short going up hill. The prescription was repeated, except that the higher dilution of *quinine*, the third centesimal, was reverted to.

On July 27th the tinnitus had been much relieved, the dyspnœa was also less, and there was no vertigo. From this time onward no recurrence of the paroxysmal vertigo took place, the tinnitus entirely disappeared, and when seen on November 3rd, 1904, except for minor ailments, the patient appeared to be in fairly good health.

In this case it may be concluded that quin. sulph. 3 relieved the urgency of the attacks, but did not remove them entirely till the cardiac asthenia had been improved by the administration of ars. iod. It is also to be noted that *quin. sulph.* 4x seemed to aggravate the tinnitus to some extent.

In the next two cases to be recorded, the attacks of paroxysmal vertigo and tinnitus were connected with, if not due to, neurasthenia—the one in a young, and the other in an elderly lady.

CASE 3.—Miss ——, aged 26. Some two years before this patient came under the writer's care she had suffered from influenza, which, among its protean effects, numbers that of nervous prostration.

Here, not only did this condition obtain, but frequent and long-lasting attacks of aural vertigo occurred. There was no deafness, but, on the other hand, actual sound hyperæsthesia was present, so that even low sounds were exaggerated into loud noises, and music was intolerable. Violent headaches, of the congestive type, were frequent, and, with the vertigo and tinnitus, were occasioned by the ordinary traffic of the streets. Even the sight of an omnibus or carriage in motion was sufficient to precipitate a paroxysm, these becoming so frequent and severe that the patient was obliged to leave home and live in the quiet of the country, where some measure of freedom from noise could be obtained.

Here, in order to relieve the constant tinnitus and secure sleep, bromide of potassium had been prescribed, and was taken daily in considerable quantities. It need hardly be stated that its effect was only palliative in some degree as a hypnotic, and it had no curative effect whatever on the main sources of the distress.

When this patient was first seen, in the summer of 1904, the first step that seemed necessary in the rational treatment of the case was to break off the bromide habit. She was, therefore, directed to give it up at once and entirely, with a warning that some aggravation of her symptoms might at first be noticed as a result of its disuse.

The general symptomatology, including the headaches, seemed to point to *Gelsem. semp.*, which was accordingly prescribed in the 3x strength thrice daily.

As anticipated, the cessation of the bromide was attended by a good deal of distress from insomnia, but by degrees sleep returned, and Gelsem. was probably helpful in this direction. It appeared, however, to have but little, if any, effect on the vertigo and tinnitus, which continued, especially as the result of any little exertion or even ordinary exercise.

The prescription was, therefore, changed to *quin. sulph.* 3, t.d.s., and a marked result was soon apparent. The paroxysms became less frequent and less severe, and after steady continuance with it at intervals for some months, life became much more endurable. The patient, however, had still to remain in the country, as the noise and bustle of town caused a return of the old distressing experiences, though to a less extent than before. In the early part of 1905, though there had been a very marked amelioration, yet the cure was not complete, and it was felt that something was requisite to restore nerve tone, the lack of which appeared to be an underlying cause of the remaining disturbance. A course of Weir-Mitchell treatment was therefore ordered, and carried out in the fullest and most efficient manner for a period of two months. *Quin. sulph.* was at the same time continued. The result was all that could be desired, not only the general level of health being raised, but the vertigo and tinnitus became practically a thing of the past.

At the close of the course, the patient was sent away for change of air and scene, and still kept under the influence of quin. sulph. 3. For over a year now she has kept well, and is able to join in the ordinary pursuits of life without inconvenience.

This case seems to illustrate the circumstance, which must not infrequently present itself to the observant physician, that a drug, though probably the simillimum to a given case, is not always sufficient to cure that case entirely, and that before its full activity can find scope, any underlying and hindering condition, such as, in this instance, neurasthenia, must first be swept away. Then, and not till then, can a fair field for its action be obtained, and its full effect observed.

It may be added that the rest cure, in this respect, appears to be to neurasthenia what the so-called anti-psoric remedies are to certain other chronic diseases, in laying a solid foundation for the curative action of the symptomatically indicated drug.

It has already been pointed out that cases of paroxysmal vertigo and tinnitus may be complicated by the presence of cerumen, but that its removal does not cure the condition, which is not caused by it. Such was the state of matters in

CASE 4.—Mrs. S., aged 64. An urgent request was received on July 11th, 1906, to visit this patient, as her condition was giving much alarm to her relatives. She had that day been returning home from the country, when she was suddenly seized while in the train by violent giddiness, roaring and turmoil in the head, with partial deafness and violent sickness. When seen she was in bed, in a state of semi-collapse, with rapid, thready pulse. She was also in a very agitated state, the violence and unusual character of the attack having thoroughly alarmed her. Restorative measures were at once adopted, and *gelsem.* and *ignatia* given in alternation. Under this treatment an amelioration of the urgent symptoms soon took place, and with the aural speculum revealed the presence of a considera fairly good night was passed. Next morning an examination able quantity of cerumen in each ear. This was at once removed in the usual way, but while the deafness was immediately relieved, no greater decrease of the vertigo and tinnitus was experienced than that which had followed the administration of the medicines. Clearly, then, the attack, though it may have been aggravated by the wax, had not been due to its presence. It was now ascertained that the patient had been living at high tension for a long period, attending and taking part in public meetings, sometimes every day in the week, and otherwise leading an exciting kind of life, which, though not felt previously, had no doubt at length culminated in the attack described as the expression of a nervous break-down. Obviously rest of body and mind was called for, and accordingly the patient was advised to abstain from all public and other engagements, and to rest quietly at home for some weeks. At the same time *gelsem.* was continued, and later was followed by remedies for various other ailments, such as constipation, indigestion, &c. This *régime* was attended by a marked improvement, both in general health and in the vertigo and tinnitus, which gradually became much less pronounced. In about a month's time she went to the country for further rest and change of air, with increased benefit to the general nerve tone.

On November 3rd the lady, who had not been seen for about two months, called to say that, though much better in every way, she still felt troubled by a certain degree of vertigo

and tinnitus. There was no sickness, and hearing was normal for the watch, tuning-forks and voice. *Quin. sulph.* 3 was now given, with the result that by November 19th every remaining vestige of her late trouble had entirely disappeared, and since that date there has been no recurrence.

It will be observed that in these three cases, while other remedies gave a certain degree of relief, the finally curative agent was *quinine.* The sphere of activity for this drug, in relation to conditions of this kind, may therefore be fairly well determined by the association of this group of symptoms, namely, vertigo, tinnitus and sickness, generally without deafness attributable to structural changes in the ear.

Where tinnitus and deafness without vertigo occur, *quinine* has no curative value, these conditions being, in such cases, due to sclerosis of the tympanic cavity.

Again, in vertigo without tinnitus, it does not seem to be of any service, not being indicated by the general symptomatology.

The reader will have noticed that all the cases related were confined to the female sex, and this circumstance corresponds, though not exclusively, with general experience.

CLINICAL CASES.

By E. W. BERRIDGE, M.D.

Case 3.—*Indium metallicum.* January 9th, 1888. P. W. B., aged 10, consulted me for constipation, from which he had suffered for five or six years. Had taken some remedies in high potency, but with only temporary benefit. Has had no medicine for a very long time. Now has stool about once a week, dark and thick, sometimes with blood; anus sore after stool; has to strain much, seizing his thighs with his hands and straightening himself forcibly; the effort makes his face red, and the head feels as if it would burst.

Diagnosis of the Remedy.—No medicine is recorded under "bursting in head during stool," though *Ratanhia* (11) has it

after stool; but there are analogous symptoms which are here compared.

Pain as if top of head would come off. *Alum., bapt., cact., cann. s., cham., cimicif., cobalt, cupr., cupr-s., kali-bi., lach., lact-ac., lith-c., sang., therid.*

—— at every jar. *Cobalt.*

—— worse stooping, worse laughing, better from cold wind. *Cupr-s.*

—— on blowing nose. *Merc.*

Pain as though straining at stool would take off his head. *Indium* (41,151.)

Pain as if head would come off, or go on forward, whenever he stands still, but not when he moves about or walks. *Rhus tox.*

Pain as if top of cranium would float off (*vertigo*), worse on looking up. *Natr-hy.*

Pain as if head were being taken off. *Xanthox.*

I gave one dose of *indium metallium*, cm. (Finckè), with immediate improvement. In four or five months he was cured, having taken four doses of cm. and one of 60 m., each dose being allowed to act until its curative effect seemed exhausted, the symptoms returning and persisting. He had no more trouble till January, 1891, when constipation returned with frequent ineffectual urging, but without any of the former symptoms. One dose of *nux vomica* 102 m. (F.C.) cured at once.

Comments.—This case adds to the *Materia Medica* an important symptom, an aggravated form of straining. All the rare metals deserve an exhaustive proving; from the analogy of *indium* we may hope to elicit from them symptoms at present registered nowhere. This is the only case where I have found *indium* indicated, and no others seem recorded.

CASE 4.—*Phosphorus.* April 22nd, 1888. Miss L., aged about 45. Six weeks ago, when going out into cold wind, felt something strike icy cold in centre of lower chest. Since then has suffered from cough, excited by lying on right side, aggravated by eating and sometimes for a short time afterwards; also worse on rising from bed in morning. Sputa thick yellow, tasteless. Cough causes pain like smarting in front of throat about root of tongue. Constant pain in centre of lower chest

as if stopped up. Cannot draw a long breath on account of a feeling of weight in centre of lower chest, relieved by sighing.

Diagnosis of Remedy.—Cough from lying on right side. *acon., alum, amm-m., carb-an., cina., ipec., kali-bi., kali-c., luesinum., merc., phosph., plumb., silic., spong., stann.*

Cough worse by eating. *Acon., amm-m., ipec., kali-bi., kali-c., phosph., silic.* (with many others that have not the former symptom.)

Cough on rising from bed. *Acon., phosph.* (with others which have not the two preceding symptoms.)

Of these two remaining remedies, only *phosph.* (1133), has sore throat when coughing. It has also most of the remaining symptoms (2421, 2437, 2447, 2475, 2493); also thick and yellow sputa.

I gave one dose of *phosph.*, cm. (F.C.) at 7 p.m.

April 23rd. Last night cough worse when lying in any position; no cough this morning; throat, chest, and breathing much better.

April 26th.—No return of cough; chest feels much stronger.

April 29th.—Quite well; and remained so.

Comments.—(1) This case is an illustration of the selection of the remedy by the process of exclusion, *i.e.*, by writing down the medicines belonging to one symptom first; then those belonging to another, and striking out those which are not common to both; continuing this process till the number is reduced to one. It is best adapted to those cases where most or all of the symptoms seem of equal importance.

(2) It also illustrates what Hahnemann calls the "homœopathic aggravation," or temporary increase of the symptoms soon after the medicine is taken, followed by relief. When this happens, it occurs speedily and lasts for a short time in acute disease; but in chronic disease it occurs later, and at intervals from time to time. The *Organon*, section 159, states that the smaller the dose the slighter and shorter is this aggravation; hence, if the dose be exactly proportionate to the strength of the disease, no aggravation will be manifest; if too large, the aggravation may be troublesome; but if too small, a repetition may be necessary. It is possible that the dose may be unnecessarily repeated without causing either the homœopathic aggravation or the production of new symptoms; the

vitality being able to overcome, without perceptible disturbance, such over-action; at the same time such error will probably delay the cure, the vitality being partially occupied in neutralising the excess of medicinal action, instead of being entirely directed to the removal of the disease.

(3) The pain in throat on coughing is verified by another case which I cured in 1872 with *phosph.*, cm. (Finckè); cough caused by tickling in throat, worse when lying on either side, especially on the left; cough hurts *os hyoides*, which is tender to touch and feels swelled.

CASE 5.—*Hæmatoxylon.*—July 9th, 1887. Miss E., aged 45, has nearly lost her voice from getting over-heated. It began with hot, sore patch in larynx yesterday afternoon. This morning, on waking, could scarcely breathe. Ever since she could remember has been subject to throat attacks from the least damp, and the slightest cold always attacks this part. These attacks last for a week badly, and continue less severely for two or three weeks more, her voice not returning fully till the end of this time. Has now soreness of throat on swallowing saliva. Feeling of a bar across centre of chest about level of clavicles; the bar feels heavy and hot, and is very burning on waking in morning; it feels like a solid square bar with sharp edges. Always has this feeling of a bar in these attacks; and later there is a feeling of fluttering of a feather there, causing constant, irritating cough, which does not relieve it; but this symptom has not yet had time to appear. Has to fetch her breath over the bar by an exertion. Both parents died of phthisis; her two sisters are very rheumatic.

Diagnosis of the Remedy.—The keynote in this case was the feeling of a bar across chest, which is found solely under *hæmatoxylon* (50); (Bar of iron around chest, *argent.-nitr.*), and the provings, though scanty, show a further similarity to the case (29, 30, 49). I gave the patient at once a dose of *hæmatoxylon* 200; and told her to dissolve a few pellets in water, and to take a spoonful of the solution every three hours till better.

July 14th.—Reports very much better. After the fourth dose the feeling of a bar was less; it felt less heavy and with less sharp an edge, and the smarting and soreness were more diffused over chest; voice has now returned. On the first

night after my prescription the upper part of throat felt inflamed and looked inflamed and glazy. The bar feeling had quite gone by evening of 10th ; at the same time cough become looser, and nose began to run, which it very seldom does in these attacks. The feather sensation hardly came on at all. Says the medicine has cut the attack short.

August 2nd.—Reports that she soon recovered ; has had one other cold, but it quickly ceased without medicine.

February 29th, 1888.—Has had no bad cold since till now, when there was excessive irritation in upper throat, worse evening and night ; feeling of great weakness in throat ; hoarseness ; a threatening of the bar sensation last night. Prescribed one dose of *hæmatoxylon* 5 m. (F.C.), prepared by Dr. Tyrrell, of Toronto, and it soon cured.

Comments.—(1) This case adds several new symptoms to the *Materia Medica*, and defines and enlarges others. The remedy deserves a thorough proving.

(2) The remedy caused the cough to become looser, and the nose to run. These are always indications of improvement. When in catarrh the symptoms leave the chest and go to the nose, the remedy should be allowed to act without repetition or interference ; to prescribe a new remedy for the nasal catarrh would be liable to throw the disease back upon the lungs.

(3) The lasting cure by this remedy of chronic catarrhal symptoms, with a history of phthisis, suggests that *hæmatoxylon* may be an antipsoric.

(*To be continued*).

ERRATUM.—Page 75 (*M.H.R.*), line 5, for *Iodium* read *Indium*.

BY DR. W. CLOWES PRITCHARD.

CASE 1.—*Turpentine Poisoning from a Liniment containing Turpentine.*—G. E., aged 50, slipped on pavement and "sprained" left knee. After accident, although knee painful, walked half a mile to station. Rested in evening. Next day (January 6th) walked three-quarters of a mile.

On January 8th procured the liniment from a chemist and rubbed it thoroughly into knee-joint, paying special attention to inner side of knee where pain was most acute.

January 19th.—Knee still painful. On advice of chemist had massage.

January 24th.—Patient noticed an irritable rash about the injured joint.

January 26th.—Rash more pronounced; most irritable. Struck knee-cap a violent blow against a sharp corner. Walked about during afternoon, but noticed knee getting very hot and inflamed, and towards evening swelling. Patient consulted me in the evening, when I prescribed *rhus. tox.* internally, and *liq. carb. detergens* (3i ad Oj) externally, and on following day put back splint on leg.

January 29th.—Again saw patient, and found knee-joint full of synovial fluid and very painful. Leg very much swollen and painful and covered with an intensely itching rash, serpiginous and scaly; skin markedly "goose flesh"; right leg similarly affected, but less severely. Ordered boracic fomentations and to take *rhus tox.* and *ars. alt.*

January 31st.—Both arms similarly affected.

February 4th.—Boracic ointment to affected parts. Œdema of right eyeball; *apis* 3c given.

February 5th.—Right eye almost closed from œdema; left eyelids very œdematous, œdema of both ears, lips, glottis, and scrotum, patient having difficulty in swallowing; irritation of skin gradually lessening, and rash and "goose flesh" disappearing; albumen (slight) in urine. For the first time I thought of "turpentine poisoning," and consequently put patient on phosphorus.

February 6th.—Very severe headache; œdema of all parts subsiding.

February 8th.—Eyes, lips, throat, scrotum, practically normal; effusion of knee almost gone; violent indigestion after midday.

February 10th.—Practically well.

Summary of Symptoms.—Curious irritable rash; "goose skin"; œdema of various parts; headache; choking sensation in throat; violent attack of indigestion.

CASE 2.—*Nux vomica in Sciatica.*—G. C., aged 55, consulted me *re* severe sciatica in right leg. Patient had had several severe attacks, one lasting fifteen weeks, compelling him to stay in bed and submit to hypodermic injections of

morphia most of that time. He did not believe in homœopathy, but came as a last resource.

Patient is a nervous, pale, spare man, enjoys fairly good health, and complains only of the sciatica and dull, heavy, stupefying headaches, with vertigo and dimness of vision. The sciatic pain is very severe and at times unbearable, extends from hip to knee, and is always on the right side. Prescribed *rhus tox.* and told patient to return in a week. This he did, but was no better. Prescribed *nux vom.* 3x, and patient to return in a week. This time patient reported that he was cured, and remarked that the effect of the medicine was magical. This took place two years ago, and patient has not had a bad attack since. He has had slight returns, but informs me that two or three doses of the medicine invariably removes the pain. The headache is always rapidly relieved by *phosph.* 3c.

I.—SELECTED CASES FROM THE PRACTICE AT THE LONDON HOMŒOPATHIC HOSPITAL.

By J. ROBERSON DAY, M.D.

Tonsils and Adenoids.—Reginald B., aged 6½, was brought for treatment in September, 1906. The school doctor had advised his parents to have adenoids removed. The patient was a fair-haired boy, presenting the usual appearance of mouth breathing and defective speech; deafness, which was always worse in damp weather and whenever he caught cold; he had also enlarged tonsils. He was put on a course of *tuberculinum* 30, in weekly doses, and *baryta carb.* 12 was given twice daily. He began to improve at once; has got through the winter very well. After a time the *iodide* was substituted for the *carbonate of baryta* in the same dilution. The school doctor during his treatment again offered his advice, on this occasion that his tonsils should be removed! Neither of these operations were done, and on February 8th, 1907, he was hearing well, and quite a different boy.

Varicella and its Vagaries.—To-day, February 11th, a mother brought her child, aged 4, Ruby M., and gave a remarkable family history. When *three days old* she had a

severe attack of varicella, and still shows many deep scars as evidence of the disease. The three other children had chicken-pox at the same time, and the family living next door were similarly attacked. Now, the incubation period may be as long as twenty days, although the average time is fourteen days. The point of interest is, was this three-days-old child infected before birth, or at birth ? If the latter, the incubation period was reduced to three days.

I can recall a boy who had two severe attacks of chicken-pox in one year. Another boy gave the disease to his mother, who had it severely—this was a second attack. This is only further evidence which shows the vagaries the acute specifics are liable to.

Hæmaturia and Chronic Nephritis.—Edgar C., aged 13, was sent to me on October 8th, 1906, passing dark hæmorrhagic urine for the past four days, with frequent micturition. The urine was loaded with albumen, gave a brilliant reaction to the guaiacum test, and under the microscope showed abundant casts (epithelial, granular, and with blood cells) of all sizes. It appeared that for some months past he had been troubled with frequent incontinence of urine at night, but his mother had sought no treatment for this. He was admitted and treated with *terebinth.* 3, every four hours, and on October 26th, *canth.* 6, thrice daily, with absolute rest in bed and appropriate diet. He steadily improved, the blood disappeared, and the albumen lessened. The incontinence was reduced to once a week or so. He had occasional headaches and vomiting. On November 23rd the medicine was changed to *plumb.* c. 30. On December 31st he was decidedly better, the urine only showing a trace of albumen by the nitric acid test, which is the most delicate of all. On February 1st, 1907, the notes say he went five weeks without any enuresis, then he ceased to take his medicine, and twice in ten days had incontinence of urine. His mother reported to me to-day, February 11th, that the incontinence is quite cured, although when I last tested the urine there was still a trace of albumen. He is now working in a motor factory.

Opium in Headaches.—Harold H., aged 6½, came on November 9th, 1906, suffering from headaches ; worse in the morning. He had been ill for months ; was wasting ; very heavy and dull ; would sleep for days ; bowels were confined.

This boy was a typical opium subject, with a dark skin like a Chinaman; thin, with a morning cough, and perspiring. His nights were disturbed by dreams. *Opium* 12, thrice daily, was prescribed. On November 22nd he was better in every way. On December 18th he was again very much better, only had one headache since attending. His mother stated he had derived more benefit from attending the hospital than anywhere else, and he had seen many doctors previously.

On February 1st he appeared quite well and like himself, with bowels acting regularly, sleeping naturally without dreams. Everyone remarked on his improved colour. The only remedy given was *opium* 12, which was now continued once daily.

Dorothy J., aged $3\frac{1}{2}$, was brought to the children's clinic with great deformity of the left femur. She had evidently suffered severely from rickets and still showed evidences of the disease.

The mother gave a remarkable history :—She fractured the right femur at $1\frac{1}{3}$ years, the left femur at 2 years, the right femur at $2\frac{1}{2}$ years (a second time), the left femur at $2\frac{3}{4}$ years (a second time). She was admitted for X-ray examination.

Hospital News in Brief.—Satisfactory reports as to the financial state of the hospital are to hand. Many economies have been effected, patients have been invited to subscribe where possible towards appliances, &c., and in other ways the dispensary account has been reduced.

It is quite expected that before long the new wing will be commenced. The site is already the freehold property of the hospital, but the houses now standing must be pulled down, and new hospital buildings are very costly to erect at the present time.

The nursing department has seen changes of late. Since Miss Brew's resignation many alterations have been made.

The Nursing Committee are now engaged in a consideration of how best to fill the present vacancies with satisfaction and permanence. No effort will be spared to place the London Homœopathic Hospital in the very front rank of training institutions.

II.—RECURRENCE OF MALARIAL SYMPTOMS AFTER FIFTEEN YEARS' QUIESCENCE.

FROM THE CLINIC OF DR. BURFORD.

REPORTED BY E. CRONIN-LOWE, M.B.LOND.

C. H., a married woman, aged 36, was admitted into the Ebury Ward of the London Homœopathic Hospital on January 26th, 1907. She underwent an operation, ether being used as the anæsthetic. During her convalescence, there occurred quite a marked recurrence of previous malarial symptoms.

The following are notes of the case :—

Fifteen years ago, when seven months pregnant, she became suddenly ill, with high fever, lasting over three weeks, and which during that time showed a daily periodicity of considerable regularity. There was first a well-marked "cold stage" with shivering, this giving place to a "hot stage," and this again followed by profuse sweating.

She had never been in a malarious district, had never been out of England, and this illness occurred at Redhill. Her husband, however, had been in Africa previously, and had suffered from malaria, and it was thought at the time that she had been infected by him. (I doubt that we can accept such theory.) She was treated allopathically with quinine, but remained very weak and anæmic for some three months after this. Her child was born a week after the illness ceased, and has always been well and strong.

On the third day after her operation in hospital on January 28th, 1907, she complained of not feeling so well. But it was not until the eighth day that she told fully of her previous illness, and then she was having recurrent febrile attacks. These were quite mild, the periodicity was marked, the cold, hot, and sweating stages easily discerned, the whole cycle lasting on the average about three hours, but recurring somewhat irregularly—sometimes in daytime, sometimes at night. The temperature during this time never exceeded 100°. Blood films were prepared during the hot stages and examined by Leishmann's methods, and while showing no actual leucocytosis, yet there was an increase of mononuclear leucocytes to 15 per cent., and of eosinophiles to 4 per cent. This,

according to Sir Patrick Manson, is frequently present in post-malarial states, and is diagnostic. No plasmodium bodies were discovered—nor was the spleen enlarged.

Natrum mur. 30, was the remedy prescribed, and after its administration the condition slowly subsided, and in five days entirely disappeared.

This is the only recurrence of the malarial taint that this patient has experienced since her initial illness fifteen years ago.

This case serves as a very interesting example of the deeply acting influence of those more serious diseases which, although apparently eradicated by the medicinal treatment used at the time of infection, and during the period of their manifestation, yet remain latent and reappear on some such occasion as this, when the natural defence being embarrassed, the imprisoned enemy gains the opportunity it awaits.

Simple though this case is, it nevertheless opens a wide field of reflection. For why should a disease, after so many years, suddenly manifest itself without any sign of fresh infection? for such possibility was disproved both clinically and microscopically.

No doubt, during the primary illness, a certain amount of immunity was established against the malarial invasion, and this seems to have been perpetuated as an active suppression of the disease, not an eradication. Probably "opsonins" of some variety were responsible for this custody. Then some intercurrent disorder, in this case the surgical shock of an operation and anæsthesia, taxing the patient's defence, these old-established "legions" were recalled to reinforce against the new invasion, and so released their prisoner. For only in such a way can be explained the interruption of this long-established latency of so virulent a disease.

Attempt has recently been made to prove that each specfic disease has a set of special opsonins. Our case would tend to contradict such an idea. For why, if so, should the malarial custodians be requisitioned, when there should be idle armies awaiting the new attack?

Hospital Reports.

*** The Editors request that all correspondents will kindly condense their reports as much as possible, consistent with a smooth and effective rendering of the facts they wish to convey. Items of *merely local* interest should be omitted.

As there seems to be some misunderstanding in regard to this section, we would point out that there are two kinds of matter wanted for it—

(1) News, reports of meetings, &c., which must be compressed into one, or at the most two, paragraphs of not more than ten or twelve printed lines.

(2) Reports of interesting cases occurring in Hospital or Dispensary practice, new methods of treatment, and all purely professional matters. These should be carefully, or, if needful, elaborately recorded and described. Each contributor will be allowed two pages of the REVIEW every month for this purpose.

Newspaper reports, unabridged, need not be sent. Such reports must be compressed and will come under (1) above, otherwise all such newspaper and unabridged reports will be laid gently, but firmly, to rest in the waste paper basket.—EDITORS, *B.H.R.*

TUNBRIDGE WELLS.

THIS first report for the REVIEW of homœopathic doings here must be brief, as the work, owing to various causes, has of late been specially pressing. One reason for this is the epidemic of influenza which has prevailed from December onwards. Here, as in most places, it has been neither so extensive nor severe as some of its predecessors, but in these respects it will rank only below those of 1890, '91 '92. The disease has not been serious except in the feeble, from age and disease, and where it has been neglected, when it has shown its old virulence. The remedies which have been required and have proved efficacious as of yore, are *aconite, gelsemium, arsen. iod., bryonia, phosphorus,* and occasionally *antim. tart.*; one or more of these, selected according to the indications, have met practically all the cases. *Alcohol* the writer has never used in influenza, and he is glad to recognise that enlightened medical opinion is now with him, and we may now feel assured that as the youthful essayist said of pins, it has "saved thousands of lives" "by not swallering of it!" If a stimulant should be needed small doses of *strychnine* answer admirably.

Another reason for the pressure in our work is that we are a man short, Miss Neild, M.B.Lond., being in Boston, U.S.A., where she has gone as a British Homœopathic Association scholar. As this Journal is now published under the same

auspices, its readers may be interested in knowing what she is doing. She writes under date of January 27th : "I had a very satisfactory interview with Dr. Sutherland (Dean of the Medical Faculty) on Friday. I am to take six hours a week materia medica, three hours theory and practice of medicine, two hours diseases of children, and two hours diseases of women, besides clinics at the hospital and dispensary. In the afternoon I went to Dr. Turner's lecture on 'Remedies in Typhoid' : very interesting. Yesterday I had a materia medica lecture at nine o'clock, and in the afternoon went with two of the senior students to the Emerson Hospital and saw some operations. Dr. Emerson operated so well, teaching and demonstrating every step at the same time, and I thoroughly enjoyed it."—F. N.

BRISTOL AND CLIFTON.

THE principal homœopathic institution in Bristol is the Hahnemann Hospital and Homœopathic Dispensary in Brunswick Square, Bristol, which owes its existence mainly to the judgment and foresight of Dr. S. Morgan, who secured the premises twenty-four years ago. There are six beds and two cots in the public wards, and two private wards. Sales of work in 1906 brought in £440, by the aid of which considerable improvements have been effected in the equipment and accommodation.

Another institution is the branch Homœopathic Dispensary at 71, Queen's Road, Clifton ; and the Müller's Orphan Houses have as their attending physician Dr. C. Osmond Bodman, who succeeded in that post Dr. Eubulus Williams.

CASE OF EMPYEMA OF FRONTAL SINUS. RECOVERY UNDER SILICA 30.

REPORTED BY DR. J. HERVEY BODMAN.

E. F., aged 43, housewife, first came under treatment as an out-patient at the Bristol Homœopathic Dispensary on December 16th, 1901.

Her chief complaint was that for two years she had suffered from constant pain over the right eyebrow, and creamy discharge from the right nostril. The pain was worse mornings. There was soreness of the right half of the head, and great sensitiveness to cold. The pain seemed to have made the

sight of the right eye weak of late. The nose was much stopped up, especially the right nostril.

For a considerable part of the time she had been suffering in the above way, she had been attending as an out-patient at the Bristol General Hospital, in the special department for diseases of the nose and throat. Eighteen months before she first came under our observation, the right maxillary antrum had been opened, and for nine months she syringed it regularly; but since then she had allowed the opening to close. There had been no pain over the jaw recently. What led to her coming to the Homœopathic Dispensary was, her being told at the General Hospital that there was an abscess of the frontal sinus, and that it would be necessary to open the bone and drain it; a friend hearing of this advised her to give homœopathy a trial.

The prescription she received on December 16th was silica 30, t.d.s.

The notes of the subsequent course of the case are as follows:—

December 23rd.—The last few days she has been much more free from pain than for months. Rep.

December 30th.—Much less pain; less discharge. Sight of right eye much better again. Rep.

January 6th, 1902.—Less discharge. No pain except when exposed to cold wind. Rep.

January 13th.—No pain; discharge much less. Rep.

January 20th.—No pain; discharge more clear and less yellow. Rep.

January 27th.—Discharge quite clear; no pain. Rep.

February 10th.—No pain or discharge. Rep. b.d.

March 3rd.—Head quite well.

April 7th.—No pain or discharge.

Remarks.—The above case exhibits the action of the homœopathically-chosen remedy particularly well, because in the first place the pathological condition was well defined, and the diagnosis vouched for on excellent authority. Secondly, the long duration of the symptoms, and their constancy during that long period, excludes the possibility that the marked relief which immediately followed the administration of the remedy was merely a coincidence—that it was only a case of *post hoc*

and not *propter hoc*. Lastly, the fact that only one remedy was used and no accessory treatment was employed, places the whole of the credit to the account of the one remedy.

In order to show that this is not an isolated case, it is intended on a future occasion to give details of other cases of a similar nature.—J. H. B.

LEICESTER HOMŒOPATHIC DISPENSARY AND COTTAGE HOSPITAL.

THE annual report of this Institution has just been issued. The Cottage Hospital contains six beds and has admitted fifty-one patients during the past year. Three abdominal sections took place, an ovariotomy, an exploratory operation for gall-stones, and an operation for appendicitis. The Hospital is made, as far as possible, self-supporting, and a sum of £162 7s. was received from patients during last year. There is, however, a deficit of £64 in spite of rigid economy. At the annual meeting, held at the Town Hall, Leicester, under the presidency of the Mayor, Sir Edward Wood, J.P., Mr. Thorneloe, besides his ordinary subscription, gave a donation of £5 towards the debt.—E. C.

THE HAHNEMANN CONVALESCENT HOME, BOURNEMOUTH.

THE annual meeting of this Institution, with its two homœopathic dispensaries, was held at the Home on February 6th. There was a good attendance of the friends and supporters of homœopathy, including the Dowager Countess Cairns. Mr. S. Sanders Stephens, J.P., a retired medical man, who formerly practised as a homœopath at Cannes, took the chair, and was supported by Dr. Nankivell, Chairman of Committee; Mr. A. Peach, Treasurer; Dr. Hardy, Visiting Physician; Dr. Ord, Visiting Physician and Physician to the Dispensaries; Dr. B. W. Nankivell, Surgeon to the Home and Physician to the Dispensaries, and others.

The report disclosed that during the past year a legacy of £500 had been left to the Home from the estate of the late Mr. James Gibberd, of Bournemouth; £80 had been promised by a friend to the endowment fund, and an anonymous donor, who for several years has given £50 per annum towards the

maintenance of a night nurse, again renewed the gift. The Home requires an income of £1,700, and there is unfortunately an annual deficit of about £200. A Household Linen Association, maintained by Bournemouth ladies, contributed during the year useful articles to the value of £49.

During the year 183 in-patients had been received, most of whom came from London and Hampshire, and the great majority were phthisical. As there are only thirty-three beds, this involved considerable pressure and some delayed admission during the winter months.

The out-patient work is carried on at two dispensaries, one at the Home on West Cliff, where there were 544 patients and 1,694 attendances, and the other at the eastern end of the town in Holdenhurst Road, at which there were 452 patients and 1,393 attendances, while the Visiting Surgeon visited 257 persons with 1,107 visits during the year.

Of the 184 phthisical in-patients treated, 114 left much improved, and others improved to a less degree; only four derived no benefit at all, and for the second year in succession no death occurred in the Home.

HOMŒOPATHY IN BIRMINGHAM.

DR. FEARON introduced homœopathy into Birmingham in 1845, and two years later the first public dispensary was opened, and was at once very successful, the receipts from paying patients reaching a total of £325. In 1859 a hospital was added to the dispensary, and twenty-three in-patients were received, the out-patient attendances then reaching 17,138. In 1863 the out-patient department was enlarged, but this proved inadequate, and an application to Queen's Hospital for accommodation having been refused, a removal was effected in 1875 to the present site in Easy Row. Work was carried on in this building till 1901, when the old portion was pulled down, rebuilt and enlarged, with the result that there are now fifty beds, an up-to-date operating theatre, a nurses' home, and every modern requirement.

Since 1885 the number of out-patient attendances has remained stationary, and so have also the total receipts. The subscriptions have fallen off, but the receipts from paying patients have increased. This want of progress of late years

is attributable to the diminished number of medical men in Birmingham practising homœopathy, there being only four now against seven twenty years ago.—A. A.

HOMŒOPATHY IN PLYMOUTH.

DR. FOX seems to have been the first to practise homœopathy in Plymouth, and after him came in succession Drs. Morgan, Christopher Wolston, Joseph Blake, Neild, Cash Reed, and Alexander, down to the three representatives at the present day, Dr. Midgley Cash, Dr. Newbery, and Dr. Wilmot. The dispensary had its origin at the shop of Mr. F. H. Foster, homœopathic chemist, in 1858; but in the early seventies, on account of increased work, it was removed to 6, Princes Street, and in 1884 the Devon and Cornwall Homœopathic Dispensary and Cottage Hospital was opened in Flora Place, Union Street. This, however, soon proved inadequate, and in 1893 the Earl of Morley opened the new hospital in Lockyer Street, under the title of "The Devon and Cornwall Homœopathic Hospital and Three Towns Dispensary." Here the head-quarters of homœopathy in Plymouth still remain, but there is no intention of standing still; efforts are being made for enlargement, adjoining premises have already been purchased, and as soon as the necessary funds are provided the number of beds will be increased, and the general accommodation of the Hospital improved.—W. H. N.

PROPOSED HOMŒOPATHIC COTTAGE HOSPITAL FOR SOUTHPORT.

A WELL-ATTENDED meeting of the residents of Southport was held recently at the Town Hall, Southport, to consider the desirability of establishing a homœopathic hospital as an expansion of the very successful homœopathic dispensary. His Worship the Mayor of Southport, F. W. Dixon, Esq., presided, and was supported by Dr. Simpson, Dr. Cash Reed, Dr. and Miss Blumberg, Dr. Abbott, Dr. Hughes, Mr. and Mrs. von Stralendorff, Mr. and Mrs. A. S. Thew, Rev. J. Ashby, Rev. H. Harris, Mr. C. F. Jesper, M.P.S., and Mrs. Jesper, Mr. H. Capper (Thompson and Capper), &c., &c. Numerous letters of regret at inability to attend were received.

NECESSITY FOR A COTTAGE HOSPITAL.

Mrs. von Stralendorff moved: "That this meeting approve of the establishment of a cottage hospital, to be conducted on homœopathic principles, in accordance with such rules and regulations as shall be approved of by the British Homœopathic Association." Dr. Simpson seconded this resolution, which was supported by the Rev. J. Ashby, put to the meeting by the Mayor, and carried.

COMMITTEE APPOINTED.

Mr. A. S. Thew proposed the following resolution: "That this meeting pledges itself to assist in every way possible the furtherance of the scheme which forms the subject of the first resolution moved and duly seconded, and for this purpose invites the following ladies and gentlemen to allow themselves to be appointed a general committee, with power to add to their number:—Dr. Simpson, J.P., Mrs. Wm. Thornton, Mrs. Lockhart, Miss Atkinson, and Mrs. von Stralendorff, with Miss Boyd, Rev. S. Sinker, Rev. Dr. Brook, Rev. Joseph Ashby, and Mr. von Stralendorff. This was seconded by Mr. Lockhart, and carried.

PRACTICAL SYMPATHY.

Mrs. von Stralendorff moved the following resolution: "That this meeting wishes to express its thanks to the British Homœopathic Association for their offer to send down a deputation to assist in the proceedings of the evening, and regrets that it should not have been possible to arrange the meeting for a convenient day." In doing so she announced the donations and promises which had been made to them for the proposed cottage hospital: Dr. Simpson, £900; A Friend of the Cause £120, for current expenses for three years; legacy from Miss Jackson, £90; Mr. and Mrs. von Stralendorff, £50; Mrs. Kissel, £25; Mrs. Jesse Howarth, £25; Mrs. Benecke, £10; Miss Kissel, £10; Miss von Stralendorff, £5; Mr. J. P. Stilwell, £2 2s.; Mr. Henry Zeigler, £2 2s.; Miss Amy Benecke, £1 1s.; Mrs. Scott, £1 1s.; Mr. J. McLean, £5; Mrs. Kissel, £5 (subscription); Miss Kissel, £2 (subscription). Mr. John Cockshott, London, has promised an annual subscription of £16 for five years. Besides these definite gifts the British Homœopathic Association will contribute a substantial donation no doubt, and I myself ask

to be allowed to furnish a private ward. These are our foundations. May the public build upon them.

Dr. Cash Reed seconded, and stated that the total number of patients treated last year at the dispensaries at Hope Street and Roscommon Street, Liverpool, was 91,160.

Dr. Blumberg, in proposing a vote of thanks to the Mayor for presiding and lending the parlour, said that homœopathy was a certain view of therapeutics which he thought had in the course of the last hundred years quite vindicated itself.

Dr. Hughes seconded, and the motion having been carried, the Mayor responded briefly and the meeting terminated.

CROYDON HOMŒOPATHIC DISPENSARY.

THE annual meeting of the Croydon Homœopathic Dispensary was held at the Art Gallery, Croydon, on Friday, February 15th, at eight o'clock. His Worship the Mayor, H. Keatley Moore, Esq., presided. There was an excellent attendance of subscribers and friends of the Dispensary.

The annual report of the medical officers, Drs. Purdom and Munster, was read, showing that an increase in dispensary work had been attained each year since 1903, the total attendances at dispensary in this latter year being over 4,000, and those in 1906 being over 5,000.

There is, in addition to the medical department of the Dispensary, a flourishing dental department under the supervision of C. J. Hinchliff, Esq., L.D.S.

The year 1906 further showed that 692 home visits had been paid by the medical officers, and that these home visits entailed in two instances the administration of anæsthetics for operation.

The balance sheet indicates a balance of £34 5s. 7d.

The reception of the detailed report was proposed by the Mayor, seconded by Mr. Stewart, and carried with acclamation by the meeting.

Dr. Charles Wheeler, of London, next read a paper upon "Tuberculosis and the Homœopathic Character of its Tuberculin Treatment," with a special reference to opsonins. Dr. Wheeler's paper was lucid, carefully worked out, and listened to with the greatest interest. His comparison of the tubercle bacilli, phagocytes and opsonins, to a descent on our coast by

pirates, their partial repulsion by local levies, their further aid by imperial forces, was received with marked appreciation, the Mayor remarking that however ignorant they had been before about opsonins, now they felt they had the truth of the matter with them.

Dr. Burford next gave a short account of a recent visit to American homœopathic institutions, illustrating his remarks by a series of photographs of the more important homœopathic hospitals in New York, Philadelphia and Boston. The picture of the largest homœopathic hospital of the world, that on Blackwell's Island, in New York, excited special attention.

The customary votes of thanks concluded the meeting, which was throughout of an enthusiastic character.

We heartily congratulate our friends, Dr. Purdom and Dr. Munster, on the excellent public work they are doing in Croydon, and on the marked appreciation of their services to the Dispensary shown at the annual meeting.

Correspondence.

[See *British Medical Journal*, February 2nd, 1907.]

AN OPEN LETTER.

To SIR SAMUEL WILKS, M.D., F.R.C.P.

SIR,—Although I am a member of the British Medical Association of twenty-two years' standing, I know from past experience that this letter would not be published in the Journal, therefore I address it direct to yourself.

Perhaps of your courtesy, through your influence, the Editor *might* consent to print it.

In reply to your numerous rather belated objections to homœopathy, allow me to ask if you know of any medical theory, except *similia similibus*, which has survived the criticism of 100 years, although, to be strictly accurate, homœopathy was scarcely known in this country till sixty years ago.

You say "errors live as long as truths." What medical error has survived so long?

You say "*similia similibus* has not, *in my knowledge*, been recognised by a single medical school in the civilised world." Your knowledge is evidently very faulty. Do you admit that the United States of America is civilised? If so, let me inform

you that there are in that progressive country eighteen (18) homœopathic medical colleges and over 16,000 medical men who practise homœopathically.

You very wisely enumerate the essentials of a good medical education as given by the regular colleges in this country. Allow me to inform you—you seem to ignore the fact—that there is no physician acknowledging homœopathy in this country who has not passed the curriculum of one or other of those colleges which meet with your approbation.

You do not think homœopathy has taken a strong hold of the lower orders. You would put it down to their superstitious ignorance if they did.

You disapprove of Disraeli's judgment as if he were the only famous gentleman who had favourably considered the subject. How about Archbishop Whateley's judgment? He was a master of logic, you may remember. John Bright also was by many considered tolerably sane.

Earl Cawdor was considered fit to direct the Admiralty by the late Government, as well as to supervise the working of the Great Western Railway. He is also Chairman of the British Homœopathic Association.

But this is very tedious talk. Your supposition about the working of the minds of the medical men you meet may be correct; it is not complimentary to your *confrères*, dear Sir, but the minds of homœopathic physicians do not work that way.

So long as medical men do prescribe medicine—you scarcely suggest that drugs should be discarded altogether—we ask that they be prescribed scientifically, not in the haphazard fashion which evidently has your approval.

Why do you continue to fling disparagement at a body of men honourably engaged in extending the boundaries of science for the good of humanity—men equally as well educated as their neighbours, and quite as well aware as yourself that drug-giving is only one of the functions of a physician—not quite so minor a function, however, as is generally considered by the majority who have given this subject as little study as you evidently have yourself?

Ramsgate. W. M. STORAR.

[Sir Samuel Wilks has written a very courteous letter to

Dr. Storar, in which he states some of his objections to homœopathy. As these, however, seem to be examples of that contradiction in terms known as "intuitive judgments," they are of no scientific value.—SENIOR EDITOR, *B.H.R.*]

Dr. Searson sends us the following :—

DEAR DR. SEARSON,—I received your pleasant letter after your return home, and was glad to know of your safe journey, and that you had a pleasant time, in spite of the regrettable drawbacks at Atlantic City.

In reading over the advance sheets of our proceedings, and in one of the British journals, I notice an omission which I much regret, and which I have had corrected—viz., that your name does not appear in the list of corresponding members of the Institute. As I made these nominations myself I know you were included, and your name will appear as it should. I hope you did not notice this oversight, or if you did, this tardy notice will set the matter right. You will doubtless receive your volume of Transactions in due course.

With my kind regards, and hoping you will favour us with a longer stay next time,

Believe me, faithfully yours,

Fifth and Wilkins Avenue, (Signed) J. H. MCCLELLAND.
Pittsburgh, Penn.,
January 12th, 1907.

DEAR DR. MCCLELLAND,—I am indebted to you for your graceful letter, and I appreciate the feeling which prompted it. My attention had been called to the fact that my name did not appear with those of the other British delegates who were appointed corresponding members of the Institute, and I had learned from you that I had been so appointed and also elected Vice-President of the Congress. As one of the duly appointed delegates of the British Homœopathic Society, I now welcome the correction with pleasure, and thank you for it, and the kind letter with which it is accompanied.

Believe me, with kind regards,

64, Seymour Street, Yours faithfully,
Portman Square, W., (Signed) J. SEARSON.
January 29th, 1907.

Obituary.

THE LATE DR. H. GOULLON, OF WEIMAR.

FOR the following interesting details of the life of this indefatigable disciple of Hahnemann (whose death was recorded in our last issue), we are indebted to the *Leipziger Populäre Zeitschrift.*

Born near Ulm, in June, 1836, Goullon took his doctor's degree at Jena in 1859, and in the same year passed the *Staat's Examen* at Weimar. He was then appointed Assistant Physician to the Hospital for the Insane in Jena, acquiring there a rich psychiatric experience. This was followed up by a visit to Paris, where he paid special attention to the same class of cases, attending also courses by Ricord, Chassaignac, and Desmares. In 1862 we find him in Russia; then in Rudolstadt, and finally, in 1865, in Weimar, where he continued to practise until his death.

Goullon's earliest work for homœopathy began in the winter of 1864-1865. From this date he collaborated successively in the *Allgemeine Zeitschrift f. Pharmazie, und Toxikologie;* in the *Allgemeine Homöopathische Zeitung;* in the *Neuer Zeitschrift f. Homöop. Klinik,* of Hirschel, and, since 1870, in the *Populäre Zeitschrift.* He also wrote in 1870 in the *Internationale Homöop. Presse,* and, when this disappeared, in the *Homöop. Rundschau.* In fact, there was hardly a single (German) homœopathic periodical to which he did not give useful help; useful by reason of his great talent for seeing the interesting side of every question, and by the extent of his erudition, which was based upon a profound knowledge of the *Materia Medica.*

Besides periodical publications, Goullon brought out the following independent works: *Précis of Mental Diseases* (1867); *Scrofulous Diseases and their Treatment* (of which the second edition appeared in 1897); *On the Poison of the Honey-bee* (1880). He also edited the eleventh edition of *Caspari's Domestic Manual* in 1873. In 1872 he carried off the prize instituted by the *Central Verein* by his work on *Saccharine Diabetes;* again, in the same year, by his study of *Graphites;* and on a third occasion, in 1877, by his *Thuja.* His last work was the editing of the third edition of his father's book on the

Diseases of Infancy, and of the seventeenth edition of Hirschel's *Arzneischatz*. This literary activity spread Goullon's fame far beyond Weimar and its immediate neighbourhood; and his long and steady collaboration in the *Populäre Zeitschrift* found him clients (by correspondence) even in Africa and Asia. Entirely destitute of personal pretensions, Goullon devoted his whole existence to the service of his patients up to the last moment of his life. His name will remain inscribed in indelible characters in the history of homœopathy.

J. G. B.

Notices, Reports, &c.

THE Earl Cawdor, the Treasurer of the London Homœopathic Hospital, Great Ormond Street, W.C., has received a cheque for £400, being part of a legacy for charitable institutions, left by the late Mr. Alfred Beit for distribution by the Executors in their absolute discretion.

BRITISH HOMŒOPATHIC ASSOCIATION, WINTER COURSE OF LECTURES.—Dr. Stonham and Dr. George Burford have each completed their series of Lectures in this Course.

Dr. Roberson Day will Lecture on the "Treatment of Some of the Diseases of Children," on March 5th, 8th, 12th, and 15th.

Dr. MacNish will Lecture on "Certain Diseases of the Stomach," on March 19th, 22nd, 26th, and 28th.

These Lectures will be delivered at Regent House, and will each commence at 9 o'clock.

Our colleagues are invited to call the attention of any professional men likely to be interested in the foregoing subjects to these series of Lectures. The wealth of good matter contained in these hour-long discourses will repay the attendance of medical practitioners.

Dr. J. Murray Moore, of Leamington, has opened Consulting Rooms at 4, Church Street, Warwick, where he attends on Wednesdays, from 4 to 5 p.m.

NOTICE TO CORRESPONDENTS.

*** *We cannot undertake to return rejected manuscripts.*

AUTHORS and CONTRIBUTORS receiving proofs are requested to correct and return the same as early as possible to Dr. MCLACHLAN, 3, Keble Road, Oxford.

The Editors of Journals which exchange with us are requested to send their exchanges to Messrs. BALE, SONS, AND DANIELSSON, LTD., 83-91, Great Titchfield Street, Oxford Street, London, W.

Communications from Dr. TESSIER, Paris, and Dr. WOUTERS, Arnhem, will be published in our next issue.

LONDON HOMŒOPATHIC HOSPITAL, GREAT ORMOND STREET, BLOOMSBURY.—Hours of attendance: MEDICAL (In-patients, 9.30 a.m.; Out-patients, 2 p.m. daily); SURGICAL, Out-patients, Mondays, 2 p.m., and Saturdays, 9 a.m.; Thursdays and Fridays, 10 a.m.; Diseases of Women, Out-patients, Tuesdays, Wednesdays, and Fridays, 2 p.m.; Diseases of Skin, Thursdays, 2 p.m.; Diseases of the Eye, Mondays and Thursdays, 2 p.m.; Diseases of the Throat and Ear, Wednesdays, 2 p.m., Saturdays, 9 a.m.; Diseases of Children, Mondays and Thursdays, 9 a.m.; Diseases of the Nervous System, Thursdays, 2 p.m.; Operations, Tuesdays and Fridays, 2.30 p.m.; Electrical Cases, Wednesdays, 9 a.m.

Contributors of papers who wish to have reprints are requested to communicate with the Publishers, Messrs. BALE, SONS, AND DANIELSSON, LTD., who will make the necessary arrangements. Should the Publishers receive no such request by the date of the publication of the REVIEW, the type will be broken up.

All books for Review should be sent to the Publishers.

Papers and Dispensary Reports should be sent to Dr. MCLACHLAN, 3, Keble Road, Oxford.

Advertisement and Business Communications to be sent direct to the Publishers.

Communications have been received from Dr. BERRIDGE (London), Dr. GHOSE (Calcutta), Dr. SEARSON, Dr. STORAR, DAVID CHRISTIE MURRAY (*Referee* Office), Dr. A. SPIERS ALEXANDER, Dr. AVENT (Birmingham), Dr. GALLEY BLACKLEY (London), Dr. J. H. BODMAN (Clifton), Dr. GEORGE BURFORD (London), Dr. DYCE BROWN (London), Dr. CAPPER (Leicester), Dr. A. C. CLIFTON (Northampton), Dr. ROBERSON DAY (London), Dr. MURRAY MOORE (Leamington Spa), Dr. NEILD (Tunbridge Wells), Dr. NEWBERY (Plymouth), Dr. W. CLOWES PRITCHARD (St. Leonards), Dr. H. WYNNE THOMAS (Bromley), Dr. J. T. WOUTERS (Arnhem), Dr. PAUL TESSIER (Paris).

BOOKS AND PERIODICALS RECEIVED.

Indian Homœopathic Review, November. *Homœopathic Recorder*, January. *North American Journal of Homœopathy*, January. *The American Physician*, January.

THE BRITISH
HOMŒOPATHIC REVIEW.

APRIL, 1907.

APPRECIATION: BY THE EDITORS.

It is with much pleasure the Editors record their cordial appreciation of the evidences of goodwill and encouragement, brought to their notice concerning last month's issue of the Review. They have commenced their Editorial work in the spirit and with the intention of continuously improving their Journal, and ever bringing it more and more into line with the requirements and desires of the subscribers. "*Ohne Hast, ohne Rast*" is their working rule, and it is their wish and intention that each issue of the Review shall as far as possible mark some advance on those which have preceded.

With this inspiring spirit the Editors are sure that they may anticipate that success which waits on well-doing. For this a conjunction of forces is necessary; and the Review can only be kept up to its desirably high standard by each member of the constituency taking some share in the contributions which annually constitute the Review. An enormous amount of excellent, ofttimes brilliant, homœopathic work is done in this country which finds no useful record in the professional Press. Born to blush unseen, much of its usefulness as incitement and help to colleagues is lost, who in similar circumstances would gladly turn to account the record of experience. Homœopathy suffers a tremendous loss in this country in that the daily routine of successful homœopathic work in the hands of the general practitioner finds but very little expression and therefore is assumed as non-existent. Whose practice is not

charged with cases such as the following? A young lady, suffering from chronic otorrhœa for many years, had found prolonged treatment on ordinary lines and including repeated and re-repeated operations, of no avail for cure. She and her friends alike despaired of losing what seemed to be a permanent disability. Coming under the care of a homœopathic general practitioner, she was put upon *silica* in dilution. In three months the hitherto inveterate discharge had ceased, and the patient was as far as possible well. *One such case, sent up by each of our subscribers only once annually, would mark a new era in the influence of homœopathy on the profession:* would, in fact, from the sheer weight of accumulation, compel a serious attempt at verification.

It is in this great work we confidently enlist the co-operation of each homœopathic physician in this country. What we have written of homœopathic private practice applies with equal force to homœopathic hospital work. We have already arranged for these pages to contain an epitome of the work our Provincial and Urban Hospitals are doing, and our readers will thus judge of the enormous value of these institutions to the communities they serve.

Before concluding, the Editors would record their conviction of the wisdom and the public spirit of the Association in making this REVIEW a perfectly free Journal, as unfettered and as unrestricted an exponent of opinion as in the past. While the Association is responsible for the financial support of the REVIEW, no limit, except that of space, is placed on the freest expression of view or conviction as regards matters homœopathic. It cannot be too clearly understood that the arena thus offered is free and open to all alike, without fear and without favour; and that the Editors are charged to have only one object in view—the enhancement of British professional homœopathy. In the conduct of their duties they will carry out this high behest for the protection of the minority as well as the airing of the ideas of the majority; and they open and will continue their Editorial career in the spirit of the motto of one of His Majesty's ships of war, "*Ut veniant omnes.*" For themselves, they have the great tradition of the Freedom of the Press to maintain; and this they are empowered to do by virtue of the office they have the honour to hold.

Editorial Notes and News.

Why Quinine should not be used in Influenza.

WE believe that we know at least one reason why. In the Harben Lectures for 1906, Elie Metschnikoff discusses the question of "phagocytosis," and some of the agents that impair or increase the phagocytic action of the white blood cells. Now tincture of opium, alcohol, and *quinine*, as well as a "number of other substances regularly employed in medicine," *weaken* phagocytic action, so that the bacilli are permitted to multiply without being checked by a sufficiently strong phagocytic reaction. In other words, all these agents have a harmful action on the white blood cells (phagocytes) the agents of natural defence against infective microbes.

* * * *

THERE can be little doubt, we think, that the influenza bacillus finds its way into the blood and there lives and multiplies for a certain time, producing "toxins" that ultimately kill itself, but may first kill the patient if the phagocytic reaction is too weak to start with, or is weakened by improper medicines, or proper medicines improperly administered. I do not think that on any other hypothesis can the rapid and frightful ebbing of strength, so often met with, be explained, or the profuse and persistent sweats. Now, when such a poison enters the blood one would expect its entrance to "be betrayed by a leucocytosis," or, as Metschnikoff would call it, "a phagocytosis"; and it is surely most unwise to adopt measures that would lessen this process, or paralyse "phagocytic action." We fear, therefore, that the explanation of the prophylactic virtues of quinine must be looked for in some other direction.

* * * *

Abdominal Pains in Children.

THESE furnish a striking example of the truth of the adage, "Things are not what they seem." There is no doubt that there is often a great similarity, clinically, between acute abdominal and acute pulmonary disease. In acute pleurisy the pain is often referred to the abdomen; and it is no uncommon thing to confound acute pulmonary disease with acute appendicitis. In acute pneu-

monia, more especially *apical*, there may be vomiting, distension of the abdomen, and pain over the right iliac region; in this case, however, the abdominal wall will not be really rigid, but supple, and freely palpable, *with patience and a little guile*, showing that the mischief must be looked for elsewhere. Further, there may be the history or presence of cough, pointing to pneumonia, increase in rate of respiration, and alteration of its *rhythm* in broncho-pneumonia, viz., *inspiration, pause, expiration*, the latter being made with an effort, and often with a "grunt." The normal rhythm is, of course, *inspiration, expiration, pause*. So, too, on watching we may detect a "jerk" in respiration, pointing to pleurisy. Never forget to examine for spinal caries in cases where a child complains of pain in the abdomen.

* * * *

Other Diagnostic Points.

IN both cranial and abdominal inflammations we may have piercing screams, restlessness, and sudden startings from sleep; but in the one case the child will probably put its hand to its head and rub the ear or temporal region, or bang its head with its fist; while in the other it will most likely draw its hand across its abdomen. Again, in *appendicitis* (the most common form of peritonitis in children) constipation is frequent at the onset of the disease (in pneumo-coccal peritonitis *diarrhœa* is the rule), with frequency of micturition and pain during the act, and real rigidity of the right rectus abdominis muscle. In *intussusception* there is sudden acute abdominal pain, the passage of blood-stained mucus per anum, and possibly a sausage-shaped abdominal swelling. In abdominal troubles in children never forget to make a rectal examination.

* * * *

Homœopathic Wards in General Hospitals.

DR. RIDPATH, of Sunderland, writes us advocating the necessity for the formation of Homœopathic Wards in General Hospitals supported by the public. He thinks that at least one ward should be assigned for the reception of patients who desire to be treated by homœopathy, the Governors appointing some local homœopathic practitioner to the post. He points out, further, that the homœopathic

ward could be worked at a smaller cost than the other wards, as the drug bill would be less. Such a ward, too, would be able to deal with a larger number of patients, as the time of each in hospital would be shorter than in the ordinary wards. We commend the suggestion to the powers that be.

* * * *

"Hemlock" and "Spotted Fever."

IT is a curious fact that there seems to be in the popular mind an idea that "Hemlock" is a cure for "Spotted Fever." But there are many "Hemlocks," though they all belong, we believe, to the same Natural Order—Umbelliferæ. First comes the *Conium Maculatum*, or spotted hemlock; but this is not the hemlock we use, though it may be useful at times, *e.g.*, for the peculiar form of vertigo sometimes present. Then there is the Five-leaved Water Hemlock, the Phellandrium aquaticum (*Œnanthe Phellandrium*). This plant usually grows *in* the water. Again, there is the North American Water Hemlock (*Cicuta Maculata*). But *the* hemlock for "spotted fever" is the Water Hemlock, or Cowbane, the *Cicuta Virosa*. It commonly grows on the *borders* of ditches and rivers; its stem is furrowed, so that it can be distinguished from the "spotted" stem of the true hemlock. A fifth "hemlock," also called Water Hemlock, is the Hemlock Dropwort, or *Œnantha Crocata*. It belongs to the same order as the others, and grows also in moist places.

* * * *

Formic Acid and Diphtheria.

CROOM was induced to use *formic acid* in diphtheria as a *general tonic* (*Edin. Med. Journ.*, October, 1906). The usual antitoxin treatment was carried out at the same time. Comparing 100 cases so treated with 300 in which *formic acid* was not used, he found that death from cardiac failure was reduced from 8·6 to 2 per cent., and paralysis from 14 to 3 per cent. This seems too good not to have some relation to homœopathy. There is some reason to believe, according to the researches of German scientists, that the poison of the honey bee contains formic acid, though we do not believe that the well-known curative powers of *Apis*, in diphtheria, is due to that substance alone. It is a curious acid to choose as a general tonic, and we doubt if it ever would reach the blood at

all, as it is so very easily reduced, and for this reason is a very powerful antiseptic. In his next series of cases we would advise Dr. Croom to use *Apium virus*, without "the usual anti-toxin treatment."

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Sleeping Sickness, or Negro Lethargy.

WHEN the German Commission issued their report on November 25th, 1906, there were 986 patients under treatment, who were lodged in large camps at Sese, near Entebbe (Uganda). The presence of trypanosomes in the enlarged lymphatic glands is a most constant feature of the disease, a positive result having been obtained in 347 out of 356 patients examined. The result of the injections of the new arsenical preparation "Atoxyl" are described as satisfactory; the trypanosomes completely disappear from the circulation within a few days, and do not return for at least a month, and then only in small numbers. "Atoxyl" is Meta-Arsenic-Acid Anilide (C_6H_5 $NHAsO_2$). Aniline itself is Amido-benzene (C_6H_5 NH_2), and behaves as a feeble base. "Atoxyl" contains 37·69 per cent. of arsensic, and answers to the usual tests for that element, even though it is an organic arsenic compound.

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Nitrate of Silver in Ulcer of the Stomach.

DR. CRAVEN MOORE, in an article in the March number of the *Practitioner*, after remarking that *silver nitrate* was formerly extensively prescribed in hyperacidity and gastric ulcer, and gained a favourable reputation, quotes some investigations on the action of this salt on gastric secretion made by Baibakoff. He found that *silver nitrate* administered in doses of $\frac{1}{50}$ to $\frac{1}{3}$ grain in pill to a number of cases of gastric disease of various types increased the amount of hydrochloric acid secreted, the peptic power of the gastric juice, and also the motility of the stomach. He accordingly concludes that its use is contraindicated in hyperacidity and ulcer. This is a good instance of how physiological experiment leads astray in their therapeutics those who do not accept the homœopathic law. We know from a long experience that *nitrate of silver* is one of our most useful drugs in the treatment of gastric ulcer, hyperacidity, and gastralgia. But we do not give it in doses of $\frac{1}{3}$ grain.

Vaccine Treatment in Pyorrhœa Alveolaris.

TREATMENT by vaccines is coming more and more into use, and one of its latest applications is in the treatment of Pyorrhœa Alveolaris, as related in the Erasmus Wilson lecture by Mr. Kenneth W. Goadby, D.P.H.Camb., M.R.C.S. Eng., &c., Dental Surgeon, Bacteriologist, and Lecturer on Bacteriology, National Dental Hospital. He shows that in addition to the local symptoms various systemic diseased conditions arise from absorption of toxins from the gums. Of these the chief are an anæmia with a fairly marked leucocytosis; gastro-intestinal disturbances of a toxæmic nature, frequently associated with neurasthenia; pigmentation of the skin; acneiform eruptions; furunculosis; chronic rheumatic affections; recurrent stomatitis; depression, often amounting to melancholia; general malaria and extreme fatigue on slight exertion. He finds that local applications like curetting, &c., are best postponed till the lowered resistance to the infective organisms has been raised, which he effects, after an examination of the opsonic index of the patient's blood serum to the various staphylococcal groups of micro-organisms concerned, by injecting the vaccines of those the opsonic indices of which are found to be low. By these means the various constitutional affections are cured, the opsonic index of the patient's blood is raised, and he is then in a condition to derive more benefit from local surgical procedings, the wounds from which heal more quickly than when operation is done previous to the vaccine treatment.

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British Homœopathic Society.

THE sixth meeting of the session was held on Thursday, March 7th, at the London Homœopathic Hospital, at 8 o'clock. Dr. J. H. Clarke, President, presided. Dr. Murray Moore, of Leamington, read a paper, entitled "New, Old, and Forgotten Remedies, Part II." The remedies treated of were *lactic acid, lemna minor, œnanthe crocata, lathyrus sativus, passiflora incarnata,* and *spiritus glandium quercus.* Following the discussion on this paper, Dr. H. E. Deck, of the London Homœopathic Hospital, read a paper entitled "First Impressions of Homœopathy, with Illustrative Cases." Dr. E. Neatby showed specimens of fibromyoma and ovarian dermoid

cyst with twisted pedicle, submucous uterine myoma, and multiple myomata associated with carcinomatous degeneration of the cervix. The next meeting will be held on Thursday, April 4th; Section—Surgery and Gynæcology.

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Treatment of Lachrymal Obstruction.

THE surgical operations introduced for the cure of certain simple maladies, which cannot be influenced by drugs prescribed *per contrariis*, are often worse than the diseases. This is frequently true of the common operation for blocking of the nasal duct by slitting up of the canaliculus, followed by constant and painful probing, which has sometimes to be kept up for years. We are glad to see from a lecture by Dr. Herbert Parsons, published in the *British Medical Journal*, that these facts are being recognised, and the grave damage done to the delicate parts involved by this violent procedure, is causing attention. Fortunately, a simpler and harmless method of treating these cases has been devised, namely, by daily syringing through the lachrymal sac a weak solution of some astringent, especially *sulphate of zinc*. This is said to cure easily all early cases, which have not been probed. For ourselves homœopathic remedies will generally cure such cases if taken in time, without the trouble of syringing. But we are glad to see signs that an objectionable and painful operation for a trivial malady that often can be cured according to the law of similars will soon be relinquished. In extreme cases, where all other measures fail, extirpation of the lachrymal sac is recommended as preferable to the old incision and probing, and it provides a practically radical cure.

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Homœopathy and Quacks.

THE perusal of some articles on "Celebrated Quacks," now appearing in a contemporary, has suggested the question, "Do Homœopaths Patronise Quacks?" To which there can be only one answer—a decided negative. We never remember having heard of any person having an intelligent conception of the principle of homœopathy, and having experienced benefit from such treatment, resorting to quacks or quack remedies. There can be no more efficient safeguard from this pernicious habit than a knowledge of homœopathy.

And this undeniable fact we would commend to the consideration of the two or three weak-kneed brethren amongst us, who, from a lofty pinnacle of ultra-medical ethics, declaim against our spreading a knowledge of homœopathy amongst the laity. Surely in charity to their bodies it is right for us to protect our patients from such snares in these days of universal patent medicinism? It is instructive also to note that our brethren of the older schools of medicine, who complain so loudly of the ravages made in their practices by quacks and the use of patent drugs, have themselves largely to thank for the fact. For from whom did the laity absorb the ridiculous idea that the body could be purged of all ills by pills and draughts? Has it not been by the continued use of these violent measures by the profession (against which Hahnemann and his followers have protested for a century past) that such ideas have been fostered, and thus patent-medicine vendors flourish? It is also true that the prevalence of these evils exhibits the re-action of the public against that portion of the profession who still endeavour, ineffectually, to exorcise disease by nauseous mixtures. To both of these evils homœopathy supplies the antidote and the remedy.

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Adenoids and Homœopathy.

A SIMILAR ailment too frequently relegated to the surgeon, even by homœopaths, is caused by adenoids in the post-nasal cavities of children. In the March number of the REVIEW is reported a case of adenoids complicated by enlarged tonsils, as they commonly are, cured by a course of homœopathic remedies. Dr. Roberson Day, who narrates the case, has a wider experience in these and other diseases of childhood than probably any other homœopath, and we should welcome some further account from his pen of the curability of these troubles by drugs, and especially as to what proportion of cases he finds it necessary to relieve by surgical measures.

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Modern Diagnosis and Homœopathy.

DR. OGDEN, writing in the *Medical Brief* for March, concludes an able article on modern advances in diagnosis and their importance to all physicians, with these significant words: "It is true that Hahnemann and his contemporaries made

brilliant cures without all this latter-day knowledge, but how much more could have been accomplished by such minds had the diagnostic aids of to-day been theirs to command. Bigotry can never promote science and truth, and without these there can be no advance in medicine. To be able to discern truth and follow its teaching, this is the mark of mental balance which I think is best exemplified by him who adds to his knowledge of medicine a special knowledge of homœopathic therapeutics. All that belongs to the science of medicine is his by inheritance, by tradition, by right."

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Trypsin in Cancer.

THIS treatment, of which so much has been written lately in the daily papers, appears to have effected no permanent good in any of the cases so far reported, according to the *British Medical Journal*. Reports from seven independent observers after histological examinations of portions of a morbid growth, after it had been supposed to have been favourably influenced by the treatment, failed to show any check to the ordinary rapid growth of a carcinoma. Possibly further experience may prove that there are some cases in which the cancerous growth may be retarded by the use of trypsin; but the outlook is not encouraging at present.

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General M. O. Terry's Challenge.

GENERAL TERRY, Fort Myers, Florida, U.S.A., sends to every class of homœopathic practitioners in the British Isles, of all degrees of and shades of opinion, whether *curantur* or *curentur*, whether in the Homœopathic Directory or out of it, an invitation which is, at the same time, a challenge. We heartily commend it to every member of the B.H.S. and the B.H.A. It is this: "My dear Doctor, If you have, during your connection with the Homœopathic School, suggested a new thought of permanent value to the profession, and indirectly bearing on humanity, the authenticity of which cannot be questioned: if you have in medicine or surgery, including military equipment, devised, assembled or invented mechanical appliances or apparatus which are of advanced value and used in the profession, I shall be glad to have type-written, very brief and illustrated reports of the same, if

appropriate, as soon as possible, as I am arranging an article for the *American Institute of Homœopathy* for its meeting at Jamestown during the month of June, 1907."

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"The Priestcraft of Medicine."

UNDER this title Mr. Labouchere has been discussing in *Truth* the ethics of the medical profession with point and fervour. As for point, this was afforded by the case of Dr. John Shaw, a respected specialist in the West End, who had concluded from his extensive experience that the main cause of the alarming increase in the incidence of cancer was over-operating. Dr. Shaw states that he endeavoured to get a fair hearing for his views "through the usual and proper channels," but found "the position hopeless." Urged by a strong sense of duty, he then addressed the public directly on this matter in a book in which he details his conclusions and their evidence. This brought the Royal College of Physicians down on Dr. Shaw, the Registrar writing an official letter requesting "an explanation" of this procedure. Dr. Shaw's reply was spirited. After a statement of the persistent boycotting of his views, he adds: "Not only do I resign the Membership of the Royal College of Physicians, but I shall take off my name from the Medical Register, in the hope that —from the outside—I may be better able to rouse the conscience of the Profession, and the consciences of the people and their Parliament." . . . This is the stuff of which far-seeing and thorough-going Reformers are made.

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"Incorporated Brahmins."

Mr. LABOUCHERE is perfervid on the situation, and its dangers to the public. "It will be seen at once that the question which the Royal College of Physicians has thus raised, is one of supreme importance to the public at large." And, quoting from the Registrar's letter, "The book has been obviously written with a view to its being placed in the hands of the general public. . . . It is thought to be very undesirable that patients should have their attention directed to much which is thus communicated." What, asks Mr. Labouchere, does this mean? "It means that the patient must be kept in the dark; that he must have no opinion but

that of his father confessor, the family doctor; that knowledge must be confined to the initiated, in order that they may be supreme; that the Gospel of Science must not be preached in a tongue understanded of the people. And all this, forsooth, not for the benefit of the priesthood of medicine, but for the welfare of the laity, who will assuredly go to the devil if they are allowed to have an opinion about their own salvation." Plain speaking, this, with a vengeance.

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Vox Populi.

"BUT in these days the public claims to know the whole truth in matters of medicine no less than in matters of theology. The doctrine of a sacred caste presiding over mysteries incomprehensible to the uninitiated is out of date in matters affecting the temporal welfare of the community, as much as in those affecting its spiritual." Here is the essence of our case in a nutshell. Unpopular professional doctrines, a thorough-going professional boycott, the necessity of enlisting the forces of education and culture on the "outlander" side—this is the Homœopathic case over again. And all that Mr. Labouchere has said with fervour and point over the case of one man, may be re-stated with more fervour and greater appositeness over the wrongs of the whole Homœopathic body.

Original Articles.

CEREBRO-SPINAL FEVER.[1]

BY THE SENIOR EDITOR.

INTRODUCTION.—Though at present we believe the chances of a general epidemic of this disease occurring are very remote, nevertheless sporadic cases may be met with anywhere and by any one. It was thought therefore that a short account of the disease might be interesting and perhaps useful to our readers. The gravity of the subject must be our apology for the length of the article.

The disease is specially prevalent in *cold weather*, and we hope (after our excessively cold winter) that the advent of

[1] The second part of paper, entitled, "Symptoms and Diagnosis from the Homœopathic Standpoint," held over till next month.

warm weather will put it to flight. Children should be specially safeguarded from cold—no bare legs or bare arms. Mothers, even the best of them, often heap an unnecessary amount of clothes on the *bodies* of their children, while the legs and arms are left bare. This is most unwise, in the light of the fact that in most cases of the disease there is a *slight cough* in the early stages; also because of the possible close alliance between the pneumococcus and the diplococcus intracellularis of Weichselbaum, which latter is regarded as the chief, if not the only, cause of acute cerebro-spinal fever. Be that as it may, the disease seems to arise under the same general insanitary conditions of soil and air that give rise to epidemic pneumonia. Further, just as the pneumococcus may be found in the saliva and buccal secretions of the apparently healthy, so according to Councilman (1898) and Ludwig Jehle (1906 and 1907) the meningococcus may be found in the naso-pharynx of both children and adults who have been in contact with cases of the disease.

It does not seem to spread by direct infection from the diseased, but by healthy adults that have come into contact with those suffering from it; the organism in such "contacts" is often present in the naso-pharynx, and in such adult cases hawking and spitting may spread the disease.

As regards the blood there is a marked leucocytosis, containing a large percentage of polymorphonuclear cells, and some large mononuclear ones actively phagocytic towards the polymorphs. In the clear part around the nucleus in many of the polymorphs, diplococci may be seen. The diplococcus resembles the gonococcus in the fact that both are found chiefly in the cells, whereas the pneumococcus is chiefly extra-cellular.

Synonyms.—Cerebro-spinal meningitis; Epidemic cerebro-spinal meningitis; Pestilential purpuric fever; Malignant purpuric fever; Cerebral typhus; Black sickness (Dublin); Typhus syncopalis; Petechial fever; Cerebro-spinal typhus; Spotted fever; Congestive fever; Cold plague, and so on. These are a few of its numerous names. These names, however, are apt to fix attention on local structural lesions, which may or may not be present, to the exclusion of a consideration of the real nature of the malady. By Murchison it was regarded merely as a variety of typhus fever.

Historical.—There is reason to believe that this disease has prevailed as an epidemic in Europe at different periods and different places during the fourteenth, sixteenth, and seventeenth centuries; and in the eighteenth century in France, Germany, Italy, England, Ireland, and Scotland. More than two hundred years ago, Sydenham described it as *Typhus petechialis novis.* In February, 1805, it prevailed in Geneva and its environs until April. It appeared at nearly the same time in different parts of the city; this outbreak was described by Vieusseux. It occurred in limited epidemics during the following years until 1816 in various continental towns. It seems especially to affect young recruits in the army *e.g.* in Paris (1814), Grenoble (1814), and Metz (1815); these epidemics were almost exclusively confined to the garrisons, just as some fifty years later it was specially severe among the recruits of the Royal Irish Constabulary, stationed in the police barracks in the Phœnix Park.

In 1806 it arose in the United States at Medfield, Massachusetts, and prevailed at various points in New England and Canada. It extends from place to place just as other epidemic diseases appear to do, although there does not seem to be any transfer of the disease by actual contact. The epidemics, too, are limited both as to duration and locality. In England, for example, up to the present at any rate, it has never prevailed as a regular epidemic. With the exception of a number of cases that broke out in Liverpool in 1846, it has but rarely been met with, and then only in single cases or small groups. Many of the epidemics have attacked a single class in the community, *e.g.* soldiers in garrison (France, 1837), civil population (Gibraltar, 1844), convicts in galleys (Procida, 1840), inhabitants of workhouses (Ireland, 1846). The year 1846 brought the malady into the British Islands, where it sprang up in Dublin, Belfast, and Liverpool. Suddenly in the early part of the winter of 1854 it made its appearance in Sweden, a country which had, up to this date, escaped. Here it raged with peculiar violence in a widespread and fatal epidemic. Norway, curiously enough, escaped till 1859. In the winter of 1860-61 it visited the Netherlands. In our own country, the most extended and the most destructive outbreak showed itself in Ireland in March, 1866, and reached its greatest development

in the following winter; Dublin suffered chiefly, as I have before stated. Scotland has, up to the advent of the present epidemic, enjoyed a remarkable freedom from this disease. During the early part of 1865, a disease of this nature prevailed epidemically about the lower Vistula, where the common people gave it the trivial designation of "The Belly-Ache." It had some of the characters of *typhus*, but its characteristic lesions were seen chiefly on the surfaces of the meninges of the brain and spinal cord.

Mortality.—This is high, on an average about 60 per cent. In some of the American epidemics it is placed as high as 75 per cent. Among the Irish Constabulary it reached 80 per cent. Like other epidemic diseases, the mortality is highest at the commencement of the epidemic. It is very fatal about the age of twenty.

It occurs especially in winter and spring, and prevails more in cold than in hot weather. In Ireland it usually prevailed in winter and early spring. It is more commonly met with among children under ten years of age; after childhood it usually attacks those approaching the age of puberty or in early adult life. Among children it seems to attack both sexes equally, but in adult life, males more than females—robust males between the ages of fifteen and thirty are its chief victims.

It is believed to be caused by the *diplococcus intracellularis* of Weichselbaum (1903). This organism is present in the meningeal exudate, and in the fluid obtained by Lumbar puncture; it is found almost invariably within the polynuclear leucocytes, where it exists in pairs or tetrads. In the light of what is known about "phagocytic action," one cannot help remarking that this seems a strange habitat for the organism to choose. There is some doubt as to how it gains entrance to the body, but a diplococcus similar to this has been found high up in the nasal cavity of affected persons, as well as in "contacts," and it seems likely that in this way the organism may reach the brain. Some sporadic cases have been believed to be due to the pneumococcus, others to a streptococcus or staphylococcus; it is possible, however, that these organisms are more frequently associated with an acute *secondary* meningitis, *e.g.*, to otitis, which has been overlooked, than with the real epidemic cerebro-spinal meningitis.

For the sake of completeness we may give a classification of meningitis in children :—

(1) Traumatic or simple.

(2) Non-tuberculous.

(*a*) Secondary to disease of bones, middle ear, &c., and set up by the presence of a streptococcus or staphylococcus, bacillus coli, or other pyogenic organism.

(*b*) Those due to the presence of the pneumococcus, often secondary to pneumonia or pleurisy.

(*c*) The sub-acute posterior basic meningitis, due to the presence of a special diplococcus (Dr. G. F. Still, 1898).

(*d*) Whether a fourth sub-group should now be made, to include the true epidemic cerebro-spinal fever caused by the meningococcus of Weichselbaum, is doubtful. It may be merely a virulent form of the former.

(3) Tuberculous.

Post-mortem Appearances.—In some cases death takes place so rapidly that the changes found at the autopsy are slight; for sometimes "the first symptoms of the disease are the phenomena of death" (Stillé.) Serous exudation and intense hyperæmia, with an abundant exudation and infiltration of leucocytes into the pia mater, are the early lesions met with. Later, the most marked intra-cranial lesion is the whitish-yellow or the yellowish-green fibrino-purulent deposit found at the base of the brain, and spreading over the convolutions as well. The origins of the nerves seem to be buried in and compressed by the deposit. The ventricles may be distended with pus. The disease is, in fact, an acute purulent cerebro-spinal lepto-meningitis. In some cases purulent inflammation of the eyeball (*panophthalmitis*) is met with, and curiously enough it is most frequently the *right* eye that is attacked; both eyes are seldom affected, and rarely the left eye alone. There is an increase in the cerebro-spinal fluid, and the convolutions are flattened from distension of the ventricles, from blocking of the foramen of Majendi with pus, or thrombosis of the veins of Galen in the velum interpositum. The inflammatory process is apt to spread along the optic and

auditory nerves, resulting, finally, in blindness and deafness. In the cord the subarachnoid space may be filled with pus, causing the dura to bulge out. Usually the pus collects most in the lumbar region.

Symptoms.—After an incubation period of unknown length, the patient is usually attacked suddenly, when apparently in vigorous health, by faintness, vomiting of greenish matter and intense pain, referred especially to the back of the head and neck. There is intense headache with vertigo, with severe rigors (or, in a child, convulsions) and high fever, 102°-105°. The vertigo is sometimes very marked, even in the recumbent posture (*conium*). With the intense headache there is marked prostration, with tenderness and pain in the back of the neck and along the spine, so intense as to make the patient scream out. So sudden is the invasion at times and so great the collapse that the patient has the sensation that he has received a blow on the occiput. Sometimes the headache is felt as a constricting band. There is also general and intense hyperæsthesia of the surface, so that the least touch is painful, probably due to involvement of the posterior roots of the spinal nerves. There may be opisthotonos. Retraction of the neck, rigidity of the cervical muscles, is usually a marked symptom, often with torticollis. Delirium is frequent and is acute, with muscular twitchings and cramps and convulsions, either general or of one arm or leg; this stage tends to pass into a state of dulness and apathy, and ultimately complete coma. The bowels are usually constipated, and the abdomen often retracted or boat-shaped. In some epidemics, and in a few patients in every epidemic, there are blotchy purple spots and petechiæ on the face, abdomen and legs: this has given rise to the name "spotted fever," though in many cases no "spots" can be seen. The *temperature* is so variable that no typical range can be indicated; generally it is of the remittent type, or it may be looked upon as a continued fever with well marked remissions, like "jungle fever." The *pulse* shares in variation like the temperature; it may be *slow*, frequent or irregular; it is rarely rapid unless pneumonia be present. Its frequency does not accord with the height of the temperature—as so often happens in septic states, where the fever may be moderate but the pulse rate very high. The *respiration* is slow

and irregular as the disease progresses, often of a sighing character, and sometimes of the typical Cheyne-Stokes variety. Herpetic eruptions on the lips are common, as well as herpes zoster. Urticarious, eythematous and roseolous rashes have been observed, and at times pemphigus appears. The eruptions, when present, are markedly symmetrical. The *tongue* is coated with a white soft fur, but clean at the tip and edges, but afterwards dry and brown. The thirst is usually insatiable and tormenting. The pupils in the early stages are usually contracted, later irregular, and towards the close widely dilated. External strabimus is the most frequent form of ocular paralysis. The fundus is rarely normal. Deafness is common during the acute stage, and is also its most frequent sequel. Bulging of the anterior fontanelle is one of the regular symptoms in young children. There is intense restlessness even though the patient is unconscious.

Complications and Sequelæ.—Pneumonia is a common complication and a frequent cause of death; less often we meet with pleurisy, bronchitis aud pericarditis. Acute inflammation of the larger joints is a frequent complication; the joints are red and swollen, and the inflammation often terminates in purulent intra-articular effusion. Other results are chronic headaches (meningitic), chronic hydrocephalus, loss of memory, aphasia and general mental impairment; defective vision from optic atrophy, iritis, retinitis or keratitis; defective hearing from the cerebral lesion, otitis media, otitis interna or neuritis of the auditory nerve; paralysis of the cranial nerves, or of one or more of the limbs is not uncommon. Hæmorrhages are frequent in the more malignant forms—into the skin, from the nose, uterus, bowels, kidneys and ears. Inflammation and suppuration of the parotid glands occurs occasionally.

Diagnosis.—This must be made from the whole taken together, the *tout ensemble,* or the broad or general effect, the general "make up" of the case. Special points are—the sudden invasion with rigors, intense vertigo, vomiting, headache and noisy delirium: the pale face, red conjunctivæ, *contracted pupils: retraction of the head.* Herpes labialis and herpes zoster are frequent. Intense hyperæsthesia of the surface and along the spine, so that the least movement causes intense suffering; tetanic convulsions may bring about a fatal

issue from lock-jaw or asphyxia; there is a great tendency to opisthotonos. There is also the irregular temperature, the cerebral character of the respiration, cerebral vomiting and the peculiar position in which the patient lies; cervical and dorsal pains, intense pains in the extremities of a neuralgic character, from irritation of the posterior roots of the spinal cord, aggravated by the least movement. Death is generally by coma, or from paralysis of the heart and respiration by lesion of the *medulla oblongata.* In sporadic or doubtful cases a diagnostic lumbar puncture should be made, and the fluid examined for the characteristic organism. The fluid obtained from the lumbar puncture contains typical meningococci, both free and within the cells. Sometimes it is so turbid as to look like pus.

It must be distinguished from—

(1) An ordinary *bilious attack,* or the onset of *acute Glaucoma.*

(2) *Tetanus,* or lock-jaw. This often occurs after trivial injuries, and occasionally is epidemic amongst newly-born children. In idiopathic cases there is generally a history of sleeping on damp and infected soil. In this disease *the mind is not affected.* The bacillus, too, is different; it is found in the soil, and particularly in manure; one end is knobbed like a drum-stick, and it grows into long threads, and is mobile and anaërobic ("bacillus of Nicolaïer").

(3) *Diphtheria.*—The presence of false membrane in the fauces, and the detection of the Klebs-Loeffler bacillus.

(4) *Purpura Hæmorrhagica.*—Distinguished from this affection by the intensity of the fever, and the localised nervous symptoms.

(5) *Typhoid Fever.*—In most cases of this disease there is the slow development of the symptoms, the dull headache, absence of vomiting and diarrhœa, the characteristic temperature curve (not always present), abdominal symptoms and the Widal reaction (difficult to get in the early stages of typhoid). There is, as a rule, no cervical pain, no retraction of the head, no herpes, and no leucocytosis.

(6) *Typhus Fever.*—The petechial rash (if present) in cerebro-spinal fever appears suddenly, without any previous mottling of the skin; the nervous symptoms should also distinguish it. The temperature curve, too, is more regular, and there is a characteristic mouse-like odour about the patient in typhus.

(7) *Pneumonia.*—In children especially the head is often markedly retracted, and there may be double optic neuritis suggesting cerebral abscess. In fact, in any disease in a child with high temperature the head may be retracted. There may also be joint affections in pneumonia, from inflammation induced by the pneumococcus or a streptococcus. But if such cases are seen from the first the pneumonia will be observed to precede the symptoms of cerebro-spinal meningitis.

(8) *Acute Rheumatic Fever.*—Redness and swelling of the joints may occur in cerebro-spinal meningitis, and this at first sight may suggest acute rheumatic fever. In this affection, however, the joint symptoms occur at the onset, and there is an absence of cervical retraction, muscular rigidity, facial paralysis, and cutaneous eruptions.

(9) *Tubercular Meningitis.*—The onset in this affection is not usually so sudden; the aching, hyperæsthesia and cervical retraction are less, and there are usually no cutaneous eruptions. But the retraction of the abdomen, irregular pulse, Cheyne-Stokes respiration, are much more common. Further, tubercles may be seen in the choroid.

(10) *Malignant Scarlatina.*—The rash and the sore throat should guide.

(11) *Malignant Small-pox.*—In some cases this disease has been mistaken for cerebro-spinal meningitis. It must be borne in mind, however, that cerebro-spinal meningitis may complicate or be complicated by several of the above diseases, so that it may be quite impossible to distinguish them. On the other hand, too, diseases that ought to have a slow onset, such as typhoid fever and tubercular meningitis, may apparently develop quite suddenly, and make an exact differential diagnosis almost or quite impossible.

To the homœopathic physician, however, an intelligent interpretation of the symptoms and physical signs will in most cases lead to a correct diagnosis of the *remedy*, even if it is not always possible to make an exact diagnosis of the disease.

Our allopathic colleagues plead in extenuation of their want of success in curing new diseases, that the disease is new to them, and that they have had no opportunities to study it, and to ascertain by experiment (on whom?) the effect of remedies upon it; or, inasmuch as they have not yet discovered

the specific causal organism, it has not been yet possible to have a "serum" prepared. This plea, no doubt, seems at first sight plausible, and to have a show of wisdom; but it is fatal to all pretensions that their therapeutics is a Science, or anything near it.

The homœopathic physician must shelter behind no such subterfuges as an excuse for incompetence. Homœopathy, if a Science, must furnish us with the means of treating new and unknown diseases, must enable us to treat the very *first case* even with certainty and precision. It is a Science, and it can do this. For we have one series of phenomena (the signs and symptoms of the disease as manifested by the patient) and a *law* relating these to another series of phenomena—the symptoms produced in the healthy by drug-provings as recorded in our *Materia Medica.* This great law of cure makes the homœopathic physician the most independent of all practitioners. For he has the world and everything in it, and all the forces of Nature at his command, to use according to the dictates of that law. He does not need to wait for the "latest pronouncements of Science" on the subject, or to follow the therapeutic vagaries of Vienna, Paris, London, or even Oxford.

Treatment.—While taking note of all recent investigations in the fertile field of bacteriology, and of the reputed causal relation of microbes to disease, the homœopathic physician must not magnify the microbes into bogeys, being firmly convinced that the indicated remedy will cure the case (where cure is possible) just as if they were not there. It can make no difference to the indicated remedy whether the microbes are the *cause,* or merely the *concomitants* of the disease. We must not allow the microbes to tie our hands, or make the presence of this or that micro-organism an excuse for sitting down and doing nothing. Microbes must have existed from the beginning, and if they cause disease now, they caused it then; but the "old brigade" cured their cases in happy ignorance of diplococci, pneumococci, staphylococci, streptococci, &c.

It is the great privilege of the homœopathic physician to be able to foretell, to know in advance, because Homœopathy is a science in the truest sense of the term—*the* science of therapeutics. The following medicines, among others, may be consulted, preparatory to searching the *Materia Medica:*

Aconite.—At the onset of the disease, when there is *much fear manifested*, and mental or bodily restlessness; no position is satisfactory. Chill and fever with great thirst for cold water. Despairing mood and fear of death. Painful stiff neck. If this medicine is of use at all, it must be at the beginning, and before exudation has taken place. From a theoretical point of view, one would not expect it to be a remedy of the first rank in this disease. Still, if its characteristic symptoms are present, it should be used, theories notwithstanding. The same holds true of *belladonna*.

Apis mel.—Great restlessness and tossing which affords no relief. Crying out and screaming as from stabbing pains. *Great* pain in the occiput, and sensation of stiffness in the neck and back. Scanty urine, but seldom any thirst. Numerous spots or little elevations all over the body, red or purplish. Smoky opacity of the cornea and obscuration of sight. Constipation with retracted abdomen. Stupefaction and stertorous respiration and sometimes great dyspnœa, as if every breath would be the last. Pulse may be slow. Squinting, grinding the teeth, and boring head into pillow. Patient very fidgety and whining. On theoretical grounds, this medicine should be often indicated.

Cicuta.—Moaning or complaining; pupils dilated or contracted; dumbness and deafness; face ashy pale or bluish; cramp in the muscles of the neck, with inability to move or turn the head; the head is spasmodically drawn back, with stiff neck; trembling or starting or jerking of limbs; irregular respiration, starting at the least noise; violent jerks in any part, or throughout the whole body; rigidity of the spine; strangulation on attempting to drink; violent convulsions, after which the patient lies as if dead: trismus; insensibility; double vision, *dilated pupils* and staring look; jerking of the eyeballs, muscles of face, arms, and hands.

This is a most likely medicine. Dr. J. H. Baker, Batavia, U.S.A., has reported a series of sixty consecutive cases of the disease, in all stages and in all degrees of severity, treated by this medicine alone without a single death. (*Hahnemannian Monthly*, vol. viii., p. 42.)

Camphora.—When there is great coldness and paleness; almost pulseless from the first shock of chill, without reaction.

The skin is cold as marble, deadly pale or blue, yet the patient does not desire covering. There is often cramp in the stomach, and the pulse is small, weak and slow.

Most likely to be useful in the *fulminant variety*—the meningitis cerebro-spinalis siderans of Hirsch, and the *méningite foudroyante* of French writers. The poison seems to fall upon the patient like a thunderbolt. He is struck down without warning in the midst of health, and speedily falls into a state of collapse, and may be dead in a few hours. There is usually a violent chill, and the skin becomes blue and cold; it may be clammy to the touch or bathed in a profuse perspiration. The face is shrunk and livid, the eyes deep sunk in the orbits. There is retraction of the neck, and general convulsions may usher in profound coma, the forerunner of death. The pulse is weak from the onset, and quickly grows more rapid and faint. Death usually takes place in from five to twelve hours. Tourdes, writing of the epidemic at Strasburg, in 1840 and 1841, states that soldiers full of youth and strength were stricken in the street, at drill, in the barracks, whilst at meals, and succumbed in a few hours.

Crotalus.—Intense headache with feeling of tightness in the brain. Red face and delirium with open eyes. Red ecchymosed spots all over the body. Pain in all the limbs. *Heart-beat feeble.* Convulsions and paralysis.

Gelsemium.—When the attack is ushered in by blindness, then headache and a feeling as if a *band were round the head.* Great drowsiness; itching of head, face, and neck; loss of vision and speech; nausea; feeble pulse and laboured respiration; trembling and complete loss of muscular power; *sweating relieves.* Eyelids paralysed; double vision and dilated pupils. Dull pain in the back of the head. *Feels as if intoxicated.* Head feels too large, and eyeballs feel sore. This medicine was used by Bartholow for this disease.

Opium.—Stupor with deep slow breathing. Congestion to head; *occiput feels heavy as lead.* Very quick or very *slow pulse.* Drawing the body backwards and rolling it from side to side. Spasms with tossing of the limbs. *Worse while sweating.* Delirium with wide open eyes. Face purplish and swollen (c.f. *cicuta*—face bluish and puffed up). Fearfulness and tendency to start.

Helleborus. — Sensorial apathy. Face pale and puffed. Soporose sleep, with screaming and starting from stabs of pain. Rolls head night and day. Lower jaw sinking down; chewing motions of mouth. Squinting, pupils dilated. Bores head into the pillow; forehead wrinkled. Involuntary throwing or whirling about of one arm and one leg. Coffee-ground sediment in the urine.

Veratrum Viride.—During the first stage with coldness of the surface; loss of consciousness; laboured, slow and irregular pulse. Later, trembling as if frightened, and on the verge of spasms; convulsions with loss of consciousness; retraction of the head; rolling of the head, rolling up of the eyes; opisthotonos; very frequent and feeble pulse. *A red streak down the centre of the tongue.* Dim vision with dilated pupils. Cold sweat on face, hands and feet.

Many other medicines may be required, according to the special and peculiar symptoms manifested by the patient as :—

Æthusa, arg. nit. (strongly recommended by Grauvogl): *arnica* (stupid apathetic condition; great soreness all over as if bruised; ecchymosed spots on the skin): *arsen.* (extraordinary prostration of strength with great restlessness; great thirst, drinks little and often. For the intermittent type of the disease): *cimicifuga; cuprum acet.* (convulsions and cramps beginning in the extremities, especially in the fingers and toes): *digitalis* (slow pulse, white stools, bilious vomiting, and boat-shaped abdomen): *lachesis* (sleeps into an aggravation; neck stiff, and excessively sensitive to touch; hæmorrhage from the bowels, looking like charred straws; ecchymosed spots on skin): *phos.* (for pneumonic complications): *rhus tox., zinc* (constant fidgety motion of the feet; evidences of fear on awakening; rolls head from side to side; cries out, starts and jumps during sleep).

As regards individual symptoms :—

(1) Retracted abdomen, in.—*Verat. alb., apis. dig., cup. acet.*

(2) Spots on the skin.—*Arn., apis, æthusa, crotalus, lach.*

(3) Opisthotonos with convulsions.—*Verat. v., cicuta, dig.*

(4) Slow pulse.—*Apis, cicuta, crotalus, dig., bell.*

(5) Sensation of a blow on the occiput.—*Cimi., crotalus, bell., nat. m.*

(6) Tongue white and furred with clean tip and edges.—*Arsen. bell., gels., rhus t., sulph.*

These are merely a few pointers; individual cases must always be closely compared with the various drugs in the *Materia Medica.*

I have said nothing about *potency*, as each one will have to settle that question for himself. My own inclinations are towards the higher potencies. The late Henry N. Guernsey, in reference to this question, in Cerebro-spinal Fever, says, "In this grave disease I have the best success from using remedies ranging from the 200th to the 40m., always withholding the remedy at every amelioration, and usually repeating it at every aggravation."

Camphora, however, I believe should be used in the form of *Rubini's Tincture*, the size of the dose, mode of administration, and the frequency of repetition, the same as in the early stage of true cholera.

THE PROGRESS OF HOMŒOPATHY IN ENGLAND.

By Dr. W. T. ORD.

II. The Provinces—A Call for Progress.

The notable forward movement that has characterised Homœopathy during the last fifteen years in the Metropolis, has affected the provinces to a very limited extent. Indeed, except in one or two isolated towns, no such progress can be observed beyond the limits of the London suburbs. The reason for this is not difficult to ascertain, seeing that the new London Homœopathic Hospital, with its surgical wards, its special departments for various disorders, and its staff of physicians and surgeons, has been and is the rallying point for all recent Homœopathic progress. This has not provided a centre for efforts from which the provinces could benefit, except to the extent that the provincial homœopathist may always count on finding a bed there for any case requiring surgical or special skill, or of especial interest, and a welcome from colleagues ready to assist and treat his patient.

But the most important of the supplies provided by the Central Homœopathic Hospital in the United Kingdom, namely, that of young homœopathic practitioners who have passed through the wards as resident medical officers, and are on the look out for openings for practice, has totally failed to

provide for the needs of provincial towns. The supply so obtained is wholly inadequate to the demand, and it is also found that the men prefer to work at or near their Alma Mater, and hence seek practices in the Metropolis and its suburbs rather than further afield. From this it has come about that the numbers of doctors practising homœopathically in London and its suburbs have greatly increased during the last few years. The Metropolis was never so well represented in this respect as now, whilst the supply that ought to have reached the provinces has been withheld, and a great paucity of men has been and is being there experienced. But few provincial hospitals of sufficient size to support resident Medical Officers exist, the chief being those at Liverpool and Birmingham. It is doubtless due to this fact that in the former town there are found more homœopathic practitioners than in any other city outside London.

But in the provinces generally no marked advance in the progress of homœopathy, whether amongst medical men or the laity, has been noted in recent years. To give our London colleagues an idea of the state of stagnation there existing, we can best do so by asking them to imagine what prevailed in town under the old hospital *régimé*. There was little or no surgery, there were no special departments or specialists, and few modern improvements in hygiene or nursing had penetrated its walls, whilst the out-patient department was poorly attended and inadequately staffed. It is still so, speaking generally, in homœopathic work and practices in the provinces. We do not by this imply that our provincial brethren are lacking in up-to-dateness in their ideas or methods, but they lack the opportunities, and few find time amidst the arduous routine of daily practice to advance the cause of homœopathy, or to spread abroad a knowledge of its usefulness.

The proportion of homœopathic practitioners to the population in the provinces compared with London shows a wide discrepancy. A simple arithmetical calculation will show that, counting the names given by the *British Journal of Homœopathy* in the supplement issued in January last, there should be three times as many men in the provinces in proportion to the population as are there shown, in order that the rest of the United Kingdom should be as well represented as is London

and its suburbs. That this is the prime factor in producing the present unsatisfactory condition cannot be doubted. In many towns patients are constantly inquiring for a medical man who prescribes by the law of similars. Whilst such important cities as York, Cambridge, Derby, and many others are unrepresented, who can wonder at this? From such health resorts as Buxton, Dover, Malvern, Weymouth, and others, the cry is continually heard "come over and help us!" These towns, which have no resident homœopath, cannot adequately be served by weekly or occasional visits from another town. The result is that homœopaths settling in those places have to be satisfied with such local treatment as they can obtain, often trying to supplement this by using their own homœopathic remedies assisted by some book on domestic treatment, a naturally unsatisfactory and sometimes dangerous expedient. So in time they cease to trouble about the unattainable and become more or less satisfied with old-school methods. From this there is a continual loss to the cause of Homœopathy, to which there can be no remedy save in an increase in homœopathic practitioners. The lack is also felt in towns where these are found; for the supply is nearly always inadequate to the demand, and hence the better class work is best attended to, and it is found impossible without assistance, which is rarely forthcoming, to answer to the demands of dispensary and working-class practice. All honour is due to many of our colleagues who with great difficulty and often at considerable personal loss maintain dispensaries and give valuable time and assistance to these, which could be far more profitably to themselves employed elsewhere. It is by such self-denying efforts that the flame of truth is ever kept alive; Homœopathy owes a debt that can never be repaid in many towns to such men. We would there were more of them!

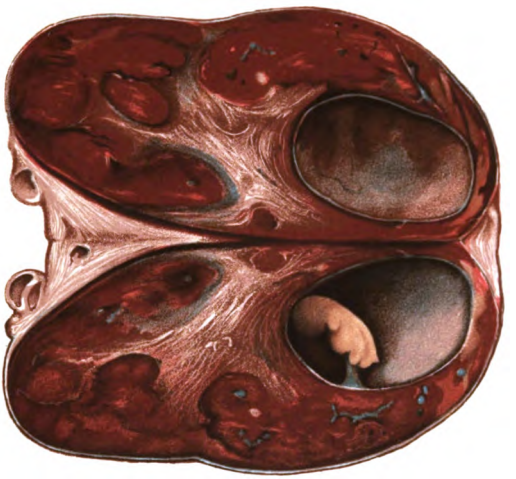
Two other hindrances to the progress of our cause may be noted, both due to the peculiar conditions of isolation experienced by many provincial homœopaths. One is the frequent difficulty of finding a man to fill up a death vacancy, or even to do *locum tenens* work during an illness. The other is the need of consultants to give skilled opinions in cases of difficulty and doubt. In places near the Metropolis this is not felt, but in distant and isolated towns the lack becomes a serious one.

It is evident that the condition of Homœopathy in the provinces is far from flourishing, and it is perhaps now being better understood than ever before that there exists an urgent need to further the cause by some special effort. In this lies the value of the work of the British Homœopathic Association, and it is to this body that the eyes of all interested in the question are anxiously turned. What the London Homœopathic Hospital has done for Homœopathy in the Metropolis we hope and expect will be done for its advance in the provinces. This is, however, a distinctly more difficult and complex problem, and anything but easy of solution even were unlimited funds placed in the hands of the Association for the purpose.

Already, however, some progress has been effected, and signs of increasing interest in Homœopathy are observed in several provincial centres. The most notable of these, and the most important, so far, is the offer of financial assistance by the Association to hospitals and dispensaries in the smaller towns. This does good in several ways: firstly, by inciting others to seek and give local aid, which had previously been withheld; secondly, by stirring up interest in Homœopathy in the neighbourhood; and, thirdly, in giving help and encouragement to the local homœopathist when he especially needs it. The recent revival of Homœopathy in Southport is a case in point, where our colleagues, stimulated by proffered aid from the British Homœopathic Association, initiated a notable forward movement with great success. It is to be hoped that this admirable example will be followed elsewhere.

It is, however, impossible for these and other efforts to produce the looked for revival in our cult until an adequate supply of homœopathic doctors can be obtained. Nothing can make up for this loss, and revivals in places where no medical advice in Homœopathy can be obtained are of little permanent effect. It is to this fact that the attention of the Association and of all interested in the progress of Homœopathy is directed. The problem is a most difficult one, but it must be faced and solved if our efforts are to have permanent success. It ought not to be insoluble, and personally I believe that there is a way by which success might be obtained, and recently qualified men induced to study, accept, and take up practice on Homœopathic principles. But that, as Kipling says, "is another story," and cannot be dealt with in this brief paper.

(To illustrate Drs Burford and Wheeler's Paper on a Case of Tubal Gestation.)



FALLOPIAN TUBE IN SECTION
SHEWING
UNRUPTURED TUBAL GESTATION.

Bale & Danielsson, Ltd del. et lith.

ON A RARE INSTANCE OF EXTRA-UTERINE GESTATION DIAGNOSED BEFORE RUPTURE, AND REMOVED INTACT.

By GEORGE BURFORD, M.B.

Senior Physician for Diseases of Women to the London Homœopathic Hospital; Fellow of the British Gynæcological Society; Honorary Member of the Homœopathic Medical Society of New York, &c., &c.

AND

CHARLES E. WHEELER, M.D., B.Sc.Lond.

Formerly Physician to the Sanatorium, Nordrach-upon-Mendip; Assistant Physician to the London Homœopathic Hospital; Director of the Research Department of the British Homœopathic Association.

WITH PLATE, SHOWING FŒTUS *in situ* IN THE UNRUPTURED TUBE.

DR. CHARLES WHEELER, in attendance on a lady suffering with recent uterine hæmorrhage, came to the conclusion that it was due to early pregnancy, and asked Dr. Burford to meet him in consultation. The history was fairly clear. Married less than a twelvemonth, this lady had normal periods till December, 1906, except for a delay of fourteen days before the September period came on. When this delayed one appeared, however, it was perfectly normal in every way, and did not suggest an early miscarriage.

In January the period was missed, and about six weeks after its expected advent comparatively slight hæmorrhage, irregular in its course, but never entirely ceasing, continued up to the time of consultation. Once and again a small clot had been passed: but no membranous shreds were at any time noticed, nor was the flow ever malodorous. Further, abdominal or pelvic pain had at no time been a marked feature, and the patient felt so well that she resented the rest and the restrictions on which Dr. Wheeler had insisted.

Some two weeks after the commencement of hæmorrhage, a consultation was held and the aspects of the case reviewed. Physical examination—a matter of considerable difficulty in this instance—indicated, from the somewhat enlarged and softened uterine organ, the occurrence of pregnancy; but the clinical history did not quite tally with the usual symptoms of an early miscarriage. The possibility of an extra-uterine

gestation was discussed, and it was decided to administer an anæsthetic, and, while clearing up the remaining points in the physical condition, to arrest the uterine hæmorrhage also.

Examination under anæsthetic clearly showed a soft elongated swelling apparently running parallel to the long axis of the uterus, and about the size of an English sausage. The uterus was pushed over to the right. The diagnosis of tubal gestation was at once made, and in order to eliminate any complicating condition of the endometrium this was scraped without drawing the uterus down. Shreds of membrane were thus removed from the uterine interior, and the cavity was lightly packed with gauze. The voluminous curettings from the uterus were now submitted to an expert for microscopical examination. Had the large decidual cells commonly present in the uterine exfoliations in tubal gestation been demonstrated in this case, a valuable confirmatory element in the diagnosis would have been established. But careful and repeated examination failed to reveal characteristic decidual elements; the pathologist's finding was indeterminate.[1]

This negative result gave us pause; for besides this there were two other important diagnostic elements lacking, which are usually present in developed cases of tubal gestation. These factors are: (1) the repeated occurrence of pelvic pain, due to the distension of the tube; and (2) the symptoms of collapse, due to hæmorrhage from rupture of the gestation-sac. Both these diagnostic aids were conspicuous by their absence. A careful review of the clinical history, together with the physical examination, confirmed us in the belief that we had here to deal with a veritable case of extra-uterine gestation. Granting the lack of support from the microscopic investigation, and the absence of two important clinical symptoms commonly present, the residual evidence neverthess dovetailed satisfactorily in authenticating the presence of extra-uterine gestation rather than any other pathological abnormality.

As positive evidence we had—

(1) The hitherto unbroken bodily health.

(2) The regularity of the period up to eight weeks prior to date.

[1] Prof. A. Martin, in his classical work, "Die Krankheiten der Eileiter," mentions five of his own cases where an examination of curetted fragments gave the same negative result.

(3) The irregular, almost painless, leakage from the uterus of a fortnight's duration.

(4) The increased size and softened consistence of the uterine organ.

(5) The absence of any characteristic products of gestation in the uterine cavity.

(6) The finding of a definite one-sided swelling by the side of the uterus, and obviously tubal in origin.

(7) The correspondence of this with what a six or eight weeks' tubal gestation would probably be in point of size.

On the other hand, there were—

(1) The absence hitherto of any abdominal pain of note.

(2) The lack of decidual elements in the curetted shreds from the uterus.

(3) The non-occurrence of collapse or any other indication of intra-peritoneal hæmorrhage.

Assessing the values of these negative indications, the time had presumably not yet arrived for the consummation of abdominal hæmorrhage. The absence of decidual elements in the uterine shreds has, as already indicated, been noted in other cases; while as to the lack of abdominal pain in the clinical history, this, though a commonly observed symptom, is not invariable.[1]

In any case, we had to deal with a pelvic growth clinically associated with the uterine hæmorrhage. The balance of evidence indicated this growth as probably an extra-uterine gestation discovered before rupture. The patient and friends were accordingly advised of these facts and our interpretation; and operation recommended. To the latter consent was at once given, and the lady was transferred with extraordinary precautions to a nursing home for the necessary procedure.

The following day Dr. Burford opened the abdomen—Dr. Johnstone and Dr. Wheeler assisting—and immediately came upon the distended left Fallopian tube, as previously diagnosed, adherent, and purple-black from the hue of contained blood-clot. But there was not the slightest evidence of any effused blood in the abdominal cavity, the fimbriated end of the tube was sealed, nor was there any sign of rupture at any

[1] "Wehen-artige Schmerzen zwar sehr haufig das vorzeitige Ende der Tubarschwangerschaft begleiten, aber doch durchaus nicht constant." Martin, "Die Krankheiten der Eileiter," *op. cit.*

part of the thinned-out tubal wall. Our diagnosis was confirmed : we had evidently to deal with that *rara res in terra*, a Fallopian tube converted into a gestation sac, exposed by operation, anterior to rupture.

The gestation tube is spoken of by authorities as spherical, or pear-shaped. Our specimen could more properly be described as sausage-shaped, and of about the same dimensions—an English sausage being naturally the standard.

The adherent distended tube was carefully separated from numerous points of attachment, elevated from the pouch of Douglas, ligatured and removed in the usual way. The left ovary remained behind intact. The right appendages were examined and found normal. It is the duty of the abdominal operator always to examine the vermiform appendix : that ceremony was here foregone, the viscus having been removed at some earlier time.

The abdomen was closed in terrace-form, and the patient put back to bed. The recovery was unbroken, no rise in temperature accruing, and the incision healing throughout by first intention. From the nursing home a journey to the seaside was made three weeks and a half after operation.

We cannot put our hand, at this present moment, on any similar case in medical literature where an unruptured gestation tube has been diagnosed as such, and removed before the catastrophe. Doubtless similar cases have found their way into specialist literature, but they are so uncommon that we have no clear recollection of these. As a matter of fact, rupture and its clinical issues are usually important elements in the diagnosis of extra-uterine gestation, especially during its first three months. Usually the first definite signal of the ill-starred conception is in the more or less serious internal hæmorrhage which ensues on the expulsion of the embryo from the tube into the abdomen. True, this is often preceded by uterine hæmorrhage, such as is observed in an early miscarriage ; but it is not given to many to differentiate with certainty between primary uterine hæmorrhage due to miscarriage, and secondary uterine hæmorrhage due to tubal conception. To the trained observer the character of this secondary hæmorrhage furnishes at least hints for further investigation as to the presence or no of tubal pregnancy. It

was the character of the hæmorrhage that in this case raised the suspicion of tubal pregnancy before any pelvic examination had been made.

In this case, further, two elements commonly present were also wanting: the occurrence of colicky pelvic pains and the presence of decidual cells in the membranous shreds obtained from the uterus. The irregular pains, due to the increasing distension of the tube, are important clinical contributions. And when decidual cells can be demonstrated in the uterine curettings or exfoliations, these lend definite aid to the diagnosis. But, as this case testifies, both may be concurrently absent, without invalidating the conclusion to be drawn from the other symptoms and physical signs.

Finally, let us put as pointedly as possible, how necessary it is to examine carefully each instance of suspected miscarriage, before making a positive statement as to its ordinary character. If the case presented no other features of interest, it were worth recording as showing a pitfall in the path of the unwary obstetrician. Ninety-nine cases may pass without a break in the uniformity of the diagnosis of ordinary miscarriage, but the hundredth may prepare an unpleasant surprise for the medical attendant, accustomed to rely on the laws of average. For there is no reputation so precarious as that of the obstetrician, and the price to be paid for this sustained reputation is eternal vigilance.

PERCENTAGE FEEDING.

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

Physician in Charge of the Department for Diseases of Children at the London Homœopathic Hospital.

THE feeding of infants is a perennial subject for discussion. More has been said on this than any other allied topic, and there is no reason to suppose we have yet heard the last word. It appears to correspond in medical literature to the theme of Washington in American journalism; no periodical, I am told, is complete without some reference to this subject. But notwithstanding all that has been written, it is only comparatively recently that any really scientific work has been done in the matter. The duty of feeding the infant is usually relegated

to the nurse, who soon finds out that she possesses, at any rate, the practical knowledge which the doctor lacks who is a "physician for women and children," and has given his respective charges that amount of attention which varies directly with their anatomical bulk.

I do not intend to enter into the question of the various ingredients which compose the mixtures ordinarily met with in the feeding bottle. Each nurse has her own ideas upon the subject—usually there are so many tablespoonfuls of milk, so many of barley-water or lime-water, a teaspoonful of cream, and a lump of loaf sugar, if the luxury of milk sugar is not available.

In such a mixture we are obviously thinking of spoonfuls of milk and their relation to the water; but no regard is paid to the composition of the milk. Perhaps, if the baby vomits we give less cream, or if curds appear in the motions we reduce the milk by diluting further with water. After a few more or less unsuccessful shots, we manage to hit off a mixture which the child tolerates, and upon which it will thrive. If we fail, as is often the case, the nurse will try a patent food (their name is legion), or a well-meaning neighbour will suggest a food which suited her child so well. This is no overdrawn picture—we have all passed through this experience, and frequently been humiliated thereby.

In the new method of percentage feeding all this is changed, and we learn to think in percentages, instead of in spoonfuls.

Cows' milk, carefully obtained from a selected herd (not from a single cow whose milk is liable to great variation), is chosen as being the best substitute, on the whole, that we have for mother's milk. These cows are periodically inspected by a veterinary surgeon, subjected to the tuberculin test, for Prof. Koch's views are now quite upset, and we know tuberculous milk is highly dangerous to give to children. Every precaution is observed in obtaining this milk to prevent the entrance of dirt, and with it germs. It is milked through cotton-wool, into sterile pails—at once cooled to 40° F., then at the Dairy Farm bottled in sterile glass-bottles, and sealed with a cardboard disc. There is no sterilising or pasteurising—the milk is sent out in the natural raw condition without any preservatives.

This is the source of the percentage milk; and the Americans, who have done so much in pædiatrics, were the first to originate this idea, and make it possible to write a prescription which shall represent the required strength of the milk, varying its percentage composition at will.

We must steadily bear in mind the percentage composition of human milk, which is the type we imitate—Fats, 4 per cent.; proteids, 1·5 per cent.; sugar, 6 per cent.; salts, ·2 per cent.

Cows' milk differs in many respects from human milk—it has less sugar and more proteid; nor is this all. The proteid differs in character in many important respects. The proteid of all milks is an exceedingly complex body, and not yet fully understood, but there are at least two important bodies in it—lact-albumen and caseinogen. The former is greatly in excess in human milk; the latter in cows' milk. Lact-albumen is in solution and resembles serum albumen. Caseinogen is in suspension, due to phosphate of lime.

The proteid further *behaves* differently. Acetic acid added to human milk causes only small flocculi to form; when added to cows' milk large masses of curd form. Gastric juice or rennet acting on human milk, causes fine flocculent curds; but with cows' milk, large solid curds.

We are all familiar with the fine flocculent, curdy vomit of a breast-fed baby, and the solid masses like casts of the stomach which a child fed on cows' milk will occasionally bring up.

Such, then, are the chief characteristics of the proteid which is by far the most troublesome body to deal with, and the mistakes in infant feeding are usually owing to too high a percentage of proteid being given.

The fat or cream is in the form of an emulsion, and under the microscope minute fat globules are seen. The sugar or lactose is in complete solution. The salts are practically the same in cows' and human milk.

The *proteid*, *fat*, and *sugar*, are the three constituents which we must vary in our prescription. Always *begin* with low percentages, it is easy to go higher; it may upset the baby to start with too high a percentage, and then we lose time by having to begin again; like climbing a ladder, we must begin at the bottom step.

During the first few days of life whey may be quite sufficient for feeding. Its composition is:—Fat, 2 per cent.; proteid, ·8 per cent.; sugar, 4·5 per cent.; salts, ·6 per cent. This even may be too strong in proteid, and a prescription—fat, 2 per cent.; proteid, ·5 per cent.; sugar, 4·5 per cent.—would be safer.

The great advantage of the prescription method is obvious, for we can vary *each* element at pleasure. In the old way if we increased the cream we at the same time increased the proteid, which we might not desire to do; it was impossible to vary *one* element, without at the same time affecting the others.

It may happen the child is vomiting, and this may be due to the fat proving a difficulty—so we reduce the percentage of fat, leaving everything else as before. Here then we know what we are doing. We may almost compare it with homœopathic prescribing, where we administer only *one* medicine at a time. The results that follow are due to the change in this one thing.

If curds appear in the motions, it is desirable to lessen the proteid—this we do then without further change.

The progress a child makes is to be decided by its weight. All babies should be weighed regularly *once* a week under the same conditions, and the weight recorded on a chart. If the child gains in weight, progress is being made, so we very gradually increase the percentages, feeling our way step by step.

In America there are no less than sixteen "Milk Laboratories" as they are called, where milk prescriptions can be made up to the order of the physician, and in London we now have one such Laboratory. The milk thus prepared is sent out in small tubes, each containing the required amount for the meal. These tubes are corked with plugs of sterile cotton wool. They only require to be heated by the nurse to the proper temperature for the child (98° F.), and then the wool cork is removed, and a nipple drawn over the end of the tube, which forms the feeding bottle. Thus there is no pouring the milk from one vessel into another after leaving the Laboratory: there is nothing for the nurse to do but warm it, and give it to the child. These are obvious advantages, and help to keep the milk from the risks of contamination.

In the difficult cases of feeding which we occasionally meet with, prescription feeding may save the life of the child. When we are so situated that a Milk Laboratory is not available, it is possible by working with a milk of known cream strength (*e.g.*, a 10 per cent. or 7 per cent. cream), to so modify the milk as to make it equivalent to various formulæ.

I will conclude by giving brief notes of two of my patients who had previously had every advantage under the old system of feeding, to say nothing of skilful homœopathic treatment, and yet they could not retain the milk offered them, and whose recovery was obviously due to this new method of feeding.

Master C. E. S., aged 7 months, was a bottle-fed baby, suffering from vomiting and diarrhœa. A variety of foods had been tried, and in addition the milk from a cow kept in the paddock. On October 28th, 1902, Dr. Wynn Thomas kindly asked me to see the case with him. We decided to stop all milk and give only wine, whey and *merc. sol.* 12. If vomiting continued, rectal feeding was to be employed. On October 29th he was decidedly better. I saw him again on January 27th, 1903, he had been taking whey ʒj., raw milk ʒj., lime water ʒss. Seven feeds in twenty-four hours. On February 18th I advised prescription feeding, beginning :—

Fat, 2 per cent. Sugar, 6 per cent. Lact-albumen, ·75 per cent. Salts, ·2 per cent.	8 feeds in twenty-four hours. ʒiv. each.

Dr. Thomas then wrote me, since putting baby S. on this percentage milk, he has been making steady progress. On February 23rd the prescription was altered to fat 2 per cent., sugar 6 per cent., whey proteid ·75, caseinogen ·50 ; and again on February 27th, fat 2·5 per cent., whey proteid ·90, caseinogen ·75. The weight of the child on February 20th was 13 lbs. 2 oz. ; on February 24th, 13lbs. 10 oz. ; and this weight steadily increased, and henceforth the progress was uninterrupted.

The next case I was requested to see by Dr. Burford, the three-weeks-old daughter of Lady E. B. The baby had been losing weight since birth. The motions were green like spinach, and sour, four in twenty-four hours. There had been vomiting, but not recently. *Nux. v.* and *merc. sol.* had been given, and subsequently *cham.* 12. The child had been

taking a mixture composed of 2 parts lime water, 3 parts cream, 3 parts milk and 7 parts water. ℥xviii. in twenty-four hours.

The child was very small and wasted. Fontanelles wide open, sutures unusually evident, a small patch of craniotabes on the left side of skull. The whole condition suggested a premature child, and by calculation was probably a week or two premature.

As a result of our consultation, it was decided first to give only albumen water for twenty-four hours, and then to give fat 2·5 per cent., milk-sugar 5·5 per cent., whey proteid ·75 per cent., caseinogen ·25 per cent., eight feeds per diem each of 1½ oz. (December 8th), green stools continuing the proteid was reduced and prescription given, fat 2·55 per cent., milk sugar ·5 per cent., whey proteid ·75 per cent.; and 2 oz. feeds, eight in twenty-four hours. Also *merc. cor.* 3x.; pils ter (December 11th).

On December 15th, Dr. Burford reported decidedly improved, sleeping well, no sickness, motions digested, no mucus or diarrhœa, greenish-yellow or yellow stools.

Another attempt was made to strengthen the proteid per cent., but the stools at once became greener, so the ·75 per cent. was returned to, and during the week the baby gained *14 ozs.* By December 20th there was great improvement, the quantity of the milk was increased to 2½ oz. every two hours. On December 26th the following was given, fat 3 per cent., milk sugar 6 per cent., whey proteid ·75 per cent.; and on January 11th, fat 3·5 per cent., milk sugar 6·5 per cent., whey proteid ·75 per cent., caseinogen ·25 per cent., 3 oz. every two and a half hours.

The progress was subsequently uneventful, and the weight increased steadily. I saw this little patient recently, and she is a very fine child, whose life was saved, I consider, owing to percentage feeding.

CLINICAL CASES.

By E. W. BERRIDGE, M.D.

(*Continued from p.* 164.)

CASE 6.—*Allium cepa.*—December 19th, 1877.—The Rev. A. J., aged between 50 and 60, caught cold during the first week in December, resulting in frontal pain, lachrymation, pain in left eye, weakness, and loss of appetite; for these symptoms he took *sepia.* On 14th he went out of doors in a cold wind. His cold improved, but eye became worse. On 15th had pain and lachrymation of left eye, with running from left nostril; he took *euphrasia* with relief. On 16th, at noon, the pain returned, with water from left eye and left nostril; this lasted till 7 p.m., then ceased. On 17th the symptoms returned, at 12 or 12.30 p.m.; again he took *euphrasia,* and in the evening they suddenly ceased. Yesterday the attack came on at 1 p.m., lasting till 5 p.m., then decreasing. To-day, eye felt nearly well in morning, except photophobia; there had been a little lachrymation during night. At 1 p.m. aching pain came on in left eye and left brow; after thirty minutes, bland lachrymation, heat, and redness of left eye, with running from left nostril; this lasted till 5 p.m., then decreased.

Diagnosis of the remedy.—The periodicity of the symptoms and the time of their inception, were here very characteristic; but the *Materia Medica* contained no *simillimum.* Another aspect of the case had, therefore, to be taken as the keynote or starting-point in the selection of the remedy. There was little characteristic in the symptoms themselves; but in their combination was found the solution of the homœopathic equation: the ophthalmic were conjoined with nasal symptoms.

With coryza; left eye, lachrymation. *Allium-cepa, arsen., aur-mur.* (spirting out), *calc.-sulph., carb.-veg., carbol.-ac., zinc.*

—— redness. *Allium-cepa., arsen., aur.-mur., zinc.*

—— photophobia. *Allium-cepa, zinc.*

The choice now lay between *allium-cepa* and *zinc,* the former of which alone has catarrhal symptoms from exposure to cold wind (79, 80, 403). I prescribed one dose of *allium-cepa* 200 at 6.30 p.m.

December 20th.—No redness, nor return of paroxysm; not the slightest pain to-day till 2.30 p.m., and then very slight; a little lachrymation at times.

December 21st.—No paroxysm, but only a little pain in eye about 1 p.m., and less than yesterday; feeling of lachrymation, and still a little photophobia.

December 24th.—Much better. The eye remained a little sensitive to cold air for a few weeks, but subsequently recovered.

Comments.—(1) This case illustrates the value of concomitant symptoms in the selection of the *simillimum*, but too much importance must not be attached to them. In *Wirkungen des Schlangengiftes*, 1837, Hering says: "Care should be taken not to adopt the notion that a remedy can cure groups of symptoms in a patient only if they occur in the order in which it produces them; it is capable of curing groups which it does not produce in the same combination at all; whose component parts were observed in a number of different provers, and frequently in quite a different order." The comparative value of the concomitants may be determined thus: if they are essentially concomitant, one symptom being really the cause of the other (*e.g.*, lachrymation being caused by a general catarrhal condition), then this feature of the case must be considered; but if no such relation of cause and effect is apparent, the concomitance of the symptoms may be disregarded excepting as it may serve to decide the choice between two or more remedies which equally produce the symptoms of the patient.

(2) The remedy was given when the severity of the paroxysm had passed off. Hahnemann has given no such rule with regard to periodical neuralgia: but in the *Organon*, pp. 236-7, he strongly warns us, in the case of ague, to give only one dose, and that immediately after, or towards the close of, the paroxysm. Analogy, therefore, leads us to observe the same rule with regard to all periodical diseases; and this is an illustration of *progressive* Homœopathy; not building on another foundation than that laid by Hahnemann, but merely adding another stone to the temple, fully in harmony with its original design. In gynæcological cases, unless there are acute symptoms demanding immediate relief, I find it advisable to commence the treatment, or to prescribe a new remedy, just after the menses; I have seen severe medicinal perturbation arise when this rule was neglected.

(3) After the single dose of *allium-cepa*, the pain returned

later, and very much less severe. In the treatment of all periodical diseases, if, after the administration of the remedy, the next paroxysm is later and less severe, it shows that the cure has commenced; also if it comes on earlier and more severe, it is merely a temporary medicinal aggravation, and the remedy must be allowed to act undisturbed, without either repetition or change. This rule I have frequently verified in various forms of disease.

(4) When in India this patient had ague, suppressed by large doses of *quinine*. I have observed that such an occurrence will sometimes impress a periodical diathesis (so to speak) upon the system, so that his various ailments will from time to time manifest this type. Frequently when an accident occurs to a patient who has suffered from ague, especially in tropical climates, and not been radically cured by homœopathy, a fresh attack of ague comes on; in these cases, therefore, a rigor is not necessarily a sign of incipient pyæmia.

CASE 7.—*Cicuta virosa.*—January, 1882.—Mr. H., aged 71, with fatty degeneration of the heart, had suffered for about seven months with right hemiplegia. His case was given up as hopeless by three allopaths, including two West End consultants. They all said he must soon die. By homœopathy I greatly relieved him, so that he could walk a little with support. One of the consultants, on hearing of it, said that "it was simply conjuring," but he never asked me how I "did the trick." Later, the patient, through his own obstinate folly in persisting in going out in a bath-chair when there was snow on the ground and an east wind blowing, and in taking a bath at a temperature of only 96°, contracted a severe bronchopneumonia, from which I again restored him. Toward the end, dropsy of the right leg supervened. A few nights before his decease I was sent for at night. I found him suffering from violent paroxysmal cough, each paroxysm being followed by lockjaw for a few minutes: there was also a new symptom, not manifestly connected with the cough; jerking of the left arm.

Diagnosis of the remedy.—Jerking of left arm. *Calc.-carb., caust., cic., scilla., stramon, zinc.*

Trismus. *Caust., cic., stramon* (with many others which have not the jerking).

Trismus after coughing has not been recorded.

Caust. (1009) and *stramon* (1419) were ruled out, as patient did not have the "crawling like a mouse" of the former symptom, nor the diagonal action, left arm and right leg, of the latter (*calc.-c.* has the same diagonal symptom) (1099).

Cicuta was clearly the *simillimum*; besides "lockjaw" (181), it has "jerking in left arm, so that the whole body is jerked" (355). The latter portion of this symptom had not developed in the patient, but it was simply a question of the intensity of the movement. It has also the variant "Trismus, with teeth tight together." I at once dissolved a few pellets of *cicuta virosa* 1 m. (Jenichen) in water, and ordered a spoonful every two hours till relieved. I visited him the following afternoon, and found he had had a good night, much less cough, and no return of the jerking of arm or the lockjaw. He lingered in comparative ease for a few days, and then passed away quietly in his sleep.

Comments.—(1) This case shows the necessity of carrying the repertory to the bedside. Here was an extreme case, which, unless speedily relieved, would have resulted in an agonising death. An accurate prescription must be made at once; there was no time for delay, or a mistake. But what brain could contain with precision all the remedies which produce and cure trismus or jerking of arms? Many would be known to every homœopathic physician, but it might be a mere accident that he should recollect that *cicuta* thus affected the left arm. The ignorant often sneer at the consulting of books before prescribing. It is not necessary in every case, and the more characteristics the physician memorises, the less frequently will he need to do so, especially in acute cases; but he should always be prepared, for there are often apparently conflicting symptoms, and then it is a difficult and painstaking study to select the *simillimum*. Why should the homœopathic physician be reproached because he cannot remember the voluminous symptoms of the ten quarto volumes of the *Encyclopædia*? Does not the judge often reserve judgment, and the barrister bring his law-books from which to prove a precedent? Can the most learned bishop accurately quote all the Biblical verses which contain the word "faith," with the context in every case, without reference to "Cruden's Concordance"? Why should

the homœopathic physician be debarred from a similar practice?

(2) It has been asserted that though homœopathy suffices in curable cases, narcotics and anæsthetics are needed for the relief of those incurable. But surely to cure is a greater work than to palliate; and if homœopathy can accomplish the greater, why not the less? My own experience has always been that in incurable cases a strict adherence to homœopathy will do far more to relieve suffering, and procure euthanasia, than will any allopathic palliatives, only in these cases the curative action of the remedy is very speedily exhausted, and, if the patient lingers long, a fresh remedy has to be frequently selected, according to constant recurrence of symptoms in a new form.

(3) This case adds an important symptom for verification: "lockjaw after coughing."

(To be continued.)

CASE OF INFLUENZAL PNEUMONIA FOLLOWED BY CIRRHOSIS OF THE LUNG.

REPORTED BY DR. C. OSMOND BODMAN.

W. M. K., aged 13, came under treatment at the end of the first week in December, 1905, for influenza. On the 9th he first complained of a pain in the right side of the chest, with a short, dry cough; hurried and catching respiration. The temperature was 102°; examination of the chest revealed some deficiency of resonance in the right axillary region, with prolonged expiratory murmur and pleuritic friction sound. *Bry.* 3x and *phos.* 3 alt. were prescribed.

Two days later there was definite dulness of the right side of the chest below the fourth rib, with other signs of pulmonary consolidation.

On the 13th the temperature rose to 104.4°, pulse 132, and respiration 44; the area of consolidation now reached the level of the third rib, signs of fluid in the pleural cavity were detected anteriorly, and the apex beat of the heart was displaced outwards. The sputum was now blood-stained and raised with difficulty. *Phos.* 3 and *sulph.* 3 alt.

Two days later, again, pain, cough, and expectoration were all decidedly less; the apex beat was now in the nipple line,

but a small area of consolidation appeared at the angle of the *left* scapula. The tongue was covered with a thick white coat. *Ant. tart.* 3x was substituted for *phos.*

On December 20th the whole of the right lung, with the exception of the apex, appeared to be consolidated, with a small collection of fluid in the axillary region; there were also definite signs of consolidation of the base of the left lung. The temperature from this time tended to become rather lower, but assumed a somewhat hectic type, while the pulse and respiration remained accelerated. *Iod.* 3x, with a dose of *calc. c.* 30 every evening.

A week later, the physical signs in the chest were noted as much the same. An offensive diarrhœa set in, with some abdominal distension. The expectoration again contained blood, and there was a good deal of sweating. The superficial veins of the right side of the head and chest were observed to be enlarged. *Stann. iod.* 3x was ordered by day.

On January 14th the temperature, though lower, still rose to about 101° every evening, the stools were inclined to be too loose and frequent, and the sputum was now purulent and very offensive. The percussion note over the right lung was now high-pitched, with bronchial breath sounds and moist crepitations; at the base there was cavernous breathing. *Pyrogen.* 6 was now ordered.

Under the influence of this medicine the patient made steady improvement, the temperature becoming almost normal. The pulse rate fell, and diarrhœa disappeared; expectoration became less and lost its offensive odour. *Ars. iod.* 3x was prescribed.

The patient gradually lost his cough and regained strength. Subsequent examination of the chest indicated that the right lung had become completely atrophied and shrunken, there being very little air entry, while the left lung had undergone compensatory hypertrophy.

The case is of interest as affording a somewhat unusual result of influenzal pneumonia, the condition probably passing into fibroid pneumonia, followed by complete cirrhosis of the lung. The case, though at one time desperate and almost hopeless, made remarkable progress under homœopathic medicines (the effect of *pyrogenium* being especially marked), and recovery of the patient took place, though with loss of function of one lung.

POISONING BY DOAN'S BACKACHE PILLS.

IN May, 1906, I was sent for to see a servant girl, aged 22, who was thought to be suffering from measles.

In the previous March she had been attending as an out-patient for pains in the back, but after getting well she had a return some five weeks later, and seeing an advertisement that Doan's Backache Kidney Pills was a prompt and effectual remedy for all backaches, she got a box. On the directions it says, "one pill after each meal and one at bedtime; continue this dose for two days, and then take two pills after each meal and two at bedtime, and don't miss a day. If the case is of long standing, the dose may be increased to three at a dose. They cannot injure though the dose be larger than this." The patient took two pills on Thursday, two on Friday and two on Saturday. On Sunday morning a rash appeared, first on the arms and hands, and later on the legs and feet, chest and abdomen. When I saw her on the following day the rash was less marked, but still present as above stated, red, raised, mottled urticaria, the hands both much swollen and red up to the wrists, those becoming blotchy, the patches becoming more distinct towards the elbow, the upper arms almost free. The feet were so swollen and tender that she was unable to walk; she was kept awake all the previous night with itching and smarting. She also had moderately severe headache, giddiness and faintness on sitting up, sight cloudy, and on trying to read the words ran into each other; objects looked blue as if she were looking through blue glass. Bowels acted normally once daily, and there was no alteration in the urine. I ordered her a dose of liquorice powder, and mixed her some *apis* 3x to be taken every two hours. The following day the rash had almost gone, though the feet were still painful on standing. The next day she was up and doing her work.

I obtained a pamphlet that is sent out with the pills, and find it stated "some cases have been known where the poisons and impurities have been driven out through the skin in the form of a red rash, but it was one of the best results that could happen. The poisons had been gathering in the system for years, and the patient would never have had relief had they not

been removed. In such a case don't stop taking the pills, but take one only after each meal." Needless to say my patient threw the rest away.

CARIES OF OS CALCIS.

T. G., aged 13, came up to the Hospital with pain and swelling of outer side of right heel, no redness, but tender to pressure. Admitted October 22nd, 1905.

Temperature 102°, pulse 96, ordered *bell.* 1x, *hepar sulph.* 3x, alternately every two hours; the foot was put on a splint.

October 26th.—A free opening was made and drainage tube inserted, pus flowing freely.

October 30th.—Temperature now normal, no pain, but discharge free. *Hepar. c.* 3x, 4 *in die.*

November 8th.—Temperature rising, the opening was enlarged and bone scraped. *Silic.* 30, 4 *in die.*

January 5th, 1906.—Swelling appeared on inner side. This was opened and a drainage tube put through from one side to the other.

January 15th.—*Calc. phos.* 3c and *tuberculii* 30, one dose every alternate day.

January 22nd.—*Silic.* 30, three times daily; leg and foot put up in Plaster of Paris.

February 5th.—Foot no better; a large opening was made on the inner side and the greater part of the os calcis was gouged out, leaving practically a shell of bone only; the cavity packed with iodoform gauze, a strip hanging out on each side.

April 1st.—Steadily improving, much less swelling and discharge lessening. *Silic.* 30.

April 27th.—The foot still in plaster; discharge almost stopped; sent to Margate Sea Bathing Hospital. Had been getting about on crutches with a patten on sound foot.

August 1st.—Stayed at Margate two months, on return still a little discharge, but gets about.

October 1st.—Foot sound.

December 1st.—Walks without crutches, heel quite well, wears a pad in boot as the right sole is flat.

The result is very satisfactory, as at one time the question of amputation was seriously discussed.

EMBOLISM OF RIGHT BRACHIAL ARTERY.

S. J., aged 45, a laundry woman, was being attended as a home patient for bronchitis, when suddenly during the evening of February 9th was seized with intense pain in the right elbow and inner side of the arm, the forearm and hand becoming numb and cold. When I saw her an hour later the hand was stone cold and devoid of feeling, although not paralysed, for she could lift it and move the fingers; no pulse could be felt in the radial artery either then or since, though the artery can be distinctly felt, being a thin woman. No pulse could be felt below the axillary artery.

The patient was kept in bed for a week, the arm and hand wrapped in flannel with a hot bottle. *Arnica* 3c was given for the first three days, and since *hypericum* 3c t.d.s. After the first twelve hours the pain was much less, but only gradually got better during the week, and was always increased if the arm was exposed. The feeling gradually returned in two or three days, and now, four weeks later, with the exception of feeling of weakness, the arm seems all right.

The patient had rheumatic fever at 20 years and again at 25, but though she gets rheumatism in the winter months has not been laid up since. She has marked valvular disease of the heart, and when the attack came on had just ascended a flight of stairs; she tells me she had often felt her pulse beating in the right wrist before the seizure. H. W. T.

CLINICAL CASES FROM THE PRACTICE AT THE LONDON HOMŒOPATHIC HOSPITAL.

PERNICIOUS ANÆMIA.

BY BYRES MOIR, M.D., AND FRANK A. WATKINS, M.R.C.S., &c.

UNTIL within recent years it was generally accepted that progressive pernicious anæmia was of idiopathic origin, although it could be demonstrated that striking and peculiar changes were present in the blood and marrow. It was at the same time allowed that such general causes as insufficient food, bad hygiene, repeated hæmorrhages and prolonged diarrhœa could act as excitants, but that they were insufficient to produce the result.

This view has since been very considerably modified, when it was established by observation and experiment that certain chemical substances, gastro-intestinal toxins, intestinal parasites, &c., were capable of initiating the pathological lesions and general clinical features peculiar to pernicious anæmia.

At the present day it is no longer insisted that there is a cryptogenic factor in the etiology of the disease, or that the disease necessarily follows a fatal course. The essential process in the disease is a reversion of the marrow to a type of blood formation which in some respects resembles the embryonal.

Our reason for contributing this short paper is to illustrate the fact that whilst the disease is generally easily recognised by certain well-defined signs and symptoms, yet one occasionally meets with a case where most of these are absent, and consequently the diagnosis cannot be placed beyond doubt until an autopsy has been made. In pursuance of our purpose we proceed to give an extract of the clinical notes of a patient who was recently admitted into the Hahnemann Ward under the care of one of us (Dr. Moir), and the blood examinations and the autopsy were made by the other of us (Dr. Watkins). The clinical notes were made by Dr. H. L. Deck.

"J. S., aged 52, engineer, admitted into the London Homœopathic Hospital on November 30th, 1906.

"Previous to admission he had been attending as out-patient under the care of Col. Deane, his history being that three years ago he began to be subject to attacks of vomiting two or three hours after taking 'greasy food.' This vomiting had been completely relieved for twelve months by mixing Fairchild's powders with his food. He came to the Hospital complaining that he had been losing the power in the limbs during the last six months, the trouble beginning in the legs with a sensation that the ground felt very hard under his feet. After attacks of vomiting he said that a numbness and weakness would travel down his legs into the soles of his feet. He noticed at this time that he very readily became fatigued; he was very anæmic and suffered much from anorexia. He improved considerably under treatment until the end of November, when the vomiting became persistent and he was admitted into the Hospital.

"*Present condition.*—Patient is emaciated, very anæmic, and in a feeble condition. He complains of pains in legs, stiffness in knees and ankles, and has very little power in the legs when he stands up with arms hanging by side, and if the numbness be present, the anæsthetic level in arms is about the same as in the abdomen. Sensation in the soles of the feet is poor; sensation of touch is quite correct. Gait is unsteady; left knee-jerks somewhat sluggish. The pupils are equal and react to light and accommodation; no incontinence of urine or fæces. No abnormal physical signs were found in chest and abdomen, except some retraction of the left rectus over the gastric region. He frequently vomits bile-stained food, the vomiting occurring at any time.

"On December 4th the blood condition was as follows: Hæmoglobin 30 per cent.; red cells 1,800,000 per cmm.; white cell 9,555 per cmm.; colour index 0·83; differential count of white cells, polymorphonuclears 81 per cent.; lymphocytes (small) 14 per cent; large lymphocytes 5 per cent.; eosinophiles 0 per cent.; the red cells are very much misshapen (poikilocytosis) and variable in size, although no abnormally large ones were observed (megalocytes); no nucleated red cells were found (normoblasts and megaloblasts).

"Subsequently the hæmoglobin and red cells became further reduced, and on January 7th their condition was as follows: Hæmoglobin 15 per cent; red cells 910,000 per cmm.; colour index 0·82; no myelocytes nor nucleated red cells were found.

"The temperature during this time generally fluctuated between 98° and 99° F., but on occasions reached 101° and even 102.5°.

"The body weight remained practically stationary at 9 stone.

"At intervals the vomiting was troublesome; the weakness became more pronounced; the complexion of the face assumed the 'lemon' tint, and the patient gradually sank six weeks after admission.

"An autopsy was made on January 14th. The body was much emaciated, the abdominal parietes containing very little adipose tissue. The left pleura was adherent at the apex, and a small quantity of clear serum was contained within the

boundaries of the adhesions, being shut off from the general pleural cavity. Both lungs contained a quantity of serous frothy fluid. The heart was devoid of adipose tissue, looked pale and flabby; the endocardium showed 'tabby-cat' striation, and there was some thickening of the mitral valve. The abdominal viscera were very pale but otherwise looked normal, with the exception of the left kidney, which showed considerable fatty degeneration.

"The spleen appeared to be normal. The intestine was searched for worms but none were found. The marrow in the shaft of the left humerus was quite red.

"Microscopic section of the marrow showed advanced megaloblastic metaplasia of the lymphoid marrow. Fat cells being almost entirely removed."

The diagnosis was mainly arrived at by the process of exclusion. The cardinal features of the complaint consisted of a profound increasing anæmia, attended by attacks of vomiting and certain disturbances of the nervous system, which latter were apparently evoked entirely by the severe anæmia. The altered appearances of the blood corresponded to those usually associated with severe secondary anæmia.

The perusal of the above clinical notes shows that there was no history of any exciting cause, such as mental shock, emotional disturbance, persistant diarrhœa or repeated hæmorrhages; instead of the usual preservation of the body weight, there was marked emaciation; the usual "lemon" tint of the face did not make its appearance till late in the course of the disease; and there were no petechial hæmorrhages.

The blood examination revealed the fact that though the red corpuscles were very much reduced in numbers, yet the individual corpuscles contained less than the normal amount of hæmoglobin, and this was expressed by the colour index of 0·83. It is usual, but not invariably so, to find that the colour index reaches a fraction above a unit. Myelocytes, megalocytes, normoblasts and megaloblasts, were all absent. When these are present they afford valuable evidence in forming a diagnosis. Eosinophiles were also absent; when present in excess they have indicated the presence of intestinal parasites; anthelmintics administered have been followed by the expulsion of worms (bothriocephalus latus and ankylostoma duodenale), and rapid recovery of the patient.

Hospital Reports.

*** The Editors request that all correspondents will kindly condense their reports as much as possible, consistent with a smooth and effective rendering of the facts they wish to convey. Items of *merely local* interest should be omitted.

As there seems to be some misunderstanding in regard to this section, we would point out that there are two kinds of matter wanted for it—

(1) News, reports of meetings, &c., which must be compressed into one, or at the most two, paragraphs of not more than ten or twelve printed lines.

(2) Reports of interesting cases occurring in Hospital or Dispensary practice, new methods of treatment, and all purely professional matters. These should be carefully, or, if needful, elaborately recorded and described. Each contributor will be allowed two pages of the REVIEW every month for this purpose.

Newspaper reports, unabridged, need not be sent. Such reports must be compressed and will come under (1) above, otherwise all such newspaper and unabridged reports will be laid gently, but firmly, to rest in the waste paper basket.—EDITORS, *B.H.R.*

LONDON HOMŒOPATHIC HOSPITAL.

FIFTY-SEVENTH ANNUAL GENERAL MEETING.

THIS meeting of the Governors, Subscribers, and Donors of the Hospital was held on Tuesday, February 26th, at the Hospital. Earl Cawdor, the Treasurer, was in the chair, and there were present the Rt. Hon. Earl Dysart, Sir Benjamin E. Cohen, Sir Henry Tyler, Mr. John Stilwell, J.P., Mr. Chas. Stewart, Rev. C. C. Bedford, Mr. and Mrs. Tilson, Miss Olive Bryant, Mr. C. Whateley Willis, Miss Burney, Rev. Brown Gold, Mr. W. Brackett, J.P., The Lady Hope, Mr. Wm. Willett, Mr. W. H. Trapman, Miss Petrie, Mrs. Hoyle, Mr. Torrens-Johnson, and several other friends of the Hospital, besides many of the Hospital Medical Staff. Letters of regret at non-attendance were read from the Earl of Wemyss and March (President), the Earl of Essex, the Earl of Donoughmore, General Sir Stanley Edwards, General McLaughlin, Major Flood Page, Captain Cundy, Mr. R. H. Caird, J.P., &c.

Mr. Atwood, Secretary, read the report, and the Chairman (Earl Cawdor) moved its adoption (seconded by Mr. J. P. Stilwell, J.P.) in a speech setting forth the past achievements and the present and future needs of the Hospital. He especially dwelt on the projected extension of the building, for which a sum of £30,000 is required to be raised by the end of the year, and towards which Sir Henry Tyler has promised £10,000, and

Lord Dysart £2,000. The Lady Hope then, in an eloquent speech, proposed a vote of thanks to the "Board of Management and House Committee, Treasurer, Vice-Treasurer, Lady Visitors, and Lady's Guild," which was seconded by Dr. E. A. Neatby. After re-electing the President, Vice-President, the retiring members of the Board of Management and the Medical Staff, with the confirmation of Mr. James Eadie and Mr. Granville Hey as Assistant Surgeons, and Dr. C. E. Wheeler and Dr. C. E. Ham as Assistant Physicians, and after adopting the eighteenth report of the Homœopathic Convalescent Home at Eastbourne, the meeting was brought to a close in according a hearty vote of thanks to the Chairman, Earl Cawdor.

THE REPORT.

The year has been a record one with regard to the number of patients, the in-patients numbering 1,183, an increase of 51, and the out-patients 25,626, an increase of 528. The income is £215 over that of the previous year. Though legacies show a falling off there is an increase in the donations, in the subscriptions sent through the Ladies' Guild, and in the contributions from patients. The expenditure, £8,059, thanks to the expenditure committee, has been reduced to the lowest possible, and each out-patient now costs on an average 1s. 6d., and each in-patient 31s. 6d. a week, the average cost of each occupied bed being £81 6s. 5d. The Ladies' Guild has extended its activities by the establishment of a new branch at Westcliff-on-Sea, by Dr. Percy Ross. Mrs. Perks has again consented to act as President of the Executive Council of the Guild. The Medical Staff suffered a great and unexpected loss in December last, by the sudden death of Dr. J. R. P. Lambert, who had been connected with the Hospital since 1893. During the past year a new pathological department for original research purpose has been started, and among the investigations carried out is one as to the value of the "Opsonic index." A legacy of £200 was bequeathed to the Hospital by the late Mr. Alfred James Woodhouse for special research in connection with cancer and other diseases.

The increasing work has rendered the present accommodation of the Hospital insufficient, and the Board of Management are appealing for a sum of £30,000 for building extension. Of

this sum £13,725 has already been promised, including the handsome donations of Sir Henry Tyler (£10,000) and Lord Dysart (£2,000), leaving the large total of £16,275 to be collected before December 31st of this year. The Board earnestly appeal to all friends of the Hospital and of homœopathy to do their best to ensure that this sum may be obtained.

LONDON HOMŒOPATHIC HOSPITAL.

AT a meeting of the Board of Management of the London Homœopathic Hospital, Great Ormond Street, Bloomsbury, on the 14th inst., Miss Clara Hoadley was elected Matron in succession to Miss Victoria Daunt, who has been appointed Matron to the Great Northern Central Hospital. Miss C. Hoadley was one of a large number of applicants and was trained at Guy's Hospital and holds the silver medal of same. In December, 1898, she was appointed Assistant Matron to the Royal Infirmary, Preston, after two years' service she was successful in obtaining the post of Lady-Superintendent and Matron to the Royal National Hospital for Consumption of Ireland, which she resigned in 1904 to take up the matronship of the Coventry and Warwickshire Hospital, which she now holds.

BIRMINGHAM.

WE very much regret to have to announce the critical illness of our much-esteemed colleague, Dr. J. Wingfield, of Moseley. He was suddenly seized on March 7th with a virulent attack of appendicitis, which rendered an operation imperative the next day, and the latest news to-day (March 11th) is that he is still in an extremely precarious condition.

It would not be exaggerating to say that Dr. Wingfield is the most thorough Homœopath in the Midlands, and we most earnestly pray that he may be soon restored to health.[1]

CASE 1.—An unusual case of sarcoma of the skin. Mrs. E. B., aged 60, was admitted to the Birmingham Homœopathic Hospital on January 31st, 1907. Eighteen months previously she noticed several small white hard nodules on the skin of the anterior surface of the right thigh. There is no history of traumatism.

[1] We are glad to hear on going to press that Dr. Wingfield is now making steady progress towards recovery.

Some of the nodules began growing rapidly three months ago.

On admission, patient has a rather hard pedunculated growth about the size of a hen's egg, attached to the skin in front of the right thigh. It is red, and the skin over it slightly ulcerated and bleeding easily. The growth is attached to the skin with rather a broad neck.

A little above this, there is another hard lump about the size of a marble and closely resembling a keloid which has undergone vascularisation.

Immediately internal to the pedunculated mass is a bunch of small, hard, whitish nodules.

All these masses are painless and appear to grow from the skin only, though in connection with the largest of them an indurated strand appears to connect it with the cutis vera.

No enlargement of any glands in the groin can be felt.

Apart from this the patient has always enjoyed good health.

Operation.—Dr. Pardhy excised the growths with about two inches of the surrounding skin.

It was connected only with the deeper layers of the cutis vera, and did not extend to the subjacent structures.

Microscopically, a section of the removed growth shows large spindle cells with many newly-developed blood vessels, and in part granulation tissue due to cutaneous ulceration.

The patient made a rapid and uneventful recovery. (For the notes of this case I am indebted to the House Surgeon, Dr. K. M. Pardhy.)

CASE 2.—A case of protracted albuminuria following influenza; recovery.

H. C., aged 32, clerk, presented himself at the Out-Patients' Department in October, 1906, with the following history: His health had been fairly good until he had an attack of influenza in April, 1905. During the course of this, he noticed that he was passing blood with his urine. This condition lasted a few days only, but his health remained at a very low ebb, and his doctor (allopathic) told him he was suffering from Bright's disease and put him on a rigid milk diet, which he had faithfully adhered to until he came as an out-patient. He then said that his doctor had told him that he could do nothing more for him, and that no one else could, either. He had

come to us as a *dernier ressort.* In appearance he was a fairly well-nourished, pale-looking man, who said he was suffering from Bright's disease. He was very depressed, and was evidently under the impression that he was a doomed man.

His urine contained abundant albumen.

He was told to give up his absolute milk diet, and to take boiled fish, chicken, fat bacon, green vegetables, stewed and raw fruits, &c., in addition he was given *terebinth* 3x *t.d.s.*

In a fortnight there was obvious diminution in the quantity of albumen, rept. *terebinth.*

By the end of November there was a mere trace only, but he still felt very depressed and easily tired, and he was given *ars. alb.* 3x *t.d.s.*

At Christmas he felt very much better, there was no albumen, and his appearance had undergone a marked change for the better, but, unfortunately, he yielded to the temptations of the festive season, with the result that on January 1st there was again a distinct trace of albumen in his urine. *Terebinth* 3x *t.d.s.*

In seventeen days the albumen had again disappeared, and there has been no recurrence up to the present date, March 11th, when he announced his intention of taking a specimen of his urine to his former medical man, and pointing out the virtues of Homœopathy.

Throughout, the only medicines used were *terebinth* 3x and *arsen. alb.* 3x.—A. A.

HASTINGS AND ST. LEONARDS HOMŒOPATHIC DISPENSARY.

Annual Meeting.

Hon. Consulting Ophthalmic Surgeon, C. Knox Shaw, Esq., M.R.C.S., L.R.C.P.; Ophthalmic Surgeon, W. Clowes Pritchard, Esq., B.A., M.R.C.S., L.R.C.P.; Assistant Ophthalmic Surgeon, W. E. Falconar, Esq., M.B., B.S.; Physician, Percy Capper, M.B.; Surgeon, Frank Shaw, Esq., M.R.C.S.; Assistant Surgeon, E. D. Shirtliff, Esq., M.R.C.S., L.R.C.P.

The twenty-seventh Annual Meeting was held at the Dispensary on Saturday, February 9th, J. C. Burrell, Esq., of Blacklands, occupying the chair.

The Report, read by F. I. Sawyer, Esq., the Hon. Secretary,

was a most encouraging one, a brief cutting from which—"the Committee feel satisfied that during another period of twelve months the main purpose for which the Dispensary was established has been increasingly fulfilled"—shows the full appreciation of the work accomplished. A glance at the following table will show at once the great increase in the amount of work during the last three years :—

Summary of cases :—

	1904	1905	1906
Medical and Surgical	559	719	763
Ophthalmic	576	887	1,041
Dental	25	50	75
Patients visited at home	63	70	73
Total number of Patients	1,223	1,720	1,952
Total number of Attendances	5,973	6,247	6,420

The above we consider a most satisfactory state of things, especially as the patients are supposed to pay a small sum for their medicines, and also that there is an Allopathic Hospital and a separate Dispensary where patients are attended free, and no charge is made for medicine.

If the total number of attendances at the Buchanan Hospital be added to those of the Dispensary, we have a gross united total of 15,353—surely a total that any provincial town might well be proud of ! and what has been accomplished here can be done elsewhere. May the time soon come when in many towns in England this number is surpassed; then, and only then, will Homœopathy begin to take its proper place !

BUCHANAN HOSPITAL, ST. LEONARDS-ON-SEA.

Annual Report.

Hon. Consulting Surgeon, C. Knox Shaw, Esq., M.R.C.S., L.R.C.P.; Hon. Consulting Obstretric Physician, E. A. Neatby, Esq., M.D.; Hon. Surgeons, Frank Shaw, Esq., M.R.C.S.: W. Clowes Pritchard, Esq., B.A., M.R.C.S., L.R.C.P.; Assistant Physician, W. E. Falconar, Esq., M.B., B.S.; Assistant Surgeon, E. D. Shirtliff, Esq., M.R.C.S., L.R.C.P., L.S.A.; Hon. Dental Surgeon, J. R. Richards, Esq., L.D.S.

During 1906 the work at the above Hospital shows steady increase. There have been 246 patients admitted to the

General Wards, 28 to the Private Wards, and in the Out-Patients' Department there have been 1,276 separate cases, 996 renewals, and 8,933 attendances. The whole of the work has been accomplished by the Honorary Medical and Surgical Staff.

During the year 304 operations have taken place without a single mortality, a fact which we are very thankful to record, considering there have been 15 major abdominal operations, including one severe case of extra-uterine fœtation.

This year the ladies of St. Leonards and Hastings have started a Linen Guild, which promises to be a most helpful organisation.

The total yearly income has amounted to £1,523 3s. 11d., and the expenditure £1,412 11s. 6d., leaving a credit balance of £110 12s. 5d.

For this excellent state of things we are heartily thankful.

FOLKESTONE HOMŒOPATHIC DISPENSARY.

WE have received from Rev. A. L. Innes, the Honorary Treasurer, the sixteenth annual report of the above Institution, which is doing a useful work in Folkestone. During the year 417 patients attended the Dispensary, and thirty were visited at Home. This involved 1,937 consultations and seventy-five visits. The patients are admitted by subscriber's tickets or by their own payments, and by these means, by payments accruing from a Provident Department, and from subscriptions collected by the Ladies' Guild, we are pleased to see that the Institution pays its way and commences a new year free of debt.

LEAF HOMŒOPATHIC HOSPITAL, EASTBOURNE.

THE Vicar of Christ Church (the Rev. Alfred Allen), who has joined the committee, presided at the nineteenth annual meeting of the subscribers to the Leaf Homœopathic Cottage Hospital, which was held on Saturday afternoon, February 23rd, at four o'clock, in the Mayor's Parlour at the Town Hall. The attendance included Mr. Robert Carr Lambert, J.P. (Hon. Treasurer), Mr. Edward Barrett (Secretary), the Rev. W. T. Turpin, the Rev. C. B. Cooper, Dr. A. H. Croucher, Mr. George Saxon, Mr. Carlos Crisford, Mr. J. H. Haine, Mrs. Allen, Miss

Probart, Miss Bevis (Matron), Miss Margaret Nash, Miss Garvock, and Miss J. B. Forster (Nurse).

The year's work was considered eminently satisfactory, and the Hon. Treasurer was able to report a credit balance. A Ladies' Guild is in process of formation, from which great help is anticipated. The Chairman spoke in a very appreciative manner of the work of the hospital.

A hearty vote of thanks was passed to the Mayor (Alderman Henry W. Keay, J.P.) for granting the use of the Mayor's Parlour and for his services in organising the Hospital Sunday Collection on the sea front. The proceedings then terminated.

PLYMOUTH.

THE Mayor (Mr. J. F. Winnicott) presided at the annual meeting of the Devon and Cornwall Homœopathic Hospital, held at the Athenæum on February 13th.

Mr. Senior, the Hon. Secretary, read the forty-seventh annual report:—"During the year 203 in-patients were received. The number of operations was 197, the surgical dressings numbered 7,923, while the accidents brought to the Hospital were 958. In the out-patients' department 1,201 patients visited the dispensary 4,040 times; also 118 patients too ill to attend at the Dispensary received from the hon. medical staff 401 visits at their own homes."

Mr. W. Lewis, Hon. Treasurer, presented the financial statement, which showed that the annual subscriptions for the year had been £268 15s. 2d., £1 more than received last year. The Hospital Saturday street collections, envelope appeals, employees' contributions, and boxes, amounted to £159 13s. 10d.; receipts from the Working Men's Committee, £156; and Hospital patients and private nursing fees, £40 18s.; and dispensary, surgery, accident ward, and entrance boxes, £69 13s. The balance due from 1905 was £69 4s.

Dr. Wilmot presented the medical report of the number of cases dealt with at the Hospital, and the nature of many of them.

The Mayor, in moving that the reports be adopted, printed, and circulated, said he recognised the Homœopathic Hospital as one of the most important of the many institutions promoting good health in Plymouth. The report was of the most

satisfactory character, and must appeal with force to the people of Plymouth to give their moral and material support to the Hospital.

Rev. W. K. Burford, who seconded, said there was urgency for the great scheme of extension they had in mind. The Hospital was doing a splendid work, but they did not want it to be stationary.

The resolution was unanimously adopted.

Mrs. George Fox, of Falmouth, moved that the best thanks of the meeting be given to the hon. medical staff, hon. dentist, hon. auditor, and to the officers and committees, for their services during the past year, and that the committees be re-elected. Mr. W. Webber seconded, and the resolution was agreed to, Dr. Newbery returning thanks.

Mr. H. M. Adams proposed :—"That a hearty vote of thanks be given to the Homœopathic Hospital Working Men's Committee for their valuable help and services during the past year; also to those employees of workshops, factories, and firms, who aided the work of the Hospital by their contributions." The Working Men's Committee, he said, did everything with an unselfish motive. Mr. W. J. Vickery seconded, and hoped that a big effort would be made to get the funds for the new wing of the Hospital. The resolution was agreed to, and Messrs. J. Loome and W. Martin replied.

Dr. Newbery proposed :—"That this meeting, having heard of the growing increase in the work of the Homœopathic Hospital during the past years and continued during the present year, and fully recognising the inadequate accommodation of the present building for the work being done, believes that the time has arrived when an effort should be made to extend to the adjoining premises, 16, Lockyer Street, to meet the pressure on the Hospital, and rejoices that of the £2,500 required for the extension £700 has been subscribed, thus leaving £1,800 still to be raised. An earnest appeal is made to the public for liberal contributions towards this necessary extension." Mr. S. Ball seconded, and the resolution was carried.

The Mayor was heartily thanked for presiding, on the motion of Mr. Moulder, seconded by Mr. Hambly.

W. F. H. N.

Correspondence.

To the Editors of THE BRITISH HOMŒOPATHIC REVIEW.

DEAR SIRS,—*A propos* of my little article in THE BRITISH HOMŒOPATHIC REVIEW for this month on "Aural Vertigo and Tinnitus," and the remarks therein on the action of *salicylate of soda* in Menière's disease, your readers may be interested to know that, in the *Laryngoscope* for October, 1906, Heinrich Haike reports on the action of poisonous doses of that drug in a number of animals. These died in convulsions, and *hæmorrhages were found in the middle and internal ears*, with changes in the nerve cells of the cochlea and semi-circular canals.

Our provings of *salicylate of soda* have elicited the subjective symptoms only of Menière's disease, but it is interesting and instructive to note that when pushed to its ultra-physiological effects, it is capable of producing a result similar to the pathological condition usually associated with that disease.

Thus the symptomatology of our drugs not only guides to their selection for the purposes of therapeusis, but serves to indicate the pathological direction in which they act, and the structural alterations or lesions they are capable of producing.

I am, dear Sirs, yours faithfully,

A. SPEIRS ALEXANDER.

"A NOTE ON OPSONINS."

To the Editor of THE BRITISH HOMŒOPATHIC REVIEW.

SIR,—Many persons, both lay and professional, will be just now asking the meaning of this latest medical novelty.

In *Wright's Medical Annual* for 1907, in an interesting and up-to-date article upon "Opsonins and Vaccine Inoculations," we are told that these substances are called opsonins from the Greek *opsono*, "I cook for table," "I prepare pabulum for."

I trust it will not be thought pedantic on my part if I point out that there is no such verb or word as "*opsono*" in Greek; and that the name appropriately given to these substances by Professor Wright is from ὄψον, meaning (1) boiled meats, (2) anything eaten with bread to give it a relish, (3) sauce, flavouring, or rich food.

The word ὄψον (opson) is a substantive derived from the

verb ἕψω (hepso) "to boil"; when used of metals, to smelt, to refine. Whereas this *verb* is found no further back in old Greek literature than Pindar's Odes, the *substantive* ὄψον is used in the Iliad and in the Odyssey of Homer.

Wishing all success to the BRITISH HOMŒOPATHIC REVIEW,
I remain, yours truly,

JNO. MURRAY MOORE, M.D.

Priory House, Leamington.
March 16th, 1907.

Foreign Reports.

GERMAN HOMŒOPATHY IN THE YEAR 1906.

BY DR. B. KRANZ, OF HOMBURG AND DAVOS.

THE year 1906 signifies for German Homœopathy again an important progress in its development. It has been a year of diligent work in literature and practice, and if the number of German homœopathic physicians has not increased so much as our cause deserves, it is an indisputable fact that in Germany Homœopathy gains ground. Notwithstanding, this past year had brought much hostility. We mention only the names of Professor v. Hausemann, Berlin; Professor Schwalbe, Berlin; Professor Harnack, Halle; Professor Schwalbe, Heidelberg; who all took the field against Homœopathy in a more or less passionate manner. The columns of our Homœopathic journals had often to be filled with rejections and reprimands. A remarkable exception was given by the editors of two Allopathic journals, the *Aerztliche Rundschau* and the *Aerztliche Mitteilungen*. The *Aerztliche Rundschau* published a correct and just critique on a book of our colleague, Dr. Heppe, on "Allopathie, Homœopathie, and Isopathie," and later a paper of Dr. Heppe on a similar subject. In one of the latest numbers of the same journal we find an ingenious article, covering fifteen columns, by our well-known colleague, Dr. Schleyd, Tübingen, on "The Homœopathic principle in Common Therapeutics and its representation by Paracelsus" (cf. *Aerztl. Rundschau*, 1907, nro. 3, Jan. 19, 1907, and *Allgemeine Homœopathische Zeitung*, vol. cliv., nro. 7 & 8). The same impartiality appears in the *Aerztliche Mitteilungen*, the official organ of the Association of German Physicians.

In this journal we read the following critique: "Homœo-

pathy, a Word of Defence and Explanation," by Dr. Karl Kiefer, Nürnberg.

"This publication is provoked by a paper of Professor Kunkel in the *Münchener Medizinische Wochenschrift.* Kunkel had formulated the following theorems as integral parts of Hahnemann's doctrine: (1) Diseases are dynamic disturbances of the intellectual vital power. (2) The causes of the diseases are not material. (3) Cures of diseases by vital power do not take place. (4) Diseases are cured by the physicians causing a drug-disease. (5) An important part of Hahnemann's doctrine is his so-called Potency-theory. The author attempts, in contrast with these assertions of Kunkel, to point out the position of the present homœopathic physicians. He appeals to the thesis of Dr. Wolf in the year 1836, in which he asserts that the works of Hahnemann can no longer be regarded as an expression of the point of view of present Homœopathy. The author protests against the imputation that the homœopathic physicians have different views from the other physicians as respects Hygiene, Diagnostics, Pathological Anatomy, and Surgical Technics."

The two schools are only divided by the theories as to how diseases should be treated. Kiefer also defends the homœopathic physicians against the assertion that they reject the results of toxicology and the observations at the sick bed. Further, he explains the principle of *Similia similibus curantur* by giving several examples. The doctrine of potencies he bases especially upon the dogmas of Prof. Arndt and Prof. Schultz, of Greifswald, and upon very interesting botanical experiments. Kiefer also makes use of Behring's diphtheria serum doctrine in a homœopathic sense. The publication can be recommended as an explanation of the position of the modern homœopathic physicians.

Not only do allopathic journals accept articles by homœopathic physicians on homœopathic subjects and critiques on homœopathic publications, but we also have to record the pleasing fact that an eminent allopathic Professor, Dr. Ottomar Rosenbach, of Berlin, publishes an article and letters on Homœopathy in the *Zeitschrift des Vereins Berliner Homœopathischer Arzte* (December, 1906). Dr. Schlegel, Tübingen, had published the year before (August, 1905) in the same

journal, a paper under the title, "Approach of the dominant school to Hahnemann." Speaking about new books of Professor Rosenbach and the Psychiater Dr. Eschle, he showed how we Homœopaths agree in so many things with Rosenbach's new theories of cellular pathology, constitutional pathology and therapeutics. These theories are based upon the acknowledgment of the teleological principle in the organism and upon the estimation of the finest and most subtle theoretic powers. The sympathetic essay of Dr. Schlegel was answered by Professor Rosenbach in some most interesting letters to Dr. Eschle and Dr. Schlegel. The first letter begins with the words: "What Dr. Schlegel, when criticising your book, said as regards me, is of great interest to me, and I have been reading his paper with great pleasure. As I know already from two publications which he kindly sent me some time ago, Dr. Schlegel takes science and medical practice very seriously. So he tries also here to do justice to my views, so far as his position allows it." We cannot give the whole letter, but want to mention only one other important sentence: "In the *Grundlage der Therapie* I have already pointed out that Homœopathy—the doctrine of specific remedies—will gain new support in the results of modern science." All the same Rosenbach says that he cannot yet convince himself as to the truth of Homœopathy, and much as he sympathises with certain views of Homœopathy, the experiments on the living which he has made frequently, the results of homœopathic remedies at the sick bed, so far as he has tried them, do not satisfy him enough. Nor can he agree with the theoretic arguments of Homœopathy, a matter on which he writes in a very eloquent and clever manner. In connection with these letters he has written an article for the above-mentioned Berlin homœopathic journal on "Objective proving of drugs," in which he shows how in errors in observation, subjective influence might be eliminated in homœopathic drug proving. This paper of Prof. Rosenbach deserves without doubt the careful consideration of all homœopathic drug provers.

Such publications have been hitherto unusual in this country, and without any doubt they are a sign that the present position of homœopathic science in Germany is more auspicious than before.

FRANCE.

Ipecac. IN CONJUNCTIVITIS.—We have collected several cases of rapid recovery of old and severe conjunctivitis by Ipecac. A little girl of 4 years came to St. Jacques' Hospital in April, 1906; for several months her eyes were red, swollen, weeping, with intense photophobia, so that they could not be opened, even with instruments. She remained constantly motionless. The eye-lids, spasmodically closed, were full of tears that ran continually down the cheeks. The instillation of cocaine could not master the pain, and we were obliged to make use of general anæthesia by chloroform. We saw an intense redness of palpebral and ocular conjunctiva, without ulceration of the cornea; there were no granulations. In the neck were observed strumous glandular swellings. The local treatment with eye-salves produced no improvement. We tried also without any success *pulsatilla* and *calcarea carb.* On June 1st we prescribed *ipecac.* 3x. June 4th the little patient had her eyes opened, which had not happened for some months, and was playing. The result amazed all who saw the case.

Another young patient had suffered for a year from conjunctivitis and strumous and ulcerated keratitis of the right eye. *Ipecac.* 1x was prescribed on June 23rd without any eye-salve. The improvement was very remarkable, and the complete cure was accomplished by the beginning of August; the ulceration had only left a slight leucoma of the cornea.

Cafeine IN NERVOUS SLEEPLESSNESS.—Mrs. X., after great vexation, suffered from nervous sleeplessness with restlessness and heart-beating; she took, without any success, large doses of *sulfonal, trional,* and *veronal.* We prescribed *cafeine* 1st trit. 0·20, to take half before dinner, half before going to bed. The patient slept the very first night.

Action of Dilutions.—We have observed lately two interesting cases showing the importance of the potentised remedy.

A woman of about 40 came to the hospital saying she suffered with rheumatic pains in several joints, especially in the left arm; these pains increased from motion. There was also pain when breathing in the right side of the chest, and we diagnosed pleurisy. We gave *Bryonia, mother-tincture,* ten drops a day. Two days after the pains had increased, and

the patient said she suffered more and more. We then ordered *Bryon.* 6, five drops a day. From this moment the improvement was marked.

The second case is similar. This patient had articular rheumatism, and was treated without success by *chin. sulf.* We ordered *Bryon. mother-tincture*; the pains became more intense, so that the patient could not sleep. We then gave *Bryon.* 6, and immediately a great improvement was noticed.

These observations seem worthy of being reported, for we see physicians giving often *Bryon. mother-tincture* in strong doses in rheumatic pains. This treatment is not superior to that by dilutions, and will often produce aggravation.—DR. PAUL TESSIER.

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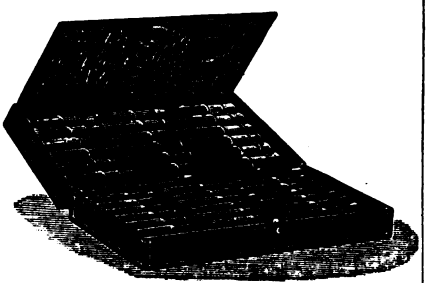

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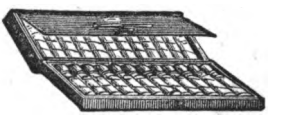

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THE BRITISH HOMŒOPATHIC REVIEW.

MAY, 1907.

Editorial Notes and News.

Rash caused by Chloretone.

CHLORETONE is *trichlor-tertiary-butyl-alcohol*, and has been introduced to the profession by Dr. Essex Wynter, as a remedy for painful and irritable conditions of the stomach, as a hypnotic, as a local sedative in vaginal pruritus and painful hæmorrhoids, for sea-sickness, and, lastly, to subdue the abnormal movements of chorea, in which he has had great success with it. Dr. Rolleston, of St. George's Hospital, in treating a case of chorea with this drug, which he records in the *Lancet* (March 30th, 1907), found, after the patient had taken 150 grains in all, that a rash supervened, which was first seen over the front and back of the hand and forearm as far up as the elbow. It consisted of flat-topped papules of a bright mulberry colour, of size varying from a pin's head to that of a pea, which faded on pressure, but quickly returned, was discrete, and itched. Two days after the eruption appeared on both ankles and in the sacral fold. On the third day the papules had changed to a number of rings, white in the centre and pink at the periphery, and tending to coalesce at their margins. On the next day the eruption had disappeared. As the rash bore a resemblance to lichen ruber planus, *chloretone* may be of service in that complaint.

* * * *

A New Test for Acetone in the Urine.

DR. B. J. F. JACKSON TAYLOR gives an improved modification of the *sodium-nitro-prusside* test for acetone in the urine. The *sodium-nitro-prusside* and urine are first mixed together, and then strong *ammonia* is carefully added.

This floats on the top, so that there is a clear solution of *ammonia* above and the urine solution below. If acetone is present, a well-marked and characteristic ring of magenta appears in from one to three minutes at the junction of the two fluids, and gradually spreads upwards. The solution of *sodium-nitro prusside* should be freshly prepared; a few crystals dissolved in a test-tube of water are sufficient. This test, devised by Dr. Jackson Taylor, has been tried in the *Lancet* Laboratory, and found to respond admirably.

* * * *

Variations in the Normal Temperature.

DR. W. CARTER recently read a paper before the Liverpool Medical Institution, and which was noticed in the *Lancet* of March 23rd, in which he recorded observations made on the night nurses of the Royal Southern Hospital, to see if the inversion of the ordinary periods of night and day duty affected the normal daily rise and fall of the body temperature. Each nurse, towards the end of a period of three months' night duty, took her temperature three times hourly. The charts showed that the normal depression occurring at 3 a.m. remained constant, even after three months of turning night into day. It seems, therefore, that the diurnal variations of temperature are deeply impressed on the organism, and are not easily affected by external circumstances.

* * * *

Cactus Grandiflorus.

A SAD fate has befallen this useful drug. It has fallen into the hands of the sub-committee on pharmacognosy, who have investigated its action, and their results have been published by Professor L. E. Sayre, in a recent number of the *Therapeutic Gazette*. They found that its action on the heart is slight and uncertain, if not *nil*, and draw this conclusion from the character of tracings taken from the right ventricle and carotid artery of dogs anæsthetised by *chloretone* and *morphia!* They have come, therefore, to the conclusions that the drug should not be made official, and that the therapeutic value of *cactus grandiflorus* is open to considerable doubt in spite of many favourable opinions expressed by clinicians. Thus do the physiological experimenters sit in judgment on

the practical physician. But where did the sub-committee learn their logic ?

* * * *

British Homœopathic Society.

THE seventh meeting of the session was held at the London Homœopathic Hospital on Thursday, April 4th, 1907. Dr. J. H. Clarke, President, was in the chair. Dr. Edwin A. Neatby read a paper entitled "Shall we be Guided in our Treatment of Uterine Fibroids by the Existing State of the Patient and the Tumour, or by the Natural History of these Growths ?" The paper emphasised the frequency with which cancerous degeneration takes place in fibroids, and its importance as a factor in the decision as to operative interference. An interesting discussion followed. A paper was then read by Dr. A. Speirs Alexander, of London entitled "Jottings from Ophthalmic Practice in the London Homœopathic Hospital." A succession of cases was given from the out-patient ophthalmic department of the Hospital, illustrating the value of internal homœopathic medication in a great many of the most common diseases of the eye. A microscopic section of the marrow and a stained blood film from a case of pernicious anæmia were shown by Dr. Byres Moir and Dr. Frank Watkins. Dr. Watkins also showed a parotid gland removed *post mortem* from a patient suffering from secondary parotitis. An endosteal sarcoma of the head of the tibia was shown by Mr. C. Knox Shaw, and a pyosalpinx by Mr. C. Granville Hey.

* * * *

British Homœopathic Congress.

WE remind our readers that the meeting for the present year of the British Homœopathic Congress will be held at Harrogate on Thursday, September 19th. The usual circular will be in the hands of our colleagues by the end of July or the beginning of August.

* * * *

An Anti-dysenteric Serum.

THE following is an extract from the *Times* of April 11th : "A communication was made yesterday to the Academy of Medicine by Dr. Vaillard, announcing the satisfactory results that continue to be obtained by him in the cure of

bacillary dysentery by the use of a serum obtained from horses. During the last year 243 cases of bacillary dysentery were treated by him and other practitioners according to this method, with the result that the mortality due to that infection was measurably diminished. A few hours only after the first injection the abdominal pains become less severe. The treatment is all the more effective in proportion as it is applied in the early stage of the malady. Dr. Vaillard affirms that anti-dysenteric serum is the only specific remedy for bacillary dysentery."

* * * *

Professor E. B. Nash.

OUR old friend has been at it again and to some purpose. This is a most excellent little book.,[1] Sherlock Holmes' ingenuity and finesse in tracking crime and criminals is mere child's play compared with the work the homœopathic physician has to do every day of his life. The essence of the study of our *Materia Medica* is *comparison*. Without comparison we cannot move a step in safety. Dr. Nash's book will help us to do so more effectively than heretofore. We hope he will treat in the same way the other three great medicines that stand in the front rank of our *Materia Medica*, viz., *calcarea ostrearum*, *arsenicum album*, and *lycopodium*.

* * * *

The Principle of Vaccination.

THE very last person in the world to object to the *principle* of vaccination should be the homœopathic practitioner, for there is only one reasonable explanation possible of its prophylactic virtues, and that is included in the word "homœopathy." True, it was not introduced under the *ægis* of homœopathy; but, nevertheless, it is a very obvious illustration of the principle of *similia*, for before Hahnemann, homœopathy was in the world. Sir Isaac Newton did not *invent* gravitation, but he discovered its laws. Gravitation itself had existed from "the beginning." Hahnemann did not *invent* the cure of disease, he only discovered the law of cure. Glimmering glimpses of it, it is true, had been seen by Hippocrates, Paracelsus, Stoerck, and Stahl. Nevertheless, to Hahnemann alone belongs the honour of making it a coherent and practicable system.

[1] Leaders for the Use of Sulphur, with Comparisons. By E. B. Nash, M.D.

The Practice of Vaccination.

BUT what of the *practice* of vaccination? On this point we believe there is room for more than one opinion. We will not enter into the question at present further than to say that we have always regarded the method, or practice, of vaccination, as well as that of serum-therapy in general, as exceedingly crude and clumsy attempts to practise homœopathy. As was to be expected, the results of this clumsy practice have not always been happy, for it needs an educated brain and a skilled hand to handle the resources of homœopathy effectively and safely. In regard to small-pox, we see no good reason why we should depart from the ordinary principles and practice of homœo-prophylaxis, as applied in such specific infective fevers as scarlatina, measles, and diphtheria.

* * * *

Cure of Consumption by its own Virus.

TAKE, again, the "cure of consumption by its own virus." This, also, we must claim for homœopathy. We remember reading, many years ago, an article on this very question by the late Sir Benjamin Ward Richardson, in which, if we remember rightly, he opposed the practice, and pointed out how the homœopaths would be laughing in their sleeves at the new turn affairs had taken. No doubt he believed that the homœopaths were such as his imagination pictured them; but the homœopath has no time to laugh in his sleeve, his time being fully occupied in healing the sick. Strange and inexplicable blindness! As if the question of homœopathy was merely the question of *a system*, instead of a law of Nature! Time itself, nay, even Eternity, is powerless to undo, or reverse, what was once true. Truth is eternal, and though, as a matter of fact, we can only catch a few sparks here and there, nevertheless, all such sparks, so long as they come from the Altar of Eternal Truth, are, like Truth itself, immortal. Homœopathy is such a spark.

* * * *

Early Diagnosis of Measles.

ON this subject many observations have been made during the last ten years. In 1895, Comby recorded the existence of an "erythemo-pultaceous stomatitis," and an erythema on the soft palate, a few days before the eruption, which

he regarded as a sign of the coming event. This, however, is not peculiar to measles. In 1896, Koplik, of New York, observed "spots" in the mouth, with a red base, irregular and starry, and in the centre a bluish-white rounded point—*bluish-white specks on a red ground.* These spots are best seen on the inside of the cheeks opposite the molar teeth. They are present in nearly all cases (80 per cent.), and appear from one to three days before the skin eruption. In 1898, Meunier noticed the pre-morbillar loss of weight—about 60 grammes a day. In 1899, Combe observed a hyper-leucocytosis (about three times as great as normal), which reached its maximum the sixth day before the appearance of the skin eruption.

* * * *

Adenoids.

THE operation for the removal of adenoids is usually regarded as a simple one, from the surgeon's point of view. There have been, however, several cases of fatal hæmorrhage from this "simple" operation. This may occur (1) in cases of hæmophilia. It is well to enquire into the possibility of this accident *before* operation—in most cases the enquiries are made after the catastrophe. (2) From an ascending pharyngeal artery on the posterior wall of the pharynx (Dupuy). (3) From the internal carotid artery having been pushed inwards by an enlarged gland (Schmiegelow). Apart altogether, however, from this risk, it must never be forgotten that operations cannot cure the constitutional basis—can neither correct the soil nor remove the roots of the plant, but only cut a little bit off the top. Should from any cause operation be deemed imperative, then constitutional treatment should be carried on afterwards, just as if there had been no operation; otherwise, there is a possibility that the constitutional state that gave rise to the "adenoids" will again manifest itself, either in a return of that affection, or in disease of some more important organ.

* * * *

American Attack on Homœopathy.

WE regret to learn that a peculiarly subtle attempt to throttle homœopathy is being made in the United States. The originators seem to be a section of extreme allopaths, who are infuriated by the recent advances made by their

colleague, Dr. Cabot, of Boston, and others, towards homœopaths. The *Hahnemannian Monthly* informs us that a Bill is shortly to be introduced into the Legislature of Pennsylvania, with the object of placing the power of granting licences for the practice of medicine and surgery in that State entirely in the hands of the old school. It is intended to introduce similar legislation into every State of the Union. This has already been attempted in New York and Texas. A single board of examiners is to be appointed by the Medical Societies of each State. This, of course, would be monopolised by the dominant school, which outnumbers the homœopathic and eclectic sections, in most States, by about three to one. It is believed that this portion of the Act was designed to destroy the homœopathic schools and colleges. In effect it would reduce the present advantages enjoyed by our colleagues across the water to the condition of thraldom under which we labour here. Amongst the list of subjects for examination proposed in the new legislation, it is notable that *Materia Medica* and therapeutics are not found. We sincerely trust that this dastardly attack on the privileges of homœopaths in that country which has set an example to the world in freedom and intelligence will meet the fate it deserves. If our colleagues present a united front to the enemy, there can be no doubt of the result.

* * * *

Physicians' Fees in America.

AN address was recently delivered by the retiring President, Dr. G. De Wayne Hallett, before the Homœopathic Medical Society of New York, entitled, "*Physician's Charges; How much should he Ask in the Present Time in Return for his Services?*" It is shown by statistics, published by the United States Bureau of Labour, that the weekly wage *of all people employed* has increased in 1905, over the ten years' average 1890 to 1900, by 52·2 per cent., and the hours of labour have decreased by 4·1 per cent., while the retail food price has increased only by 12·4 per cent. for the same period. In spite of this enormous increase in the earning power and wealth of the community, Dr. Hallett states that the physician has reaped no benefit; he charges the same for his services now as he did ten and twenty years ago. An appeal is made to the pro-

fession to increase their fees, except to the poor, in some sort of proportion to these facts.

* * * *

Materia Medica in Italy.

REUTER'S AGENCY telegraphed from Rome on March 22nd that Queen Elena had been for some time suffering from an attack of intermittent fever, which the doctors had not succeeded in stopping, as she could not take *quinine*. There are one or two other remedies that cure intermittent fever besides *quinine*. We recommend these Italian physicians to obtain a copy of Lilienthal's "Homœopathic Therapeutics," where they will find indications for the use of over one hundred remedies that have frequently been used to stop intermittent fever, with marked success. Some one or other of these would undoubtedly cure their royal patient.

* * * *

Chocolate and Cocoa.

WE are pleased to notice that the well-known firm of Messrs. J. S. Fry and Sons, Ltd., Makers to His Majesty the King, have been appointed by special Royal Warrant, Manufacturers of Chocolate and Cocoa to their Majesties the King and Queen of Spain. The firm of Messrs. Fry is one of the few whose preparations of Chocolate and Cocoa we never hesitate to recommend with the utmost confidence, being well assured of their purity. For those of us who have sometimes to go long bicycle journeys, I know of no more convenient and nutritious food than a few cakes of Fry's Chocolate. Chocolate resembles milk somewhat as approaching in composition a complete food. Its nutritive value and sustaining powers are undoubted, and we recommend and use it extensively, even though (*pace* Dr. Haig) its alkaloid, like caffeine and theine, is a member of the *purin* family.

Original Articles.

AN ANOMALOUS CASE OF INFLUENZA.

By T. G. STONHAM M.D.(Lond.).

THE influenza bacillus, or its poison, seems to be able to affect every organ of the body and almost every tissue. Consequently, the illnesses caused by it display a great variety of symptoms, and although most may be roughly classified as nervous, respiratory or gastric, yet anomalous cases frequently occur which cannot be satisfactorily placed under any of these three divisions. Influenza is a great simulator, and resembles syphilis in this respect, and some of its protean forms may with difficulty be distinguishable from well-known diseases like typhoid fever or tuberculosis. The case I am about to relate exhibited symptoms which at different periods suggested both these complaints.

J. D., a little girl aged 6, was taken ill on January 17th, 1906, with a severe shivering fit, followed by vomiting and diarrhœa and a rise of temperature to 103° F. There were no symptoms pointing to any particular organ being affected. Influenza was prevalent at the time, several members of the family had had it, and some of them were still in the convalescent stage. The attack was therefore considered to be one of influenza, and *baptisia* 1x was given. The vomiting and diarrhœa soon ceased, but the temperature remained high, ranging from 101° to 104° for a period of ten days, when it fell to normal. During the latter part of this time she complained of pain in the back on the right side, and there was tenderness on pressure over the kidney. She also had some tenderness on pressure over the bladder, and at times micturition was frequent and very painful, so much so that she screamed on passing water, and on one or two occasions there was passage of blood. This condition of the urinary functions continued intermittently for the next three weeks—on some days or parts of the day urine would be passed without pain or difficulty, at other times it would be very painful. The tenderness over the kidney remained fairly constant. There being no further rise of temperature she was allowed to get up at the end of three weeks and to resume ordinary diet. After being up a little each day for a week she was one mid-day seized with a shiver-

ing fit, the temperature was 103°, and several micturitions were very painful. The next morning temperature had come down to normal, and she was better. During the next two months these short attacks of rigor, fever, pain in loins, and painful micturition were repeated every three or four days. In the intervals she was well. The urine at times contained a few blood cells, and often a good many leucocytes and some epithelial cells. Sometimes little tubular pellets of mucus were passed, but though a careful watch was kept on the urine, nothing in the nature of a stone or of gravel was observed, and no albumen in the filtered urine. The drugs given—*cantharis, berberis, belladonna, merc. cor.*, &c.—seemed to have no effect. The repeated attacks of rigor, fever, and pain suggested one of two things—stone in the kidney or tuberculosis of the kidney.

The friends requested that Sir Thomas Barlow should be allowed to see her. He carefully examined her and could come to no definite decision, but suggested that a skiagraph should be taken which might settle definitely the question of stone. A skiagraph was taken the same day and no stone could be detected. He also advised that two or three two-grain powders of *urotropine* should be administered daily. This was done for three days in succession, with the result that the child had no more attacks.

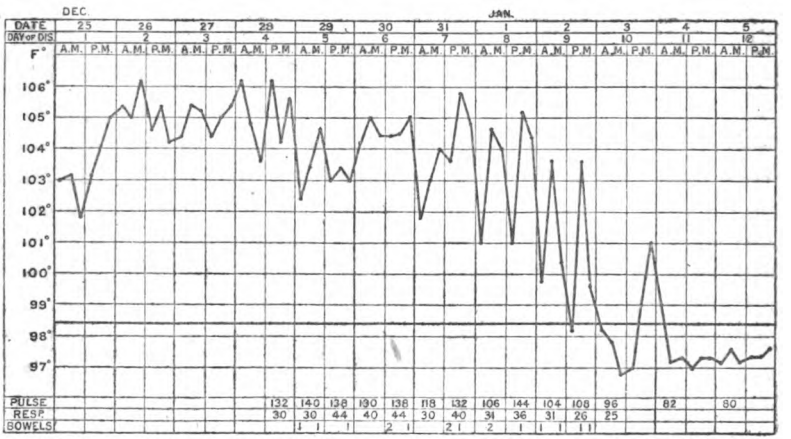
This remarkable result settled, for me, the diagnosis. A tuberculous disease of the kidney severe enough to set up such a train of symptoms extending over more than two months would not be suddenly stopped by a few *urotropine* powders. Moreover, there had never been any tubercular manifestations in any other part of the body, nor have there been since. I think it probable that the influenza bacillus had obtained a firm lodgment on the mucous surfaces of the urinary tract and had been dislodged by the action of the *urotropine* acting as a bactericide.

The patient gradually regained health and strength, but convalescence was slow, for she had been much pulled down by the long illness. She remained well till the end of the year. Then there was again influenza in the house, and on Christmas Day she had, in the morning, an attack of diarrhœa, passing very loose stools. It was thought that this might have been caused by something she had eaten, and little notice was taken

of it, but in church the same morning she had a severe rigor lasting a quarter of an hour. She was put to bed and the temperature was found to be 103°. Some diarrhœa continued, but no other symptoms. A diagnosis of influenza was again made. The next day I was called to see her suddenly, as the parents, who had taken her temperature, were alarmed at finding that it reached 106·2°. I found that this temperature was correct, but there were no other symptoms. A tepid pack reduced the fever by one degree, but all the next day it reached from 104·5° to 105·5°, and at 2 a.m. on the fourth day of the illness again ran up to 106·2°, and to the same again in the afternoon. By this time she had sunk into a typhoid condition, lying delirious, with coma vigil, picking at the bedclothes, with sordes on the teeth, a dry tongue, one cheek flushed, rapid pulse and respiration, the pulse being 132 and the respirations 30. The abdomen was a little tumid, no spots; diarrhœa had ceased. Dr. Roberson Day was called in consultation. Neither of us could find anything to account for the condition except the high temperature. The lungs were quite clear. The general condition was like that of a bad case of enteric fever in the third week, but the onset of the disease had been very unlike that of enteric. Nor was it possible to diagnose meningitis. A provisional diagnosis of influenza was made and *arsenicum* 3 ordered every two hours, with tepid sponging or packs to reduce the temperature and quiet the patient. The next day temperature was rather lower and there were three loose stools passed unconsciously, and on the sixth day she remained much the same. On the seventh day the temperature fell to 102° in the morning, but rose to 105·8° in the evening, the diarrhœa continuing: the stools were light-coloured and offensive. On the ninth day there was a crisis, but without critical sweat, the temperature falling to 98° in the middle of the day after a good night's rest, from which she woke much better and eager to take food. A post-critical rise took place in the evening, but the temperature was again normal the next morning and convalescence ensued. The chart exactly resembles that of lobar pneumonia, but throughout the patient had no physical signs in the chest and no chest symptoms. The chart also resembles that of typhus fever, as does the critical termination, but there was no headache and no rash. I think our diagnosis of influenza was a

correct one, but influenza running a very unusual course. During the course of the fever there were occasions on which she had the same pain on micturition as occurred in her former attack related above, and this same difficulty recurred once or twice during convalescence, but it was at once stopped by a couple of two-grain powders of *urotropine.* Recovery of strength was very slow, and it was found that if she was allowed to tire herself an attack of fever was brought on. After the crisis she was kept in bed for seventeen days, during which the temperature remained quite normal or subnormal, and all went on well. She was then allowed to get up. She stayed up too long and was allowed to have too much excitement, with the result that for the next three days she had a relapse, with temperature up to 103°. This is a well-known feature of influenza. Nothing is so likely to bring about a relapse as premature exertion. I have met with cases where for months after an influenzal attack any unusual exertion will bring on a febrile attack necessitating two or three days' rest, and these cases have generally been those in which the original attack had no symptoms except the high temperature and initial chill. There seems to be a variety of influenza or a peculiarity in constitution in which the poison expends its influence especially on the heat-regulating mechanism, leaving other organs and systems almost unaffected, and this mechanism is left for a long time afterwards in an unstable condition, so that it is easily deranged by any excess of the forces normally affecting it. Such appears to have been the case with my little patient.

Subjoined is the temperature chart of her last illness.



SYMPTOMS AND DIAGNOSIS FROM THE HOMŒOPATHIC STANDPOINT.

By the SENIOR EDITOR.

(*Continued from p.* 145.)

HITHERTO we have been dealing with what may be called the *clinical* diagnosis. I have said nothing about the *scientific* or bacteriological diagnosis, *i.e.*, the identification of the particular microbe associated with the disease; for example, the Klebs-Lœffler bacillus in diphtheria of the throat, or of wounds in other parts of the body, the *Diplococcus intracellularis* in cerebro-spinal fever, the *Bacillus anthracis* in malignant pustule, the bacillus of Nicolaïer in tetanus or lockjaw, the tubercle bacillus in phthsis pulmonalis, the colon bacillus in some curious forms of cystitis, and so on. Of course, such a scientific diagnosis could be made by one who had never seen the patient; but a case is not diagnosed, from the homœopathic standpoint, when the specific micro-organism has been discovered and named. "The test-tube and microscope can never take the place of careful observation" (C. B. Lockwood).

Now for the diagnosis of the remedy we must pay special attention to the *more prominent, uncommon, and peculiar* features of the case, indeed, they alone have to be almost exclusively considered and noted; *for these in particular should bear the closest similitude to the symptoms of the desired medicine.* Further, these peculiar and uncommon symptoms must be regarded as *realities*, not as mere curiosities. We see, therefore, how the two diagnoses are made, the method of making each, and how they differ: the diagnosis of the "disease" made from *general* symptoms and physical signs of *general* occurrence; the diagnosis of the *specific* remedy—specific, not in the sense of being a universal medicine for a specific disease such as pneumonia, but specific as applied to the individual patient in question, and to no one else. This diagnosis is made not from *general* symptoms common to a class of diseases, but from the *more prominent, uncommon, peculiar*, and special *symptoms* of the individual patient. In no other way, it seems to me, is it possible to find the specific remedies in the sense above indicated. In this way we at least *aim* at getting the

individual specific. It is just as impossible, nay more so, that there can be general specifics, as that there could be a coat made to fit every man, or, what is much more difficult, a frock made to suit every lady, though no doubt in both cases it would *cover* every one, more or less, and thus to a certain extent fulfil the function of clothes.

It is not always easy, I admit, to diagnose the specific remedy for the individual cases, especially in chronic diseases; and it is possible that even the youngest of us may occasionally miss the mark or come short of it. Nevertheless, it should be our continual aim, and we should be content with nothing less. Mistakes will occur, for the man who says he never makes a mistake is either a fool, or a liar of considerable eminence.

It is stated in a previous part of this paper that "symptoms," in their most general sense, might be divided into three groups:—

(1) Physical signs.

(2) Symptoms (subjective) and their history.

(3) Hereditary influences.

This represents their order of importance so far as diagnosis of the "disease" is concerned. For the diagnosis of the specific remedy the order is exactly the reverse. One of the most startling discoveries to me as a beginner in the study and practice of homœopathy was the fact that the long lists of symptoms we used to study and treasure up in our memories so laboriously against the day of examination were next to useless to me as far as the selection of the appropriate remedy was concerned. At the same time I am never content or quite happy unless I can identify the pathological substratum, not to make it a basis for the selection of the remedy, but for purposes of prognosis, dietetic and general treatment (as nursing, &c.), as well as to satisfy the *friends* (for the "friends" usually give more trouble than the patient), and, if need be, a coroner's jury.

It is quite possible that these views may not meet with general approval from my colleagues, but if we disagree on this point we need not be disagreeable about it; and we shall always welcome expressions of opinion by others on this important subject.

Perhaps some will say, on the other hand, "Is it *necessary*, then, to make this double diagnosis: is not the diagnosis of the specific remedy enough without bothering with the diagnosis of the presumed morbid anatomy, which is, you admit, of little or no use so far as the selection of the specific remedy is concerned?" We do not say that a knowledge of the pathological substratum is of no use in the selection of the remedy. But we know, as a matter of fact, that in many cases it is impossible to be quite sure what this pathological substratum or morbid anatomy is. In such cases, therefore, if we are to found the selection of the remedy on our knowledge of the morbid anatomy of the case, we would be quite at sea without compass or rudder. But the other method, that insisted on by the founder of homœopathy, is applicable in all cases, whether we can identify the pathological changes or not. Of the two, therefore, this method must always get the place of honour, the other being merely subsidiary and subordinate. At the same time the "totality" must include *everything* that can be found out concerning the patient.

Let us return once more to the question, "What is a symptom?" The "symptom" of the dominant school reminds one of—

> "A primrose by the river's brim,
> A yellow primrose was to him,
> And it was *nothing* more."

Is "a pain" a symptom? No! As it stands thus it is but the pitifullest fraction of a symptom. To be a symptom from the point of view of homœopathy, we must know a great deal more about it than its simple name. We must know, *inter alia*—

(1) Its general character, its exact anatomical position, and, if it moves, the direction in which it moves, *e.g.*, left to right, right to left, diagonally, &c.

(2) Its modalities, *i.e.*, its conditions of aggravation and amelioration, especially as regards *time* and *circumstance*.

(3) Its concomitants, especially moral and intellectual symptoms.

Only when this has been done is "a pain" identified and described, and only then is it worthy of being called a "symptom" from the homœopathic standpoint. "A pain" is just as indefinite as "a man."

We stated that in the diagnosis of the remedy, the *more prominent, uncommon,* and *peculiar symptoms* were to be specially studied, as in this way we are most likely to gain a knowledge of the characteristic peculiarities of individual patients. This method is one of choice of medication by the indications specially exhibited by the patient under consideration. Such characteristic symptoms will in all probability be found :—

(1) In the sensations of the patient.
(2) Certain localities or tissues.
(3) Modalities—conditions of aggravation and amelioration.
(4) Concomitants.

In many cases, perhaps in most, it is almost impossible to get a complete picture, but that is no excuse for not trying to get one. It is also a matter of great difficulty, in selecting the remedy, to assess the value of individual symptoms, and the share each ought to have on striking the balance of probabilities. Further, the value of certain factors in this calculation will always remain doubtful, for eight may not always mean eight, and that is why a mere mechanical enumeration will rarely give a satisfactory answer to the question, "What is the specific remedy for *this* patient? At times this method is useful, but it has to be tenderly dealt with, and used only "with brains."

In conclusion, I would suggest, as one of the Editors, that the clinical cases should, as far as possible, take the form of clinical lectures ; it would in my opinion be of great advantage both to writer and readers. The best way to be taught is to teach. Full details, such as are suggested by any ordinary "case-taking card," should be given if possible. Such as, for example :—

The usual preliminary particulars.
The complaint or complaints in the patient's own words.
History of present illness, of previous illnesses ; social and family history.
The condition when first seen, and the physical examination.
Diagnosis of the "disease." It is not enough to know the mere name, we want to know how this name has been singled out from all others. The organ or tissue

affected, and the nature of the affection, whether primary or secondary or tertiary.

Hygienic and dietetic treatment.

The diagnosis of the remedy, not merely its name, but *why* it was chosen. The question whether it is the right remedy or the wrong is of less importance than to be able to give the reasons for our choice.

It is a grand mistake to assume too much knowledge on the part of the readers. It is a mistake to say, or tacitly assume, "all this is found in the ordinary text-books," or to think that this or that point is so simple that everyone knows it, and therefore we need not mention it. Relevant details can never be too carefully recorded, or too minutely described. In particular one would like to know, where possible :—

(1) The relation of the general symptoms and physical signs to the "diagnosis of the disease" in the ordinary acceptation of that term.

(2) The relation of the more prominent, uncommon, and peculiar symptoms, *i.e.*, the symptoms *characteristic* of the *patient*, as distinguished from the "*disease*," to the assumed pathological substratum. In many cases this will be quite impossible; in some it may be possible, *e.g.*, rolling of the head (in infants) in disease of the middle ear, pulling and rubbing the ears or back of head in dentition, or banging the head with the fist in cases of meningitis. Here, in passing, I may remind you that before now, pneumonia, especially the *apical* form, has been mistaken for teething.

(3) The relation of the same symptoms to the identification of the specific medicine, and why one was chosen rather than another, out of a possible eight hundred or a thousand.

(4) Whether there are references in our *Materia Medica* associating together (or at least rendering such association probable) the definite characteristic symptoms with the assumed pathological substratum.

It may seem to some that I have made too much of pathology or morbid anatomy. But I have tried to show that, in my belief, its position is only a subsidiary one, so far as the selection of the "right remedy" is concerned; a humble assistant, not the master. But though for this purpose (the selection of the specific remedy) it does not take the high rank in our school

that it has done hitherto in the dominant school, yet we have no right to neglect its study, and as little right to use the knowledge acquired by its study in an illegitimate manner. We have no right to foist such knowledge upon the patient, wrapped in high-sounding phrases, and words that have no meaning to him, while his whole being is crying out to be made whole, and, to those who have eyes to see, showing a picture of the remedy that will do it. Above all, let us remember that "the physician's high and only mission is to restore the sick to health," and no knowledge is to be despised, or regarded as alien, that will help him to fulfil in the best possible way this important mission, in a rapid, gentle, and permanent manner, or, where cure is impossible, to smooth the rugged pathway to the tomb.

For the purpose of diagnosis all accessory aids may be used, *e.g.*, the X-rays in fractures, in stone in the kidney or bladder; the endoscope in bladder diseases; the "separator" in cases of doubtful kidney disease, as well as the resources of hæmatology. We believe just as firmly as our colleagues of the old school that *a correct diagnosis must precede correct treatment*, only we interpret the phrase in a slightly different, though in a much more complete and comprehensive way. For us it also includes a "correct diagnosis" of the specific remedy.

Finally, let me say once more, and once for all, that this Journal will always welcome expressions of opinion from those who may differ from us. It is no party Journal, but Catholic in the truest (the original) sense of that term. We may point out that the word "Catholic" comes from a Greek adjective which means *diffused throughout the whole, universal.* At a later date the term came to have a technical meaning, and to denote "orthodoxy" as opposed to "heresy." This later meaning we repudiate, and all its works; it has no place in the policy of the present Editors. In that sense it has ever been used in the past, and is being used to-day to stifle truth, except that limited and one-sided view of it which is more than half a lie, the mere "shibboleth" of a party, the badge of a priestly caste. As thus interpreted it has always been opposed to progress and freedom of thought and speech. It was this that lighted the martyr-fires of Smithfield, of Oxford, and of the Grassmarket; that hunted and shot down noble men on the moors and hillsides of Scotland, as if they had been

vermin; that was accountable for the hellish cruelties of the Spanish Inquisition. I wish I could say that all this was a thing of the past. But it is not; the same *spirit* is abroad to-day, only "restated in modern terms." The devil as an angel of light is the devil still, and a worse devil than when he appears in horns, hoofs, and tail.

It was a maxim of Roman Law that no one could cease to be a citizen against his will. In the punishment known as *capitis deminutio minor*, the condemned man was denied the necessaries of life, was forbidden the use of fire and water, that is, until he was driven to withdraw himself from the city. The *aquæ et ignis interdictio* was thus a form by which a sentence of perpetual banishment was inflicted. Is it so very different to-day? I do not think so. The man who, for conscience sake, adopts and maintains opinions contrary to the *authorised* teaching and usual beliefs of his class, is regarded as a "heretic" and will be "boycotted," and, if possible, will be deprived of the means of making an honest living. It is no question as to whether he has truth on his side or not: that is a question of *no* importance. It is enough that his views are not "orthodox," for each profession has its "thirty-nine articles." It must never be forgotten that the medical profession, our Colleges, Universities, and Hospitals *exist for the people*, not the people for them.

Such is our policy, and our pages are open to all, whether at home or abroad, and we will allow to everyone what we claim for ourselves, "a free field and no favour"; the only limitation being that of *space*, which rules, with an iron rod, Editors and contributors alike.

A MILK MEASURE FOR BABIES.

By Dr. W. M. STORAR (Ramsgate).

Twelve years Physician to the North of England Sanatorium, Southport.

SINCE Dr. Day admits that the last word has not been said on infant feeding, perhaps I may be permitted to contribute a few suggestions towards the elucidation, if not solution, of that difficult problem.

In the first place, I must remark that neither in Nature nor

in art is there any perfect substitute for the mother's own milk, and that attempts to feed babies with percentages of the ingredients of cow's milk are only laboured approximations, as close as may be, to that ideal.

Dr. Day's paper in your April number is exceedingly interesting, and displays a great deal of erudition and patience; it might even be useful to city physicians with the run of physiological laboratories, with staffs of hospital-trained nurses at command, and with numbers of highly intelligent mothers learned in mathematics and centesimals and who believe in them. In many districts, however, tuberculin testing, sterilisation, and pasteurisation are practically unknown arts, and there are not Milk *Laboratories* in every street; here they are called dairies, and the cows walk about naked. The mothers, few of them, alas, have been to Girton. So for practical every-day purposes in the country, Dr. Day's article will not receive the unalloyed appreciation it ought certainly to receive in the city.

I may be considered rather stupidly backward, as well as heretical, for saying so, but I certainly think much too much fuss is made nowadays with all the paraphernalia preliminary to introducing decent cow's milk to an ordinary baby's stomach.

I freely admit there *are* diseased cows that should never be milked, and morbid babies that should never be born. These will always deserve the scientific scrutiny which only collegiate professors with pathological laboratories can be expected to give them. But average cows, living under normal conditions in the country, do supply an average quality of milk which, when given in correct quantity, properly diluted and sophisticated, at regular intervals, to average babies, should seldom prove anything but entirely beneficial. Even a fair supply of germs may be only a stimulus to the healthy digestion of a normal infant, as "mitey" blue cheese is to the parents. As *anti*septic surgery has given place to *a*septic surgery, with every advantage to the patient, so I think it will be admitted very soon that in the transit of milk from the cow to the baby few extraordinary processes are necessary, and that little but scrupulous cleanliness is really required.

No, the faults are not so often with the cows and the babies as they are with ignorant mothers and nurses. But mothers

and nurses are not the only persons at fault, for how many physicians could off-hand prescribe the proper quantity of cow's milk properly diluted for a baby—say, three months old?

So in order to help mothers and nurses, and perhaps a few physicians who are far away from the specialised professional assistance of the West End, I have devised the accompanying chart, which I present freely to the profession, and, if I may, to the public, hoping they may find it as generally useful as I frequently do myself.

As we all know, thousands of babies are killed every year entirely through ignorance of how they should be fed. Very few babies are underfed; most of them are overfed—fed too often and on the wrong stuff. We know, too, that no baby can digest starchy food till after it is six months old. Nearly all the baby foods in the market contain starch. Therefore, no bottle-fed baby should have other food than milk, water, cream and sugar in correct quantity and proportion till after it is six months old. After two months old, or even before, babies should not be fed in the night. If the baby cries at night it does not necessarily want food. A little warm water will generally suffice to pacify it, whereas unnecessary food on an unready stomach will certainly aggravate matters.

This chart indicates at a glance how babies should be fed.

MILK MEASURE FOR BABY.

Milk, ozs.	Baby's age	Times a day
v.	6 months	6
iv.	5 months	6
	4 months	6
iii.	3 months	7
ii.	2 months	7
i.	1 month	8
½	14 days	9

ALWAYS ADD
one ounce of warm water,
one teaspoonful of cream,
and a pinch of sugar.

NO FOOD
from 11 p.m. to 5 a.m.

It shows, for any age up to six months :—

(1) Exactly how much milk, hot water and cream should be mixed for each feed.

(2) How often the baby should be fed in twenty-four hours.

(3) How long should be the intervals between feeding.

(4) By calculation the exact quantity that should be given in twenty-four hours.

This chart shows the *average* diet for an *average* baby. The amounts, calculated from standard authors on the subject, will be found to be quite liberal, but big hungry babies may have a *little* more, and less greedy ones a *little* less without fear of injury.

If the baby thrives and grows, and if the mother tells you, as I have been told, that "she scarcely knows there is a baby in the house" because of its restfulness and freedom from crying at unseemly hours, then you will feel assured that the prescription is quite correct. I am convinced that the general adoption and circulation by the Public Health authorities of a measure like this would do much to mitigate the horrors of our present appallingly excessive infantile mortality.

For myself, I hope the Nobel trustees will not overlook my claim to their beneficence, for this scientific contribution to the health and peace of the world.[1]

ACUTE APPENDICITIS AND ITS MEDICINAL CURE.

By S. PHILIP ALEXANDER, M.D., M.R.C.S.Eng.

THE following case may serve as an example of the distinct and definite curative value of a homœopathically chosen remedy in a grave and urgent malady, viz., *acute appendicitis.*

If operative interference is to be obviated, needless to say, in the patient's interest, as also from the physician's point of view, it is everything to get a case in time. If inflammatory mischief is unchecked, the tendency towards the formation of pus and perforation is manifestly the great danger, and *the* desideratum in treatment, medicinal and otherwise, is at all cost to anticipate and prevent this.

[1] Dr. Storar hopes to have this chart printed on a card and distributed amongst medical men, and for fixing on nursery walls.

I was called on March 19th, 1907, to see a little boy aged 10. The symptoms were those of catarrh of the bile-duct, viz., jaundice, light-coloured stools, vomiting, bile-stained urine, headache, milky-white tongue, and temperature of 101° F. The unusual feature in his case was slight pain complained of with tenderness, not over the gall-bladder, as might have been expected, but lower down in his right iliac region over appendix. Pain radiating into right leg and inside of thigh was a marked concomitant.

Acon. and *bryonia alt.* were prescribed, with marked relief to the biliary symptoms. The pain in appendix, however, increased, becoming spasmodic and colicky in character. At the same time, pain on touch became by the fifth day intense, a decided tumour developing over appendix, noticable to patient himself, and clearly defined by palpation and dulness of percussion note. Legs were instinctively drawn up, abdomen becoming slightly tympanitic, and stools loose and frequent, tenesmus before each motion being very acute.

Temperature rose to 103·4°, with rapid, feeble pulse, general prostration and collapse becoming imminent.

Merc. cor. 3 was prescribed in hourly doses. At first this seemed to aggravate, pains increasing in violence, but the remedy in the same potency was continued in more diluted dose. The effect was marked and unmistakable, pain and tenderness rapidly passing off, and with it tumour subsiding and becoming undiscoverable by the 28th, or ten days from the commencement of the illness.

Milk diet only was permitted, and, locally, hot fomentations with a few drops of turpentine. The complete recovery of the case was very gratifying, and in this instance the value of *merc. cor.* as the remedy pronounced and unmistakable.

The incidence of the attack, with symptoms of biliary obstruction, as also catarrh of the bowels, was somewhat peculiar, at the same time significant and indicative in determining the remedy.

Apropos of this case, I may mention another which came under my care in February, 1905, and which, though I have no notes, I well remember as causing much anxiety and exercise as to the question of operation, whether such was imperative or justifiably to be delayed in favour of persistence in the medicinal treatment alone.

In this case, also that of a boy, aged 13, the symptoms, if anything, were even more acute than the previously recorded one, the appendix tumour being elongated and larger, and formation of abscess imminent. Liver symptoms were absent, and bowels obstinately confined.

Bell. and *bryonia* were the principal remedies prescribed and persisted in, daily enemata of very hot water, somewhat contrary to the text-book rules, being regularly employed. The idea in this was to foment internally, allay irritation, and prevent as far as possible the pressure symptoms of fæcal accumulation.

The case completely recovered, the cure, if we may adopt the term, proving to be permanent, no relapse or return of symptoms having occurred up to the present time.

It may be conceded that 70 or 80 per cent. of cases of appendicitis get well without operation, but such that do so, it has been estimated, indicate the tendency to recovery within twenty-four hours.

In both of the two cases recorded above the acute local symptoms were subsequent to this period, and progressively urgent from the fourth day at least and onwards from the commencement of the appendicitis mischief.

In both cases, again, it may be remarked that local mischief was probably simple, dependent upon acute catarrh and inflammation of appendix, with its attendant perityphlitis. Had the existence of a foreign body, or even impacted fæcal accumulation in appendix, been suspected or diagnosable, a very different complexion indeed would have been put upon the prognosis, and delay in operation unjustifiable.

GOUTY HEADACHES.[1]

By W. THEOPHILUS ORD, M.R.C.S.Eng., L.R.C.P.Lond.
Physician to the Hahnemann Home and Homœopathic Dispensaries, Bournemouth.

THE great interest aroused during the last ten years in the so-called gouty diathesis, and the numerous disorders of every kind and every organ of the body attributed to uric acid, have caused rather a reaction to set in, and it is perhaps less the fashion to call everything gout and everybody gouty at the

[1] A paper read before the Western Counties Therapeutic Society at the Bath Meeting, February 27th.

present time, than was formerly the case. Between the opinions of Haig, who considers such widely different conditions as epilepsy and bronchitis as evidences of uricacidæmia, to those of others who, like Luff, confine the term gout to the old-fashioned uratic deposits on fingers or toes, with acute attacks of the violent type, there is a wide difference. As is usual with extreme views, the truth probably lies between the two.

There is, however, an increasing opinion held more firmly by many observers, that a substantial modicum of truth underlies Haig's ideas. Not, however, in attributing these conditions to uric acid, nor in changes in the alkalinity of the blood, but in the belief that a series of bodies of complicated nature and origin, of which uric acid is one, are formed as bye-products of defective metabolism. These have been called purins or alloxuric bases, and it is found that their presence is increased by all the factors which hinder metabolism, or are known to cause and predispose to the various gouty conditions. It is probable that in the different properties and poisonous effects of these bodies, and in their presence in various proportions in different individuals, lies hidden the mystery of the protean manifestations of so-called gout. It was formerly supposed that urea and uric acid were the two bye-products of proteid decomposition. But it is now known that the purins form a group including uric acid, xanthin, hypoxanthin, creatin, creatinin and others. Steady work is being done by many experimenters on these bodies, and we may hope shortly to understand their behaviour in the body, and the varied symptoms they produce, more satisfactorily.

With the pathology of gouty conditions in its present confusion, it is hopeless to expect any rational medicinal treatment to be evolved out of this chaos by those who ignore the teachings of Hahnemann. But as an example of the value of homœopathic treatment, I have chosen this evening the subject of "gouty headaches." That the various gouty poisons grouped under the name of purins can affect every organ and tissue of the body is an accepted fact. And in a well-defined and interesting series of head-symptoms, occurring in persons evidently the subjects of gouty manifestations, I think we have evidence that the cerebral blood-vessels, and probably the

cerebral membranes, become temporarily charged with gouty matter, as well as irritated by the gouty condition of the blood stream passing through them. This in some cases may become so severe as to simulate meningitis, and to produce considerable rise of temperature, but in all cases symptoms subside when a stream of pure blood, free from gouty poisons, flows through the vessels. It is this condition that I think may properly be described as the true gouty headache.

Types most liable to Cerebral Gout.

It is usually the case in gouty conditions that that organ or part of body most in daily use, or liable to strain from over blood pressure, is the one chosen to exhibit gouty symptoms. Hence we find the particular headaches I am about to describe most frequently in brain-workers and highly educated persons. Apart from education, I have noted their appearance chiefly in quick-witted persons, especially those of dark eyes and hair. As to age, they are commonest from about twenty-five years up to forty-five. I have seldom noticed them above that period, and certainly not after the age when arteries tend to become rigid. This fact tends to confirm the idea that the vasomotor nerve supply of the cerebral arteries has much to do with the production of headache, especially as it is known that in gout the smaller blood-vessels tend to contract from the presence of uric acid or purins in the blood stream. And the fact that these headaches, when severe, pulsate with the cardiac contractions, renders the explanation more probable. Also these symptoms seem more readily to affect plethoric persons, than those of the opposite type, although the latter by no means escape them.

The Predisposing Causes of Cerebral Gout.

These are briefly those that tend to the production of gout in any other part, and are well known to us all, such as diet, occupation, heredity, and environment. In diet, I have found that meat is often, but not always, a factor in their production. Next to this, I would put tea and coffee in excess. Malt liquors are of course injurious, and a glass or two of beer for a few days will quickly induce an attack in those liable to them. As to heredity, there seems no doubt that the children of parents and grandparents who have had gout or rheumatism

are more liable to these as, it is generally admitted, they are to other manifestations of a similar origin. In some of my cases, very distinct family histories of this kind have been obtained.

Occupation is of prime importance, and it is this that most frequently, in my experience, determines that the particular gouty affection complained of should be cerebral rather than articular or otherwise. Continual mental work, with little open-air exercise, after some years tends to gouty headaches. And they cannot be cured until fresh air and out-of-doors exertion has restored purity and vigour to the blood stream circulating in the cerebral arteries. This I have observed and proved repeatedly. But it is not only the obviously sedentary life that is to blame. I have had severe examples of this disorder in domestic servants, and in shop assistants. Exertion indoors never replaces open-air exercise, and indeed is little better than sitting at a desk all day.

A Typical Case of Cerebral Gout.

I will now describe a case I have selected out of many, as illustrating clearly the leading points of cerebral gout, it is only unusual in the long interval between the attacks.

Mr. R. consulted me for severe headache, stating that a previous attack had lasted two weeks, and as the present one had only just begun, he hoped I could cut it short. Patient is thirty-five years old, manager of an outfitter's shop, medium height, dark eyes, hair and complexion, looks a strong man, of intellectual type. He complains of headache commencing soon after waking each morning, gradually increasing as the day progresses. It is chiefly frontal, but extends all over the head when severe. At its worst it pulsates and jumps, and the pain shoots into his eyes, which become blood-shot and water. The agony is extreme, and he has to go to bed, only perfect rest in a dark room renders it bearable. The pain is greatly increased by moving, especially stepping or jerking the head. A cough or sneeze causes excruciating pain. There is slight nausea when the distress is greatest, but never vomiting. The pain gets more bearable in the evening, and he generally sleeps well, but feels it again soon after waking. His general health is excellent, bowels regular, appetite good—when not in

pain. He confesses having drunk several glasses of beer a day lately, which he knows is bad for him; usually he takes a little whisky. Of late he has had a good deal of worry in business and at home. He has noticed that as the headache goes off he passes a quantity of limpid urine. His habits of life appear to be satisfactory, he is not a great smoker, but he takes very little exercise, and is fond of meat, eating a good deal.

A careful examination of the patient revealed nothing abnormal, tongue was covered with a thin grey fur, but was by no means a dirty one. Pulse tension distinctly high. Urine rather scanty, of high acidity, and some lithates present on deposit.

After several days of severe pain, the patient recovered, and returned to business within the week, a result which very much pleased him. The treatment adopted in this case will be presently described.

THE CHARACTERISTIC SYMPTOMS OF CEREBRAL GOUT.

(1) *Tendency to Periodicity in the Attacks.*—This is much more marked in some cases than in others. Usually the headaches occur every few weeks or months, but they may be induced at any time by causes which are known to disturb metabolism and to stir up gouty matters. The periodicity is not so marked as in migraine or bilious attacks.

(2) *Gradual Onset and Departure.*—This I believe to be invariable, being due to the variations in the proportions of uric acid (or what the poison may be) in the blood stream. This differentiates the attacks from most neuralgias and from purely nerve pains.

(3) *Location of Pain.*—Almost always this begins in the frontal region, sometimes going into the eyeballs, and extending to temples and even to occiput. The latter position is rare, the forehead being the chief seat of pain. The frontal lobes are those most highly developed in brain-workers, and most liable to fluctuations in the blood supply, besides being more generously supplied with capillaries. This appears to me to explain their chief liability to gout pains.

(4) *Characteristics of Pain.* — Continuous severe aching, often extremely violent until the patient is completely prostrate and almost frantic from its severity. It is always felt as inside

the head, differing in this from pain of the superficial nerves. But its most characteristic feature, and one seldom met with in other conditions, is its ebbing and flowing with every movement, even to pulsations synchronous with the heart-beats. It is described as if the brain were a bag of sensitive jelly which quivered and shook with the slightest effort, even speaking increasing the pain.

(5) *Modalities of Pain.*—The most important of these is aggravation by the least movement, especially by stepping or jarring the head. Everything that increases the heart-beats aggravates the pain. It is consequently increased by coughing and sneezing, also by any mental effort. Naturally, relief is found by perfect quiet alone, such as lying down in a dark room. There is a tendency to sleep in some cases, and I have never known sleep interfered with by the pain, which, however, usually recommences soon after waking, when the blood returns to the brain.

(6) *Duration of the Attacks.*—The longest I have noted was almost continuous pain for two weeks. One day to four or five, is the more frequent duration. In the longer attacks I have found a rise of temperature to 102° F. at the climax, but this is quite exceptional, most cases showing little or no tendency to fever. Usually a mild attack comes on during the morning or afternoon, and does not cease until it is forgotten in sleep, the patient waking up free in the morning. But if immediate rest is taken, a few hours may diminish its severity.

(7) *Generalities.*—One or two other points I have noted of interest. First, the absence of vomiting and any signs of gastric disturbance. The tongue is usually clean, in severe cases of some duration it becomes white, resembling the cerebral tongue. There may be slight nausea when the pain is severe, but not always, and patients will take nourishment freely as a rule, except that they dread the movement of feeding as increasing their discomfort. There may be slight constipation, but often the bowels are regular and the motions unaffected in appearance and character from the normal. Also the passing of much clear limpid urine is a pretty constant symptom as the pain passes off. This is explained by Haig in migraine (where the same symptom may be noted) as due to the blood being cleared of uric acid, freeing the kidney capillaries from vaso-

motor contraction, and so inducing diuresis. However this may be, it is significant that the cerebral and kidney blood-vessels should be released at the same time. There must be some connection between the two events, since relaxation of the capillaries of the brain would be the probable cause of relief to the headache, as it is also the cause of the free urination.

Treatment during an Attack of Cerebral Gout.

Taking general measures first, it is evident that severe cases must be treated by rest in a dark room in the recumbent position. Employed in business as many sufferers are, they will often persevere with work until the pain becomes too intolerable to endure, and this, I am sure, prolongs the attack. However, we are justified probably in using measures to avert the pain, hoping that a patient may continue his work until evening, and that after a night's rest the attack may vanish. For this purpose I have repeatedly proved that two measures are most helpful, they are (1) drinking hot water, and (2) abstaining from food. A slight attack can often be averted, or perhaps postponed, by copious libations of hot water. The reason is a simple one. By freely diluting the blood, the relative quantity of poisonous matter contained in it per volume is diminished, and its effect therefore lessened. Hence when the amount is small this dilution may be sufficient to permit the cerebral arterioles to relax. If no food be taken, except possibly a dry biscuit, and hot water is drunk, many an attack will quickly pass. Why abstinence from food should help is perhaps through the passage of gouty poisons into the blood from the alimentary system being checked, and this, coupled with freer dilution of the blood, enables the kidneys to eliminate the poisonous matter speedily.

I pass on to medicinal treatment. And here one must reiterate the invaluable principle of *similia*, and find the correct remedy afresh for each case in accordance with Hahnemann's directions. I know of no drug that is always useful, but I have obtained valuable aid by many, both cutting short severe cases and also preventing recurrence of the malady, by giving the appropriate homœopathic remedy. I confess it is not always easy to find this, and the first attempt may fail. If

relief does not come in twenty-four hours I try another drug. The case described just now was quickly relieved, and I think cured, by *spigelia*. When the pulsations are marked *glonoin* 6x is very helpful, lower than 6x it may aggravate. *Veratrum viride* helps some cases, and when the urine is offensive, and it often is in gouty conditions, *benzoic acid* is invaluable both during and between the attacks. One might expect *belladonna* to be indicated, but this old friend has always failed me in this and in other gouty conditions. *Colchicum* also, unless strongly indicated by gastric symptoms, is of no use. *Mercurius*, *lycopodium* and *bryonia* are all occasionally of service. In mild cases I have found *mercurius biniodatus* in frequent doses of the 3x every hour for a few hours, carry off the headache.

In these days, when relief is instantly demanded and sought for in *phenacetine*, *caffeine* and other drugs so eagerly, it may be needful to add a word as to their use. They have little or no effect in cerebral gout, and the use of *caffeine* in particular aggravates; neither do the *salicylates* help, at least during an attack. But I have found 5 to 10 grains of *aspirin* give immediate relief in several cases, and have not been able to trace any harm from its occasional use as a palliative. In one case in which *aspirin* failed, a new preparation named *phenalgin* removed the severer pains; it is said to be a mixture having *antifibrin* as its base. I am opposed to the use of these palliatives, except in mild cases where the occasional use of a tablet may enable a worker to continue his occupation by carrying off a threatened attack. When the patient can rest quietly at home they should not be employed, but reliance placed alone on the homœopathic remedy.

Treatment of Cerebral Gout between the Attacks.

This practically resolves itself into treatment of the gouty condition, with such modifications as the special form may suggest. The subject is too lengthy for consideration here. One or two points only can be touched on in the order of their importance: (1) Relief of mental strain and head-work, with increased open-air exercise; (2) abstinence from butcher's meat in excess, chicken and fish being substituted; (3) no malt liquors and acid wines; (4) coffee should be avoided, and in some cases tea is a potent cause of cerebral headaches.

Two patients I found impossible to cure until they gave up tea, though neither took it to excess. One has become so sensitive to its use that a single cup of tea taken on three or four successive days will bring on a headache lasting all one day. This he has proved again and again. Sugar, and such starch foods as potatoes, are inadvisable. I have also found a weekly vapour or Turkish bath of decided value. However, careful dieting, and such exercise as a round of golf twice a week, will cure most cases. The same remedies useful during the attack should be continued during the interval, and any others that special symptoms may call for in less frequent doses.

DISCUSSION.

Dr. NICHOLSON complimented the author on his interesting paper, which was of considerable practical value. There were several useful medicines which had not been mentioned by Dr. Ord. Of these *actæa racemosa* was of frequent use, more so than any other in his opinion. He doubted whether gout was the true pathological origin of the headaches described. Very often they were purely neurotic. Change of air would cure them, often for many months, without any special treatment. If they were of gouty origin he thought this could not be so. Change of habits and of air were useful in both gouty and neurotic headaches. If they were gouty headaches they ought to be worse in later life, which was not the case, for they were generally worse in young people. Therefore he could not subscribe to the theory of their gouty source. He agreed as to the importance of seeking the remedy in accordance with the law of similars, and not by pathology. By this means nearly all cases could be cured, even without changing the habits and conditions of life, which was often impossible in workers and business people. Their homœopathic treatment was hence of great importance.

Mr. DUDLEY WRIGHT asked what Dr. Nicholson understood by neurotic as opposed to gouty headaches in these cases?

Dr. NICHOLSON said "frequently recurring headaches of nervous origin."

Mr. DUDLEY WRIGHT said he could speak with some experience on the subject, having been personally subject to just

such headaches as had been so graphically described by Dr. Ord. When a medical student he was much troubled by them, they were very severe, lasting eight to ten hours, and usually beginning in the morning in the occiput. They caused intense pulsation on the least exertion, and gave notice of their approach for some days beforehand by causing severe depression of spirits, which was very distressing. Then came the severe headache; when it had passed off he was free for some time. Their cause much puzzled him until he noticed that he always suffered from an attack after a day's fishing, an occasion which was celebrated by a heavy beef luncheon and some fine old Burton ale. He believed the beef and beer caused the headache, and on avoiding these he was more free for some time, but not entirely so, owing to other foods which he had since learnt to avoid. Amongst these was beef, which he considered as absolute poison to his condition. He obtained relief to both the depression and headaches by large doses of *bicarbonate of soda*, which neutralised the acid toxæmia to which he believed they were due. He had experienced entire relief for some years by careful dieting and exercise, and especially by deep breathing exercises. These he considered of great importance, as they produced flushing of the capillaries of the skin, which was a great safeguard to toxæmia and other blood poisons, to the presence of which no doubt these headaches were due.

Dr. GILBERT said he was very familiar with these headaches in his practice. They were especially common in city men, who were heavy eaters and took little exercise. There was no difficulty in curing them, several remedies were useful, especially *bryonia* and *epiphegus*. But patients demanded immediate relief, and he found nothing more certain than *phenacetine* and *caffeine*, repeated several times until the headache ceased; this gave good results in most cases. He had cured a severe case with *urtica ureus*, but it had failed in other cases. One lady who suffered from attacks, accompanied by severe congestion of the eyes, was cured at once by *bromide of lithia*.

Dr. B. W. NANKIVELL mentioned a very severe case of these headaches which was cured by a course of Salisbury Diet, but the headaches returned when she gave up the diet.

Dr. NEATBY said the origin of these headaches, whether neurotic or gouty, was a complicated question. Leonard Hill maintained that uric acid was as innocent as distilled water. He doubted whether uric acid had much to do with them, but they were doubtless due to some toxæmia. Some patients were relieved by purin-free diets, and others were relieved by the opposite, such as meat diets. He had found two drugs especially useful as preventives in these headaches, which had not been referred to, they were *sepia* and *natrum muriaticum*. An indication for the former was thick offensive urine, whilst *natr. mur.* was useful when the urine was profuse and of low specific gravity.

Dr. HARDY doubted whether the headaches described were really gouty, but they were certainly due to toxæmic poisoning, though what the toxin was might not be known. They did not differ much from the bilious headaches of youth. Nevertheless, the treatment resolved itself into a question of dieting. He believed it was better to reduce the quantity of food rather than alter the quality. He thought a meal of one course only was a great advantage, it was a mistake to mix meat with milk puddings and sweets. He agreed that these headaches were commonest from twenty-five to forty years, after which they became fewer. The indiscriminate use of antipyretics was certainly to be deprecated, but when needful for rapid relief he thought *phenacetine* and *caffeine* best and least harmful. As to beverages, he was strongly in favour of lager beer, and thought it far better than wines or spirits; he had found no harm from its moderate use. In the so-called neurotic headache he thought *actæa* and *sanguinaria* were remedies of great use.

Dr. ORD, in replying, said that in gouty headaches, drugs without dieting would not, in his opinion, cure, but in neurotic headaches they undoubtedly did. He distinguished between the two chiefly by the symptom of pulsation in the brain, aggravated by the least motion, which he did not believe occurred in true neuroses. It showed that the fault was in the circulation in the brain, not in the nerves. When the blood-vessels became rigid in older persons, they ceased to expand and contract under the influence of toxæmic poisons—whether called uric acid or not did not matter—hence these

headaches were not felt in later life. In younger persons the liver was more frequently affected by gouty poisons, and this caused bilious vomiting, with or without headache. In brain-workers the headache alone was commoner. Gouty headaches were benefited by change of air and scene just as neurotic ones, without drugs, but if the same diet were continued they would return. Mr. Dudley Wright's experiences were a valuable confirmation of his views. With regard to Dr. B. W. Nankivell's case, relieved by Salisbury Diet, when other cases could only be cured by a semi-vegetarian diet, the apparent contradiction could be easily explained in this way: the poisons, whether uric acid or not, which caused these headaches and other gouty conditions were produced only by a mixed diet. A meat diet without starch would not tend to cause gout, nor would a purin-free or vegetarian diet, but when the two were combined, gout resulted. Hence the change of diet from a mixture to either of these, cleared the system and relieved the symptoms. In conclusion, Dr. Ord thanked the Members of the Society for their interesting and valuable discussion; this he thought was of far greater importance than his paper, which they had received so kindly.

CLINICAL CASES.

By E. W. BERRIDGE, M.D.

(*Continued from p.* 227.)

CASE 8.—*Eupatorium perfoliatum.*—December 22nd, 1891.—Mr. F. M., aged 55, has suffered from hereditary gout, at intervals, for twelve years, usually in left great toe. For last two weeks has had an attack, sometimes in the toe, sometimes in fingers. This morning the left great toe is distinctly worse, the redness and swelling having advanced from the extreme tip and first joint to the second joint; the joint is tender on pressure.

Diagnosis of Remedy.—Gouty swelling of great toes. *Aster, benz.-ac., eupat.-perf., plumb., sabin.*

Swelling of left great toe. *Eupat.-perf.*

I gave him one dose of *eupat.-perf.* Cm. (Finckè).

May 31st, 1892.—Reported that the gouty attack was cured at once, and had not returned.

Comments.—(1) This case again illustrates the value of clinical symptoms; swelling of the left great toe has not yet been produced by this remedy. (But compare symptom 84.)

(2) In this case, even though the attack was acute, a single dose was sufficient. The general rule for the potency and the dose is, the more completely homœopathic the remedy, the higher the potency and the smaller the dose. When only a *simile*, not the *similimum*, can be found, either a lower potency or a more frequent repetition may be required; but then the results are not so satisfactory.

CASE 9.—*Magnesia phosphorica.*—January 1st, 1906.—Miss R., aged about 25, for five weeks, though not every day, has suffered from shooting pain from right upper jaw to forehead and ear; the pain is worse at night, and when eating; better by lying on painful side, by warmth, by cotton-wool in ear, and by pressure.

Diagnosis of Remedy.—Shooting from face to forehead; not recorded.

Shooting from face to ear. *Bellad., carb.-an., kali-bi., phosph.*

Pain in face better by warmth. *Calc., coloc., dulc., magn.-ph., phosph., rhodod., sanic., spig., sulph.*

Pain in face better by lying on painful side; not recorded.

Pain in face worse at night. *Magn.-ph., phosph., sulph.* (and others which have not the relief by warmth).

Pain in face better by pressure. *Ailan., bry., cupr.-ac., dig., magn.-ph., sep.*

Pain in face worse by eating. *Mang., mezer., phosph., zinc.*

Numerically, *phosph.* was in the first rank, and *magn.-ph.* in the second. But the shooting from right upper jaw into ear of *phosph.* (915) is in connection with toothache, which was absent in the patient; it was also worse in the morning, whereas the patient was worse at night. Moreover, the relief to facial pain by warmth is given by Kent in the first rank, and therefore superior to *phosph.*

I therefore selected *magn.-ph.*, and gave patient one dose. The potency was Cm. (F.C.), prepared by Dr. Tyrrell, of Toronto.

January 2nd.—Patient reports much better; had a better night.

February 28th.—The pain returned about 2 p.m., just after dinner. Gave one dose of same medicine in same potency.

December 6th.—Remained quite well till a week ago. Now has shooting pain in left side of face, back of ear, and down neck. It comes on when lying down at night; being much worse at night; better when lying on painful side, by warmth, and cotton-wool in ear.

As the conditions were almost identical, though the pain was on the other side, and slightly different in direction, I prescribed again one dose of the same medicine in same potency.

December 7th.—Had a good night, and pain nearly gone.

December 8th.—Pain worse last night and to-day. Repeated same remedy.

April 13th, 1907.—Was quite well next day, and has remained so, in spite of the severe weather.

Comments.—(1) This case shows the importance of grading the remedies which produce or cure the same symptom, as was taught by Bœnninghausen. These gradations, in cases where two or more medicines seem equally indicated, will often decide the choice.

(2) Clinical experience here adds a new symptom to the *Materia Medica* for future verification; shooting pain from right upper jaw to forehead and ear.

CASE 10.—*Arsenicum.*—November 7th, 1899.—Mr. T., aged about 45, wrote that he had a very heavy catarrh, nose running, and continuous violent sneezing which sends a severe pain down both arms; worse in evening, very bad last night, sneezing, and head seemed full of catarrh; return of pains in right side of face, and forehead seemed stuffed up, the same feeling as when he had ozæna.

Diagnosis of Remedy.—The general symptoms pointed to *arsenicum*, but the only really characteristic symptom, the pain in arms on sneezing, belongs to *alumina* (877). On the other hand, the *alumina* symptom is confined to the back of one upper arm only, and extended to scapula. *Alumina* also has no violent sneezing, which is characteristic of *arsenicum* (503, 504, 505). I sent him a powder of *arsenicum* Cm. (F.C.), to be dissolved in water, and a spoonful of the solution taken every three hours till relieved. Later he wrote that all the symptoms were quickly cured.

Comments.—This case presents no special features, except the pain in arms on sneezing, and on this account is recorded for further verification. Both *alumina* and *arsenicum* should be studied whenever this symptom occurs.

CASE 11.—*Belladonna.*—February 6th, 1892.—I was consulted by a colleague concerning Mrs. H., aged 73, suffering from bronchitis and weak heart. The most characteristic symptom was a very marked Cheyne-Stokes respiration, the respiration gradually increasing in strength, then gradually decreasing, with an interval of complete cessation before it recommenced.

Diagnosis of Remedy.—Cheyne-Stokes respiration belongs to *bellad., cocaine, op.* (*sulph., sulph.-ac.*). The remaining symptoms, the notes of which I did not preserve, as the case was not under my care, indicated *belladonna.* A few pellets of 200 were dissolved in water, and a spoonful of the solution given every four hours. The remedy acted most satisfactorily, and my colleague informed me later that the patient completely recovered.

Comments.—(1) Cheyne-Stokes respiration is of rare occurrence, but of very grave import, and seems to be connected with cardiac disease. Dr. David Wilson informed me, in 1889, that he had only seen five cases, of which only one recovered. I have only seen two, including the present, and of these only one recovered, though the other was temporarily relieved. My prognosis was, therefore, unfavourable.

(2) The *bellad.* symptom is found in a case of poisoning reported by Dr. W. Oliver in the *Lancet*, October 24th, 1891, p. 929. The *cocaine* symptom is recorded by Dr. Boldt, in the *New York Medical Record*, December 24th, 1885; it was produced on a cat. The *opium* symptom is the clinical experience of Dr. David Wilson: in a case of permanent mitral regurgitation, the olfaction of *opium* 200, for five days whenever the breathing stopped, saved life. He also informed me that he had clinically verified, with *bryonia, opium*, and *sulphur*, the analogous symptom, "stoppage of respiration," and that in a fatal case of Cheyne-Stokes respiration *sulph.-ac.* 200 had somewhat ameliorated this symptom, and removed the up-and-down movement of the larynx.

On February 6th, 1890, I prescribed one dose of *sulphur*

2 cm. (F.C.) for Mr. G., aged 67, who had Cheyne-Stokes respiration. The remedy removed the symptom at once, producing general improvement, and it did not return for some time. On November 15th, 1890, he caught cold by imprudently taking a long drive in cold weather, and pneumonia followed. He improved greatly under treatment, but early one bitterly cold morning his nurses let the fire go out. On my next visit I found him much worse, with increased pneumonia, weak action of heart, and a marked return of the Cheyne-Stokes respiration. He died in a few days.

(3) Cheyne-Stokes respiration, like the fan-like action of the nostrils, and the up-and-down movement of the larynx, is of great value in the selection of the remedy; it belongs to the class of automatic movements, and so is akin to the class of mental symptoms; being, so to speak, the involuntary expression of the state of the nervous system. The experience of physicians with regard to these, and analogous, symptoms, is much to be desired, as they may belong to other remedies than those already recorded.

(4) A symptom produced by a poisonous dose of *bellad.* was cured in a patient by the 200 potency thereof; therefore no guide to the selection of the potency in the cure of the sick can be deduced from that used in the proving.

(*To be continued.*)

Clinical Case.

By Dr. W. F. H. Newbery.

Recurring Attacks of Acute Localised Œdema.

J. C., aged 55, plumber, working in His Majesty's Dockyard, first attended Out-patients' Department on January 15th, this year. Has been a moderate drinker, chiefly of beer, and until three months ago was a chewer of tobacco. Complaining of pain in epigastrium, sinking—a good deal of flatulence, with occasional giddiness. Tongue coated. Has suffered from these symptoms for years. Has tried various remedies, and seen different doctors, without obtaining relief.

Under a course of *nux* ix ℥ii., *t.d.*, *a.c.*, he began at once to improve.

On February 5th had not been so free from pain for years, but complained of a good deal of palpitation coming on between seven and eight o'clock in the evening, and lasting till between three and four o'clock in the morning. To stop cocoa for supper. Continue *nux* IX.

February 12th.—Manifest improvement, general depression, of which patient had greatly complained, much relieved, and tongue cleaner; sleeping better.

February 19th.—Patient recovering from nasty cold and cough. *Caustic* 3x, 3h.

Patient did not come up again until March 12th. Pain had been bad, but the cold was much better. On 5th and 8th had had attacks of "urging.[1]

Right side of face swollen. On being asked if teeth were all right, patient explained that he is subject to sudden swelling in various parts. The present attack came on, as usual, quite suddenly. Began soon after 2 a.m. By 5 a.m. face was quite unrecognisable, after which swelling began to go down. Has been to various doctors, "who do not give him any information." The application of "hot water seems to bring it up," after which the swelling goes down in about the same time as it takes to get to a climax. When at its height the swelling is "as hard as a piece of iron." Repeat *nux* IX.

March 19th.—Patient's face looks normal. He now gave the following account of these attacks: First one occurred about nine or ten years ago. He left home one morning in July, feeling perfectly well. By the time he had got to Devonport (two miles) he felt a swelling over left eye. By the time he "got to shop" (quarter mile further) the swelling was as large as an egg. By 10 a.m. the swelling had so increased that left eye was quite closed. Saw the "Yard Doctor," who told him it was the effect of drink. When in reply to this he said he had not taken any intoxicants for three months, he was told his heart was weak, and that he would not live another three months. He saw his own doctor, who reassured him. Since then he has had several similar attacks in different parts —face, arms, forearms, hands—back and front—penis, testicles, but never in lower limbs, and never anywhere about body

[1] A common expression in the South-west, which means straining ineffectually to vomit.

except "privates." If left alone the swelling may take eight to nine hours to get fully developed, and the same time to go down. If the part is bathed in very hot water, the swelling gets to a head and subsides in about half the time. The patient has obtained the following medical opinions: "Stomach," "Stomach," "Metallic poisoning," "Would not say," "An excess of water in the blood." Repeat *nux.*

March 26th.—Patient has had a slight attack of the swelling to-day—this time on chin and left side of face. "Not much." Began about 6 a.m., just as he was leaving for work; at its height about 8 a.m., and a lot gone down by 9 a.m. No application of hot water. Present condition, 6.30 p.m., presents sensation to touch as though abscess were forming in left cheek.

Family History.—Father died, aged 63, of "cancer of stomach"; mother, aged 72, "of stomach and liver, not cancer." Has had one brother and five sisters, of whom only the brother and one sister are living. Never heard of any other members of the family having the same kind of swellings. Two sisters died of cancer—one of breast, after five operations; the other, a hard drinker, of cancer of liver. The other two sisters were both abstainers; both died of "apoplexy," one, the oldest, aged 27, and the other, the youngest, aged 21. Never heard of any nervous or brain trouble in the family. Father's father died at 93, and mother's father at 79. Does not know anything about his grandmothers.

As to the dyspeptic symptoms, patient says that as long as he continues the medicine he is free from pain and can enjoy his food, but when he leaves it off he "gets back into the old way again." Repeat *nux.*

April 2nd.—Patient has had attack of the swelling again to-day—"almost swollen blind at two o'clock." Now, 6.30 p.m., has only some slight œdema of upper eyelid. *Apis* 3x. ♏ii., 4h.

This case is reported while still under treatment and observation, in the hope that it may draw out some comments, suggestions, or criticisms.

Short Clinical Notes.

By THOMAS SIMPSON, M.D.

THE frequency with which tumours of the breast are summarily removed by the surgeon's knife justifies us in stating that in most instances such summary extirpation is unwarrantable. Recently a lady, aged 43, showed me how her fears had been aroused by her doctor declaring that "a lump in her left breast had the appearance of malignity about it," and he advised its removal, though she had the other breast amputated two years ago. She exhibited no signs of cachexia, had no pains, no heritage of cancer, and was in perfect physical health. She asked for a prescription, and having carefully compared notes I gave her *merc.* 6, grs. ii., every evening. The swelling vanished after nine weeks' treatment and her health is now satisfactory.

CASE 2.—A child, aged 6, of poor parents, had numerous vesicles on the nape of neck, some matured into scabs, with swollen glands in the vicinity, foul tongue and poor appetite. *Merc. sol.* 6 every evening for seven days, then *petroleum* 3 for seven days; in fourteen days the eruption had died away entirely. The only application was vaseline externally.

CASE 3.—Young woman, aged 22, applied to me for a cough which disturbed her sleep. Emaciation, heart palpitation from mitral obstruction, and dyspnœa on exertion, voice feeble and anæmia. *Ferrum phos.* 3, grs. ii., each night, fourteen doses, followed in a week by *arsen. iod.* 6 each evening, These drugs caused all her discomfort to vanish, menstruation was restored, and health improved.

CASE 4.—Town waiter, feels a tumour in scrotum, which wearies him when walking. Examination showed that hydrocele of the cord was present. *Rhododendron* 6 seemed to clear it away in three months. A suspensory bandage was worn at the same time.

CASES FROM THE LONDON HOMŒOPATHIC HOSPITAL.

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

Case I.—Eczema Cured by Sulphur.

Edith T., aged 3½ weeks, came in August 9th, 1906. Eight days previously an eruption appeared on the forehead. This presented the appearance of a yellow, scaly skin, all over the body, but worse in the face and abdomen and around the navel. *Sulph.* 200, one dose was given, and *sacch. lact. bis. die.* On August 23rd the child came again. The eruption had disappeared from the body and limbs. It "dropped off in scales," and only remained on the scalp and forehead. *Sulph.* 200 repeated, one dose. By September 6th the eczema was confined to the scalp. On September 20th the scalp was covered with seborrhœic eczema and also scaly eczema of the forehead. *Sulph.* 30 *bis. die.* On September 28th the condition was much improved, the eruption much drier, but still much caking of the scalp. Repat. *sulph.* 30, *bis. die.*, and *oleum morrhuæ* ℥i. *bis. die.* This prescription completed the cure, and when the mother saw me last on April 8th, 1907, she reported the child had continued quite free from eczema ever since.

It is worth noting that the child had *not* been vaccinated prior to the appearance of the eczema.

Case II.—Illustrates Heredity in Phthisis.

Jonathan T., aged 1 year 10 months, came to the Hospital April 8th, 1907. He had a healthy mother, who by a former husband had two healthy children. The second husband, who is the father of this child, is delicate, and his brothers have died of phthisis at about 30 years of age. Another child by this same husband is also delicate and wasting.

Jonathan has had a cough since birth, and "has been treated for consumption from birth." The motions are yellow, watery and offensive, and have been thus for the last ten months. He also has night sweats.

There were marked physical signs of phthisis pulmonalis. At the right posterior base of the lung were fine crepitations, extending to the mid-scapular region. The flesh was flabby and wasted. The abdomen was distended, and the constant

offensive diarrhœa, in association with the other symptoms, pointed to mesenteric disease as well, although no glands were felt.

Ars. iod. 3, grs. jii. *ter.*, and *tub.* 30, 2 discs weekly were prescribed. The prognosis is unfavourable; at a subsequent date I hope to report the result of treatment.

Case III.—Æthusa Cy. 3 in Vomiting.

Frank K., aged 3 months, a breast-fed child, was brought on March 4th, 1907, for vomiting, from which he had suffered for the past six weeks. He also had greenish, relaxed stools. He was well nourished. *Ipec.* 3x was given. This helped the bowels, but the vomiting continued, and on March 25th was worse, when *æthusa cy.* 3 was prescribed. This did great good, and the vomiting and crying ceased.

Case IV.—Deafness from Adenoids.

Carrie P., aged 4, came on May 31st, 1906, her mother complaining that she was getting deaf and breathing through her mouth. She presented the usual symptoms—nasal catarrh, constant mouth-breathing, follicular pharyngitis, and ragged tonsils, which, however, were not enlarged. *Phytolacca* 1x, 3h, and a spray of *phytolacca* ϕ ♏iij. to ʒss. was prescribed, together with the *chin-strap*, which is a most important adjunct to treatment. On July 6th she came with a thick yellow discharge from the nose, and the prescription was changed to *hep. s.* 12 *ter. die.* This suited well, and on August 30th she was very much better and breathing with closed mouth.

During the month of October she passed through an attack of whooping cough. On February 7th, 1907, she returned with a cold in the nose and a croupy cough; for this *hep. s.* 12 was again prescribed, and on February 15th she was very much better, hearing quite well, and breathing through the nose. Such a case would, under the old school treatment, certainly have been curetted for adenoids, and probably discharged without any medicines. Such treatment is invariably followed by a recurrence.

Hospital Reports.

*** The Editors request that all correspondents will kindly condense their reports as much as possible, consistent with a smooth and effective rendering of the facts they wish to convey. Items of *merely local* interest should be omitted.

As there seems to be some misunderstanding in regard to this section, we would point out that there are two kinds of matter wanted for it:—

(1) News, reports of meetings, &c., which must be compressed into one, or at the most two, paragraphs of not more than ten or twelve printed lines.

(2) Reports of interesting cases occurring in Hospital or Dispensary practice, new methods of treatment, and all purely professional matters. These should be carefully, or, if needful, elaborately recorded and described. Each contributor will be allowed two pages of the REVIEW every month for this purpose.

Newspaper reports, unabridged, need not be sent. Such reports must be compressed and will come under (1) above, otherwise all such newspaper and unabridged reports will be laid gently, but firmly, to rest in the waste paper basket.—EDITORS, *B.H.R.*

THE PHILLIPS MEMORIAL HOMŒOPATHIC HOSPITAL, BROMLEY.

THE Phillips Memorial Hospital completed the eighteenth year of its existence at the end of 1906. The present building was erected at a cost of £7,000 on a site overlooking the public gardens. It was opened in 1900 by Sir Henry Tyler, with a women's ward of six beds, a men's ward of three beds, a private ward for paying patients, and a separation ward, and during last winter a male ward with six beds was opened, as well as a children's ward, bringing the total present number of beds to eighteen. Additional accommodation for the nursing staff is now being provided. During 1906, 143 patients were treated in the ward, of whom 110 were discharged cured, 19 more or less improved, ten deaths, and four remaining in at the end of the year. Out-patient attendances numbered 1,760, and 559 visits were paid to patients at their own homes. A ladies' guild was formed last March and has a membership of seventy-two, with Mrs. A. K. Ledger as Secretary. It was able, as a result of a garden fête held in June, to hand over £109 to the Children's Ward Fund.

In the autumn a Children's Ward with four cots was opened, and has met a long-felt want, as previously children had to be put in the adult wards or refused admission.

A pound collection was again held, which greatly assisted in diminishing the expenditure on provisions, &c.

H. W. T.

LONDON HOMŒOPATHIC HOSPITAL EXTENSION FUND.

THE work of the London Homœopathic Hospital has altogether outgrown the accommodation; more wards are required, and especially a children's observation ward, where doubtful cases can be observed before being allowed to mix with other children; both waiting-rooms and consulting-rooms are required in the out-patient department; more accommodation is wanted in the kitchen and domestic sphere; and, lastly, it is proposed to establish—what has long been a crying need—wards for middle-class paying patients. For these purposes it is estimated that a sum of £30,000 will be necessary. £14,000 has already been promised, or paid, but much of this is conditional on the remaining £16,000 being raised by December 31st next. It is earnestly hoped that this amount will be secured, not only for the benefit that will accrue to the sick poor of the metropolis, but in the interest of homœopathy in this country, for the extension will enable the Hospital, as regards the number of its beds, to fulfil the requirements of the Senate for its recognition as a Medical School.

The Treasurer, the Earl Cawdor, has recently received £2,027 4s. 2d. from the estate of the late Mr. William Bykur, of Poole, Dorset.

OXFORD HOMŒOPATHIC DISPENSARY.

ANNUAL REPORT.

THE Committee of the Homœopathic Dispensary beg to present their thirty-fourth annual report to the subscribers and friends of the Institution.

They would call attention to the large amount of medical aid which has been afforded to those members of the community in Oxford who are unable to provide skilled attendance for themselves. The fact that no less than 820 visits have been paid to the poor in their own homes should appeal to everyone who would help the poor in the most satisfactory way.

But though the usefulness of the Dispensary is extending, the funds, unfortunately, remain nearly stationary. The Committee would earnestly appeal for increased support on behalf of an institution which brings to the homes of the very poor the services of a highly qualified medical practitioner.

BRISTOL AND CLIFTON.

A LADIES' COMMITTEE has recently been formed with a view to furthering the interests of the Homœopathic Hospital and Dispensary here. They have already held a meeting preparatory to making a start upon the several phases of work which they have before them; these include canvassing for new subscriptions, the formation of a sewing guild to keep the Hospital supplied with linen, supervising the domestic economy of the Hospital, visiting the patients, &c.

It is with regret that we note that the Hospital and Dispensary has recently been deprived of the valuable services of Dr. Samuel Morgan, who has felt obliged to resign his position upon the active staff. All connected with the institution will sincerely hope that he may yet be permitted for a long while to give us his help on the Committee and as Consulting Physician. It is noteworthy that a week or two before his resignation, Dr. Morgan had completed fifty years of service in connection with the Homœopathic Hospitals and Dispensaries of Bath and Bristol.

SEVERE CASE OF HÆMORRHOIDS CURED WITHOUT OPERATION.

REPORTED BY DR. J. HERVEY BODMAN.

A. M., aged 57, coal-miner, first attended the Hahnemann Hospital, Bristol, as an out-patient on April 19th, 1906.

His chief complaint was that for several years he had suffered from piles, from which there had sometimes been profuse hæmorrhage; but at the time of attendance what he specially complained of was a large internal pile, which became prolapsed, and caused great discomfort on every attempt to work. On account of this he had been obliged to leave off work for several weeks. He had been having allopathic medical treatment without benefit, and had been advised to undergo an operation. Being averse to this, he was very anxious for us to do our best to cure him without.

On examination it was found that there was a very large prolapsed internal pile, as large as a bantam's egg. The bowels were constipated. The first prescription was *Ac. nit.* 2x t.d.s.

On several following occasions medicinal treatment was supplemented by the injection into the substance of the pile

of a solution of *carbolic acid* with *hazeline*, as recommended by an American surgeon, Dr. Hoyt, and to the value of which attention has been drawn by Mr. Dudley Wright. The formula used was: *Acid carbol. liq.* ♏xlviij., *hazeline, aq. pur.* āā ʒss.

April 26.—About the same. Injected ♏iii. of Hoyt's Fluid into the centre of the prolapsed pile with hypodermic needle. Rep. *Ac. nic.*

May 3rd.—Condition of hæmorrhoid the same. Much depression. Injected Hoyt's Fluid ♏v. *Nux. V.* 3x.

May 10th.—About the same. Injected Hoyt's Fluid ♏v. Rep.

May 17th.—About the same. No injection. *Sul.* 6.

May 24th.—Hæmorrhoidal swelling much smaller, and does not come down so often. Injected Hoyt's Fluid ♏vi. Rep.

June 7th.—Pile still comes down at times. *Caust.* 6.

June 14th.—The hæmorrhoidal swelling is now hardly a quarter of its original size. Injected Hoyt's Fluid ♏iii. Rep.

June 28th.—Only a small external pile visible now. Rep.

July 5th.—The pile still comes down when the bowels act, but is smaller. Rep.

August 2nd.—A good deal of difficulty in defæcation, with pain and prolapse for some hours after. *Æscul.* 3x, *ung. æscul.*

August 23rd.—Better. Rep.

August 30th.—The pile still comes down on straining. *Sul.* 6.

September 13th.—Constant feeling as if the pile was pressing down. *Aloe* 6.

October 18th.—Much better; able to do light work without the pile coming down. Rep.

January 3rd, 1907.—Has been doing full work in the coal-pit for more than three months. The pile does not become prolapsed during work now, except the last three days, when his work had been exceptionally heavy. To resume *aloe* 6.

January 24th.—The pile has not prolapsed during work since the day after the last attendance. Rep.

Remarks.—This was a particularly severe case of hæmorrhoids, and the patient was quite disabled by them for several weeks. There is no doubt that the injections had a great effect in reducing the size of the hæmorrhoidal swelling, as we have seen them do in several other cases. But much additional benefit was derived from the internal remedies, and this was especially marked in the case of *aloe* 6.

BIRMINGHAM AND MIDLAND HOMŒOPATHIC HOSPITAL AND DISPENSARY.

ANNUAL MEETING.

THE Annual Meeting of subscribers and friends was held at the Hospital on March 20th, the Lord Mayor of Birmingham (Councillor H. S. Sayer) in the chair. The Secretary read the statistics, which were as follows :—

	1905	1906
In-patients	297	318
Out-patients :—		
Number of patients	3,429	3,271
Attendances	18,932	17,232
Home-patients :—		
Number of patients	291	245
Visits by House Surgeon ...	1,357	1,345

Accounts.—The Income and Expenditure account shows: Receipts from all sources, £1,807 10s. 7d., this sum including £684 from paying patients, and £343 from the Hospital Saturday and Sunday Funds.

The Expenditure was £2,194, leaving a deficiency on the year of £386 9s. 5d.

In moving the adoption of the report, the Lord Mayor said that the Hospital was one of the many useful institutions in the city. He had made an inspection of it on the previous day, and was struck with the homeliness and comfort pervading the whole building. The work had been well maintained, and although the balance sheet might cause the Committee some anxiety, they could congratulate themselves that they were moving in the right direction, the income having increased during the year, while there was a considerable reduction in the expenditure.

The Earl of Dysart was re-elected President, and the usual votes of thanks were passed to the Committees, the Hon. Treasurer, the Hon. Medical Staff, and the Lord Mayor.

After the meeting, tea and coffee were provided in the Board Room. A. A.

Correspondence.

To the Editor of the BRITISH HOMŒOPATHIC REVIEW.

DEAR SIR,—Dr. Storar says, in his letter to Sir Samuel Wilks, M.D., F.R.C.P., on p. 179 of the BRITISH HOMŒOPATHIC REVIEW for March: "What medical error has survived so long?" (*i.e.*, 60 or 100 years). I fear he will not give you the satisfaction of an answer, being hardly willing to confess errors of such a long standing. May I then point out that the system of bleeding, leeching, cupping, blistering and cauterising lasted up to the year 1860, and was in full vigour up to Hahnemann's powerful and severe criticism and contempt. His aconite by mouth in small doses replaced them all; to-day leeches in a chemist's shop are conspicuous by their absence. The vigorous protests against the dominant medicine of his day are useful in showing the negative good effects of homœopathy, for almost all the irrational practices he denounced have been abandoned. It remains for us, his followers, to exhibit the positive effects in the victory of rational and scientific medicine. Bravo! dear Dr. Storar, I think, with you, that errors must be exposed by their evils and wrongs, and right thinking and doing by permanent blessings and success. Then try each day to be better than ever before!

Yours faithfully,

V. JAGIELSKI, M.D.

"OPSONINS."

IN regard to the derivation of this word, we have consulted our friend and teacher, Dr. Alexander Souter, Professor of New Testament Exegesis, Mansfield College, Oxford, who is one of the foremost Greek scholars of the day. He writes: "The Greek word is ὀψωνέω contracted ὀψωνῶ. It was early latinised as *opsonor* (depon. 1st conjugation) as well as *opsono* (act. 1st conjugation). The meaning of the word is 'to buy provisions for a meal (especially dinner)'; 'to make the daily journey to the market for the purchase of food of all sorts.' The Latins appear to have sometimes spelt it *obsono*, but they certainly pronounced it as '*opsono*.'"

THE SENIOR EDITOR.

DR. H. WYNNE THOMAS sends us the following :—

B.H.S. GOLF.

With the idea of promoting good fellowship among the members of the Society who play golf, it has been suggested that a challenge cup (to be called the Dudgeon Cup) be provided, to be played for annually by members of the Society between May 1st and September 30th. Members desirous of competing for the cup should send in their names at once to H. Wynne Thomas, Bromley, Kent, stating their lowest handicap.

C. KNOX SHAW.
BYRES MOIR.
E. M. MADDEN.
H. WYNNE THOMAS.

Foreign Reports.

HOLLAND.[1]

WE Hollanders are living in a small country, practically everyone knows everyone else. This circumstance, together with our conservative tendencies, may explain the tardy development of homœopathy in Holland. Until ten years ago there were only four or five homœopathic practitioners, now there are twenty, with still a number of unavowed homœopaths more or less known as such. It seems to me this great increase has something to do with our narrow limits. The conversion of one practitioner stirs up the whole community of medical men, makes them think on and investigate the question. This is the reason why we are expecting a revival of homœopathy in this country in the next decade. The last proof of the improving state of affairs is the question put after a sympathetic exposition of the homœopathic doctrine by an allopath in a public journal, who asks, Is friendly co-operation of allopaths and homœopaths possible and recommendable? Though I trust that no homœopath will surrender on his conditions, dropping our doctrines of dynamisation and infinitesimals, such a question, however, after the hostilities of the whole of last century, speaks volumes to us, and will do so to our allopathic brethren, who live so closely together in the United Provinces.

[1] By an oversight this report was omitted in our April issue.

A signal victory over orthodox boycott is the recent graduation of a young doctor of medicine in the University of Leyden. His dissertation was a critical review of Hahnemann and his school. His theoretical conclusions were, as might be expected, upon the whole, not satisfactory to us, yet the mere fact that he chose such a heterodox problem is a seed from which our school will yet reap a harvest. So things are going on at the other side.

In the meantime, the homœopaths are untiring in keeping the public interest warm. Our monthly, *Homœopathisch Maandblad*, has just completed its seventeenth year, and has done a great deal for promoting homœopathy among the laity. Books and pamphlets are readily sold; Dr. J. Voorhoeve's "Domestic Medicine," of which 4,000 numbers were printed, was exhausted after little more than a year. The *Homœopathic Library*, containing easy intelligible pamphlets about colds, influenza, rheumatism, tuberculosis, &c., are wanted by all classes. The Homœopathic Association, *De vereemging tot bevoidering der homœopathie in Nederland*, sub-divided into many sections all over the country, the seat of which is in the Hague, President, Dr. H. A. J. Voorhoeve, has shown itself the great lever for raising the appreciation for the new school. Most of our new practitioners have studied homœopathy at its expense in Germany, England, or the United States. After a short enquiry of two months, they have to inform the President of their impressions, and whether they wish to continue. No money is wanted to be restituted, but after finishing their studies they are, of course, expected to settle down as homœopathic practitioners, and to refund the money lent. It is obvious how such financial agreements may lead to actual conversions in less well-to-do young men. A striking feature is the propagation of our doctrine almost exclusively among the believers of orthodox theology; and when Dr. Kuyper, their leader in politics, became Prime Minister of the Crown, it was his cherished ideal to fill the Chair of the Professor of *Materia Medica* in Leyden with a homœopath. He, however, did not succeed; no one, either in our country or elsewhere, being able or willing to take that leading position. On the first of May we hope to open a hospital at Utrecht. Next time I hope to say more about this historical event.

J. T. WOUTERS.

FRANCE.[1]

We are happy to state that in France, during late years, the number of the homœopathic physicians has much increased; among them are some very ardent adherents of Hahnemann's doctrine, who are not satisfied in exercising it only, but endeavour to spread it among the physicians of the old school they are acquainted with.

THE SALTS OF BARIUM.—Interesting communications have been recently made on the *salts of barium*, and especially on their action on heart and blood-vessels. Dr. Cartier has given a complete report, from which we take the following :—

The homœopathicity of the *salts of barium* in the diseases of the circulation is scientifically established by the experiments of many physiologists. It has not been found that *barium* has produced changes such as we see in arterio-sclerosis, though physiological changes are marked. Some provings have been made with *chloride of barium* alone, the *acetate* also is soluble, *carbonate* is not so much, but is certainly active.

Every prover compares the action of *barium* to *digitalis*, First it accelerates the beating of heart, to lessen it afterwards. and ultimately to stop the heart in systole. The blood pressure is much increased, but sinks to zero at death. There is considerable contraction of blood-vessels.

The heart symptoms observed on healthy men are numerous. *Baryta carb.* has the following symptoms : Violent, long-lasting palpitation, palpitation when lying on the left side. palpitation renewed when thinking of it, full and hard pulse. *Baryta muriat.* has very irregular beating of the heart, pulse scarcely perceptible, quick and irregular.

Hahnemann gives as indicating *baryta* old age illnesses, and consequently anterio-sclerosis; the two forms of it, cerebral and pulmonary, especially require our attention.

In cerebral arterio-sclerosis, *baryta* succeeds for dull headache, without acute crisis; the head is more heavy than painful, the face is not congested; light and passing disorders that come back above all at night when in bed.

The attending symptoms are : The sensorium is not clear, difficult speaking, headache of mentally and physically depressed persons, sensation of having the head compressed in a vice,

[1] By an oversight these reports were omitted in our April issue.

stiffness of the nape. We may also mention giddiness and ear-tingling; but *baryta* is above all useful in apoplexy, not so much as an immediate remedy than as a preventive or as a drug for distant consequences of apoplexy, palsies, disorders of language, headaches, slackening of pulse, contraction of pupils, and above all, aphasia, indicates this medicine.

In heart and pulmonary arterio-sclerosis, German doctors use *barium salts* for asystole instead of *digitalis*. These salts are especially useful in arterio-sclerosis; the sclerosis of aorta can be lessened or even cured. Allen, Hale, Hughes, J. H. Clarke, have used it in aneurisms. We would insist on its efficacy in arterio-sclerosis of the arteries of the lungs in senile asthma, in suffocating catarrh with orthopnœa, occurring suddenly during the night, with difficult breathing and a cyanosed face.

A CURIOUS CASE OF A PATHOGENETIC ACTION.—The pathogenetic actions of drugs should always be noted with interest. We would here relate the following case, which occurred in our own practice :—

A man, about 60 years old, took *digitalis* (a large dose) on November 30th, and on December 1st, 1906. On December 1st in the evening he presents hydrocele in the right side, this disappears a few days after. We attach no importance to this occurrence, but the same patient took a dose of *digitalis* on February 10th, 11th, and 12th; on the third day the hydrocele of the right side appears again.

Dropsical swelling of testicles and scrotum was noticed in the provings on *digitalis*, but it is not often thought of in cases of hydrocele, and yet it is a drug that might be useful in that condition.

DR. PAUL TESSIER.

GERMAN HOMŒOPATHY IN THE YEAR 1906.

BY DR. B. KRANZ (DAVOS.)

II.—HOSPITALS.

AFTER many years of inactivity, the German homœopaths have lately entered progressive politics, and without any doubt by and by a number of good homœopathic hospitals will arise in Germany, notwithstanding the enmity of the old school.

The most prominent of the present German homœopathic hospitals is the Berliner Homöopathisches Krankenhaus. This splendid, well-established and well-managed institution did remarkably well during the year 1906. Two hundred and sixty patients, with 12,657 sick days, were admitted; 134 operations were performed, including 92 abdominal and other severe cases.

The average cost for each patient was 5s. 3d. per diem. As paying patients are also admitted, the Hospital did not require any subsidy, but was able to subsist on its own income. Even the interest of the special funds of the Hospital could be used for increasing the capital, and for adding several important improvements to the Hospital, for instance, a villa for the resident physician, a mortuary, &c.

Besides the Medical Director, Dr. v. Schwarz, and his assistant, there are always a number of young German and foreign colleagues working at the Hospital, eager to get acquainted with homœopathy.

The good results gained by the Berlin homœopaths have not been without influence on their South German colleagues. In Bavaria, homœopathy had to suffer heavily during the last few years by the offensive attitude of the old school. But just this intolerable oppression from outside united the Bavarian homœopathic physicians, who formerly had but slight communications with each other. Special advantages will arise from this for the old Homœopathic Hospital at Munich, which has existed for many years under the same modest circumstances. During the year 1906, only 76 patients, with 2,434 sick days, were admitted, a comparatively small number for such a large city as Munich, with seven homœopathic physicians. But the Hospital is unfortunately situated in a very noisy street, and offers very little accommodation. The young Society of Bavarian Homœopathic Physicians has espoused the cause of the Munich Hospital, and is working hard to collect the necessary means for building a new hospital on a larger scale and in a better part of the town. The Hospital funds already exceed £10,500.

How necessary sufficient funds are to put a Hospital on a sound foundation can be imagined by the fate of the old Leipzig Homœopathic Hospital, which was founded in the

enthusiasm of the first hour without sufficient funds; it suffered from this mistake for many years. Two years ago work had to be stopped, and then the Hospital, came to an inglorious end, being sold to a private party. Only one flat was reserved for the large Homœopathic Library, with many relics of Hahnemann, and for the Liepzig Homœopathic Poliklinik (out-patient department), which still has more than 2,000 patients yearly. The purchase price of the old Hospital, increased by new collections, will enable the Central Verein of German homœopathic physicians to erect, sooner or later, a new "Vereins Krankenhaus."

Much more encouraging than at Leipzig are the prospects at Stuttgart, the capital of Würtemburg, where the erection of an up-to-date homœopathic hospital makes pleasing progress. In this city homœopathy has numerous followers, and even several members of the Royal Family are true homœopaths, and have their homœopathic family physicians. For many years a "Poliklinik" has been carried on very successfully, showing an attendance of 1,500 patients per annum. Formerly, there was no need for an entirely homœopathic hospital at Stuttgart, as Dr. von Sick, a well-known homœopathic physician, was the medical director of the large "Diakanissen Hospital." After his death, which occurred a few years ago, an allopathic physician succeeded him, and homœopathy suddenly lost its influence at this Hospital. Therefore the idea ripened to establish a purely homœopathic hospital, and one cannot but admire the energy with which the Stuttgart colleagues started their work. Within a short time a sum exceeding £5,000 was collected, sufficient to buy a large orchard in a suburb, on one of the beautiful hills which surround Stuttgart. The reports I received just lately from Dr. Stiegele, of Stuttgart, as regards this matter, are most promising, and the time when the Würtemburg capital will possess an up-to-date homœopathic hospital, worthy of our good cause, is, we hope, not far off.

Therapeutic Digest.

MERCURIUS CORROSIONS.—A remedy often overlooked in urinary symptoms as "frequent urination, burning and straining in the neck of the bladder, urine scanty, urine bloody, extreme tenesmus and burning with pain in the neck of the bladder, urethritis with a greenish discharge." It also presents a picture of dysentery in its worst and severest form. It is, further, one of the first remedies to be thought of in nephritis.—*Hahnemannian Monthly*, January, 1907.—J. C. GUERNSEY.

EUPHRASIA.—In eye affections, where there is great photophobia, smarting of the eyes as if there was sand in them, and a plentiful discharge of mucus and tears. It is also useful for "catarrhal inflammation of mucous membranes, particularly of the eyes, nose and throat, the discharge being abundant and watery; in cough from an *irritating catarrh* in the throat.—*Ibid.*

OPIUM.—One of the best remedies, in potentised form, for constipation, where there is entire absence of desire for stool, and no inconvenience felt from the accumulation of fæces, where there is an entire absence of expulsive effort, and the stool is in form of hard, small, black or brown pieces.—*Ibid.*

TREATMENT OF CORNEAL ULCERATIONS.—Philip Rice, M.D., Berkeley, Cal., in writing on the treatment of ulcerations of the cornea, advises the use of *atropine* as a mydriatic in all cases, strict cleanliness of the exterior of the lids and their margins, and in cases of severe pain the application of cloth pads wrung out of hot water, and applied for fifteen minutes at a time, three or four times daily. Local antiseptic treatment he pronounces not only useless but at times actually harmful. He considers the most important part of the treatment to be the selection of the appropriate homœopathic remedy, and gives as the chief drugs, with their indications, the following:—

(1) *Hepar-Sulph.*, "the king of remedies for ulceration of the cornea." The symptoms are acute; the pains are severe aching, throbbing and stitching; relieved by heat and aggravated by cold, touch, and bright light. Hypopyon is invariably present. Rawness, or a pimply eruption on the lids is

characteristic. Blood-vessels run from the conjunctiva into the ulcer. Photophobia and lachrymation are always severe. There is a general strumous condition of the patient. Mentally he is irritable, sensitive, contrary, wants many things but never advice; suggest that he do this or that and he becomes cross and stubborn.

(2) *Silica.*—In chronic ulcers, and in slow, sluggish, acute ulcers; just the reverse of *hepar.* Inflammatory manifestations are seldom severe, and vascularisation of the cornea is scarcely ever present. Painlessness of severe sloughs is often seen. Small round ulcers, not severely painful, with marked tendency to perforate, clearly call for this remedy. Aggravation from cold is as marked as under *hepar,* but is less complained of.

(3) *Mercurius sol.*—Always to be thought of in syphilitic patients. A characteristic local symptom is a great amount of infiltration round a comparatively small ulcer; a degree of opacity out of proportion to the size of the ulcer. Pain is usually severe, especially at night. Photophobia and lachrymation worse at night, from artificial light and from the glare of an open fire. The lids are swollen, crusty, and scabby; the discharge, whether thin or creamy, is always acrid; pains are worse from extreme heat and cold. *Hepar* and *silica* are both greatly relieved by extreme heat.

Mercurius cor.—Especially indicated when the symptoms of iritis are marked. The pains are agonising, especially at night; they drive the patient out of bed. Lachrymation very acrid; burns like fire; aggravation from heat both local and general; relief from cold.

Arsenicum.—The underlying condition is generally one of anæmia; there are weakness and emaciation; mentally irritable and anxious, unable to remain in bed owing to mental distress. Aggravation from cold, both local and general, and relief from heat.

Asafœtida.—Especially valuable in syphilitic patients. The most striking symptom is aching, boring, gnawing pains deep in the orbit, as if in the bones; worse at night.

Conium.—Corneal ulcers of phlyctenular origin that objectively are very slight, but subjectively intensely painful. Intense photophobia and lachrymation.

Rhus toxicodendron.—Superficial ulcerations with excessive

photophobia and lachrymation ; profuse gush of tears on opening the eyes; erysipelatous swelling of the lids; general aggravation in the morning.—*Pacific Coast Journal of Homœopathy*, December, 1906.

SAMBUCUS IN COUGH.—Dr. C. v. Bœnninghausen relates the following case: A merchant, aged 30, had caught a cold last winter while travelling. He was treated allopathically during three months, but the symptoms grew worse, and Dr. Bœnninghausen was called in. He found him with the following symptoms: For the last three or four weeks there had been a hollow dry cough with hoarseness, and much tough mucus in the larynx, cough most violent at night. Constriction of the chest, with stitches in the left side while lying on that side. Internal heat without thirst. Severe exhausting perspirations. Striking timidity. Great drowsiness, but restless sleep, waking up frequently, while an internal anxiety prevents his going to sleep again. Face pale, with a circumscribed redness of the cheeks. Pressure in stomach after food, especially after milk, often with vomiting, first of the ingesta and then of bile. Increased watery urine. Extraordinary emaciation. He prefers warmth and is better for it. Better in moderate motion than in continuous rest. Frequently impelled to take a deep breath, which he could do without trouble. *Phosphorus* seemed to be indicated by these symptoms, and a high potency of it was given with directions to the patient to report in two weeks' time. He did so, but he was no better, rather worse, the feverish symptoms having increased.

A characteristic feature with regard to the fever was then elicited, viz.: While sleeping he suffered continually from a dry, burning heat, but on waking up this immediately passed into a very profuse perspiration, which continued without interruption while he was awake until he fell asleep again, when at once the dry heat reappeared. This symptom is found only in *sambucus*, while in *phosphorus* just the opposite is found—the sweat is worse during sleep. Since the other symptoms are also found in *sambucus*, a dose of a high potency of this remedy was immediately given, with the result that in two weeks' time the patient was free from all his ailments.—*Homœopathic Recorder*, January, 1907.

Obituary.

THE profession has lost another of the old guard in the person of Mr. Thomas Miles, M.R.C.S., of Ramsgate, who died on April 4th, aged 83 years. He received his early medical education under Dr. John Epps, became M.R.C.S. 1856, and House Physician of the Homœopathic Hospital 1857. For some years he was associated in practice with the late Dr. Reynolds, then he migrated to Reading. Later on he spent seven active years at Deal, until his health failed, when he removed to Ramsgate, where he settled about twenty years ago. He was a very quiet and unobtrusive man, very diligent and attentive to his duties, and much beloved by his patients, but he seems to have contributed little to the literature of the profession. He leaves a widow and two sons to mourn his loss. He was interred at Highgate Cemetery on the 10th inst. in the presence of a large gathering of relatives and friends.—W. M. S.

Reviews of Books.

Homœopathic Therapeutics. By Samuel Lilienthal, M.D. Fourth edition. Philadelphia: Boericke and Tafel, 1907.

The fourth edition of this standard work on Homœopathic Therapeutics has reached us from the well-known publishing house of Boericke and Tafel, Philadelphia. In a prefatory note we are informed that when the third edition was exhausted it had been intended to let the book remain out of print, but that so many calls were made for it that republication became necessary. The first edition appeared in 1878, so that the work is nearly thirty years old, a notable proof of the permanence of homœopathic therapeutics, and in striking contrast to the fate of similar productions which are not based upon the law of similars.

For those who do not use Lilienthal's "Therapeutics," we may state that it is of chief value to the busy prescriber, and especially those who are unable or unwilling to use a repertory and *Materia Medica* in their search for the needed remedy. Though not perhaps the most accurate, nor the best way—it was certainly not Hahnemann's—it is a very convenient method in these hustling times, and it finds favour with a large class of homœopathic practitioners. In this method of presentation, the chief organs of the body and the principal diseases have

allotted to them a list of remedies, each of which is given with the symptoms peculiar to it and which may indicate its use in the condition referred to. For example, under "*Heart, Diseases of,*" we have fifteen pages containing accounts of the symptoms relating more or less to cardiac affections proper to one hundred and thirty-eight drugs. Amongst these are given *bismuth* and *hepar sulphuris*, neither of which are distinctly connected with cardiac disorders, whilst we note that such valuable remedies as *strophanthus* and *crategus* are omitted. However, the advantage of being able, in an emergency, to find and compare in the same list the leading heart symptoms of two or three drugs is often a distinct advantage, and may guide one quite as accurately as the more laborious search by repertory and *Materia Medica*. We have often used the work ourselves with success in this way, and although we do not consider it adapted for constant use, we know that Lilienthal's "Therapeutics" has for many years filled a long-felt want, and, indeed, was the means of extinguishing the far less satisfactory *Jahr*, a work familiar to homœopaths of a generation ago. We certainly think that few busy prescribers would care to be without a copy of "Lilienthal" for handy reference. We have found very few errors in the book, which is printed and got up in the well-known style of the great American homœopathic publishing firm.

Leaders for the Use of Sulphur, with Comparisons. By E. B. Nash, M.D., author of "Leaders in Homœopathic Therapeutics," "Regional Leaders," and "Leaders in Typhoid Fever." Philadelphia: Boericke and Tafel, 1907. Price $1.00; postage, 6 cents.

This little book from the pen of Dr. Nash will be welcomed by all who are acquainted with his writings, and who is there amongst the homœopathic school who is not acquainted with them? It is appropriately bound in a sulphur-coloured cloth cover, is well printed, and contains 160 cap octavo pages.

The plan adopted in dealing with this polychrest is best told in Dr. Nash's own words: "One remedy well studied is better than several not half understood. One of the best methods of gaining a practical acquaintance with our *Materia Medica* is to master one remedy at a time; both in itself, and in its relation to, and correspondence with, other remedies.

Dr. Adolph Lippe said, in substance: 'The man who has mastered lycopodium and its relation, is well on his way to a practical knowledge of our *Materia Medica*.' Along this line I begin the study of sulphur, taking the well-known and verified symptoms of the remedy, hoping thereby not only to fix in my memory its own range, but to understand better how to use it in conjunction with other remedies as an antipsoric, complementary, &c., and I hope, old as it is, to make its study both pleasant and profitable."

Dr. Nash accordingly goes through the schema, taking the prominent symptoms of sulphur one by one, and comparing each with the similar or allied symptoms produced by other drugs. In this way, sulphur is brought into comparison at some point or other with no fewer than 118 different medicines. Any one, therefore, who has fully absorbed the contents of this small work, will not only have an exceedingly good practical knowledge of the therapeutic sphere of sulphur, but will also have acquired a considerable acquaintance with much of our *Materia Medica*. We would advise all our readers to obtain this book, and, having obtained it, not to rest satisfied till they have thoroughly digested its contents.

Notices, Reports, &c.

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DONATIONS and Subscriptions received from January 1st to March 21st, 1907 :—

GENERAL FUND.

	Donations. £ s. d.	Subscriptions. £ s. d.
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LONDON MISSIONARY SCHOOL OF MEDICINE.

	Donations.
Borthwick, Miss	3 3 0
Brittle, Miss F. A., Winter Term, 1906-1907	5 5 0
Burford, Dr. G., per	20 0 0
Green, Dr. Vincent, Library and Museum Fund	5 1 0
Knox, Mrs. G. Walter (per Dr. C. G. Hey)	1 1 0
North, J. H., Esq., Mr. Frankin's Fee to end of June, 1907 ...	6 6 0
Phillips, Miss, Dental Fee	1 1 0
Rayner, Mrs., one Term's Training for Student	5 0 0
Total	£46 17 0

SAN FRANCISCO FUND.

Day, Dr. J. R.	2 2 0
Greig, Dr. C. J.	1 1 0
Moir, Dr. Byres	5 0 0
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Total	£13 3 0

MR. CHARLES S. SPENCER, L.S.A., has commenced practice at 226, Stamford Street, Ashton-under-Lyne, where his brother, Dr. Sandy Spencer, is in practice.

NOTICE TO CORRESPONDENTS.

*** *We cannot undertake to return rejected manuscripts.*

All MSS. should be in the hands of the Senior Editor by the 15th of the month at the latest.

AUTHORS and CONTRIBUTORS receiving proofs are requested to correct and return the same **as early as possible** to Dr. MCLACHLAN, 3, Keble Road, Oxford.

The Editors of Journals which exchange with us are requested to send their exchanges to Messrs. BALE, SONS AND DANIELSSON, LTD., 83-91, Great Titchfield Street, Oxford Street, London, W.

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Contributors of papers who wish to have reprints are requested to communicate with the Publishers, Messrs. BALE, SONS AND DANIELSSON, LTD., who will make the necessary arrangements. Should the Publishers receive no such request by the date of the publication of the REVIEW, the type will be broken up.

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Advertisement and Business Communications to be sent direct to the Publishers.

Communications have been received from Dr. BERRIDGE (London), Messrs. KEENE AND ASHWELL (London), Dr. STORAR (Ramsgate), Dr. J. H. BODMAN (Clifton), Dr. THOMAS (Bromley), Dr. W. F. H. NEWBERY (Plymouth), Dr. SIMPSON (Birkdale), Dr. ALEXANDER (Southsea), Dr. AVENT (Birmingham), Dr. DYCE BROWN, Dr. PAUL TESSIER (Paris), Dr. ROBERSON DAY, Dr. CASH REED (Liverpool).

BOOKS AND PERIODICALS RECEIVED.

Leaders for the Use of Sulphur, by Dr. E. B. NASH. *St. Louis Medical Review*, *The American Physician*, *The Calcutta Journal of Medicine*, *Medical Century*, *The Medical Times*, *The Vaccination Inquirer*, *Le Mois Medico-Chirurgical*, *The Hahnemannian Monthly*, *The Chironian*, *The Homœopathic Envoy*, *The New England Medical Gazette*, *Pacific Coast Journal of Homœopathy*, *The Medical Brief*, *The Homœopathic Recorder*, *The North American Journal of Homœopathy*, *The Homœopathic World*, *The Indian Homœopathic Review*, *Universal Homœopathic Observer*, *L'Art Medicale*, *Revue Homœopathique Française*, *Revue Homœopathique Belge*.

THE BRITISH
HOMŒOPATHIC REVIEW.

JUNE, 1907.

Editorial Notes and News.

Beri-Beri.

BERI-BERI is an endemic and epidemic multiple neuritis. The effect of the disease on the heart and peripheral nerves is indicated by dyspnœa, cyanosis, irregular pulse, and œdema, along with motor and sensory paralysis. Eijkmann found that a clinical picture, closely resembling human beri-beri, could be produced in fowls by feeding them with rice. Shortly before death these animals exhibited dyspnœa, cyanosis of the comb, and paralysis of legs and wings. Similar results were obtained by Maurer, who fed fowls with *oxalic acid*. Dr. Treutlein confirmed and extended these observations by using *oxalic acid*, soluble *oxalates* and rice meal; he also found that by using an excess of *calcium carbonate* in the food he could arrest the pathological changes in the heart and peripheral nerves. The pathological changes in the fowl are attributed to the removal of *calcium* from the affected tissues by the action of the *oxalic acid* and soluble *oxalates*. In five cases of human beri-beri Dr. Treutlein found a large excess of *calcium oxalate* in the urine.

* * * *

History of Beri-Beri.

THE disease is believed to be of great antiquity in China. It prevails most extensively in the Malay Archipelago. It is widely distributed in China, Japan, and the Philippine Islands. It is also prevalent in Burma. It has been investigated chiefly by Japanese physicians, European and native, and by Dutch physicians. The disease occurs among the Cape Cod fishermen, and there have been several outbreaks of endemic neuritis at the Richmond Asylum in Dublin—in the

years 1894, 1896, and 1897—and at the State Insane Hospital at Tuscaloosa, Ala, U.S.A.

* * * *

Etiology of Beri-Beri.

By some it is regarded as an *acute infection*, by others as a toxæmia caused by food. Baelz, Scheube, and many Dutch physicians, hold that it is due to a specific microbe. Hamilton Wright describes a *specific duodenitis* as a primary bacterial lesion, from which the poison is evolved just as it is from the throat in diphtheria. The food theory, associated with rice or fish, is widely held in Japan. In favour of this view of its origin is the extraordinary change that has taken place in the Japanese Navy since the introduction, by Takagi, of an improved diet, allowing a larger proportion of nitrogenous food, and forbidding the use of fresh fish altogether. This has led to a practical abolition of the disease. Many of the Dutch physicians in Java regard rice as the important cause of the disease. It is stated that in the prisons of Java the proportion of cases is 1 to 39 when the rice is eaten completely shelled, 1 to 10,000 when the grain is eaten with its pericarp. In some places the disease has disappeared when the unshelled rice has been substituted for the shelled. For some time past wē have ourselves been using "Japanese unpolished rice," instead of the ordinary rice, and recommending it largely to our patients. As an article of diet, both as regards flavour and nutritive value, it is greatly to be preferred to the ordinary rice. It should not be boiled, but thoroughly *steamed* when cooked by itself. We have been told that it is a very easy and a very common practice to "polish" rice of an inferior quality to look like the best. Since then we have preferred to have ours "unpolished." In regard to fish, Grimm, in his monograph, attributes the immunity of Europeans as in great part owing to the fact that they do not follow the Japanese custom of eating various kinds of raw fish.

* * * *

Treatment of Furunculosis.

Dr. R. Thorne Thorne records an interesting experience from our point of view (*British Medical Journal*, February 23rd, 1907). He writes: "In November, 1905, a lady, aged 45, consulted me for furunculosis of the face and

body, from which she had been suffering for three years, and had been treated by three other medical men. I tried every ordinary known method of treatment until July, 1906, without any effect. Therefore, in July, 1906, I persuaded her to allow me to inject Wright's *antistaphylococcic vaccine.* I had the pus from a mature furuncle examined by the Lister Institute. I then made six injections of the *vaccine,* commencing with 0·5 c.cm. and increasing up to 2 c.cm., leaving ten days between each injection. These caused no discomfort whatever, and from the date of the first injection to the present time (six months) no fresh furuncles have appeared, and the patient is in perfect health."

* * * *

Orbital Cellulitis.

IT has been shown by KNAPP that the sight is sometimes suddenly lost in cases where there is acute suppurative inflammation in the neighbourhood of the orbit. The orbital symptoms are those of cellulitis, and the ophthalmoscope shows the signs of embolism of the central artery of the retina —secondary optic atrophy, and obliteration of the retinal arteries. Three cases are given—(1) Blindness following an operation for empyema of the frontal sinus; (2) blindness following periostitis of the upper jaw of dental origin; (3) blindness following penetrating wound of the orbit, with cellulitis. Orbital cellulitis has been divided into (*a*) *œdematous,* (*b*) *phlegmonous.* The former is the less serious; the latter may end in panophthalmitis. It is often coincident with facial erysipelas, and may terminate fatally through meningitis and abscess of the brain; but under appropriate treatment most cases recover. The medicines most likely to be useful are *acon., rhus tox., bell., apis, hepar, sil.,* and *sulph.*

* * * *

The Increase of Insanity.

THE Lumleian lectures have this year been delivered by Dr. G. H. Savage, who chose for his subject "The Increase of Insanity." That there is an increase during late years he thinks is certain, but does not consider that there is any real ground for alarm. There has been no increase amongst the young and those of middle age. It is after the age of sixty

that the increase has taken place. With regard to causes, he concludes that cases due to alcohol are not on the increase, but that a certain number of cases are due to a new cause, viz., influenza, and that there is a decided increase in the cases of general paralysis. Heredity plays an important part in predisposing to insanity, but equally important as a contributing cause are unfavourable conditions of environment.

* * * *

British Homœopathic Society.

THE eighth meeting of the session was held at the London Homœopathic Hospital on Thursday, May 2nd, 1907, at 8 o'clock. Dr. J. H. Clarke, the President, was in the chair. A paper was read by Dr. J. Galley Blackley on "Latent gout, and its importance in relation to prognosis and treatment." It dealt with the influence of latent gout on the various catarrhal affections, on skin diseases, glycosuria, and chronic nephritis; the resistance of these complaints to ordinary remedies was pointed out, and the effects of specific treatment and that by mineral waters was considered. A discussion, in which several members took part, followed. Dr. Day then read a paper entitled "Chorea of Childhood." It treated of the relation of chorea to rheumatism, and gave an account of recent bacteriological research as it affects this disease. The symptoms and treatment were considered, the conclusion being based on a critical examination of 175 cases admitted to the London Homœopathic Hospital. A discussion followed. Several specimens were exhibited by Dr. Burford, the most interesting being an unruptured tubal gestation, at about the sixth week, removed by abdominal section, after an earlier appendicectomy: recovery; and a uterus with fœtus in utero in situ, removed by Porro's operation together with blocking fibroid: recovery.

* * * *

Turpentine Poisoning.

THE following case of poisoning by *turpentine* is related in the *Lancet* of April 13th, by Guy H. Coltart, M.B.Lond., M.R.C.S.: "A girl, aged 8 years, after having been exposed to the fumes from newly painted (? and varnished) woodwork for nearly a fortnight was seized on March 10th last with head-

ache, vomiting, and swelling of the left tonsil, causing pain and difficulty in swallowing. The evening temperature was 102·5°. The next day there was pronounced hæmaturia; the urine was bright red in colour, and contained albumin; temperature was 99°; vomiting had ceased, and the bowels had acted; the tongue was furred. On the 12th the urine was nearly black, the colour of stout, and contained nearly one-third albumin; both tonsils were enlarged; temperature 102·5°. In the afternoon she was removed to a nursing home, where her temperature was 103·6° on arrival. On the 13th the tongue was cleaner, swallowing easier, and temperature had fallen to 101·5°; the urine still very dark, and loaded with albumin. From the 14th to 19th there was steady improvement in all symptoms, and on the latter date she was removed home. The urine still contained a trace of albumin, but in other respects she was quite well." Hæmaturia is a well-known symptom of *turpentine* poisoning, but the tonsillitis and high temperature occurring in this case are not recorded in any of the provings or poisonings of *turpentine* in the "Clyclopædia of Drug Pathogenesy. We cannot but think that these symptoms occurred independently of the small amount of *turpentine* taken into the system by inhalation. Probably a tonsillitis rendered the system more susceptible to the influence of *turpentine*, as shown by the hæmaturia, the more so as four other persons living in the house were not affected by the smell of the paint.

* * * *

Scopolamine Poisoning.

DR. A. W. MOORE, House Physician of St. George's Hospital, relates this case of poisoning. A drop of 1 per cent. *solution of scopolamine* was instilled into the eyes of a little girl 4½ years, to dilate the pupils preparatory to estimating the refraction. This was at 3 p.m. At 4 p.m. she was delirious, alternately talking and crying incessantly. The colour was good, the lips unduly pink, temperature normal, and pulse 80. Later in the evening the delirium became more marked, and continued all through the night till the next morning. It was of a joyous character, and consisted of constant disconnected chattering. Frequent licking of the lips and smacking of the mouth were noticeable, and lasted

some hours. Frequently tried to get out of bed, and there was no sleep all night. Other features of the delirium were that she saw cats crawling about on other patients' beds; she also picked up imaginary hairs from the bed-cover and ate them; she would warm her hands before an imaginary fire, which would be first on one side of the bed and then on the other. She would not eat bread and butter, but drank a little milk. The delirium lasted eight hours. In the morning she was rational, quiet and obedient, and the pupils were less dilated. About twenty-four hours after the instillation of the drug, drowsiness came on; if she were awakened she would immediately turn over and drop again into a deep sleep. This condition lasted twelve hours, there never being any real coma. She then woke up completely recovered. No treatment was given except a small injection of *strychnine* when the drowsiness came on. The above symptoms were, therefore, the pure effects of the drug.

* * * *

Researches in Immunity.

It appears from some recent researches by Ehrlich that immunity is a condition that can be established, not only in the higher forms of life but also in the lower, even in the protozoa. For instance, certain synthetically produced colouring matters, such as trypan-red, fuchsin, &c., are parasiticidal to trypanosomes, but by repeated injections trypanosomes can be made invulnerable to any given dye while remaining vulnerable to others; there must, therefore, be different groups in the protoplasm of the trypanosome, which different poisons select as their points of attack. This is further illustrated by paramœciæ, which are able to live in strong solutions of trypan-red, but lose their reproductive power in even quite weak solutions. It would follow that in treating diseases due to animal protozoa by a parasiticide, large doses should be given to kill the protozoa outright, as repeated small doses may only render the parasite immune to the drug, But how will the body cells of the host be affected by these large doses? The problem remains—to find something that will kill the living cause of disease and yet will not injure the patient.

Ethyl Chloride.

WE take the following cutting from the *General Practitioner* of May 4th. We wonder whether the child's urine was examined for *acetone* before the administration of the anæsthetic. This, we think, should always be done. "Before taking evidence at Southwark Coroner's Court on Saturday in regard to John Thomas Harman, aged 9, who died under an anæsthetic at Guy's Hospital, the Coroner said that the anæsthetic used in the case was ethyl chloride. Since 1895 it had become general as applied to dental operations. He knew of 22 fatalities altogether, and in that court he had held four inquests following deaths from the application of this particular anæsthetic. Christian Hugo Rippmann, clinical assistant at Guy's Hospital, said there was administered to deceased three cubic centimetres of ethyl chloride. The operation was for appendicitis. By the Coroner: Deaths under ethyl chloride were 1 in 3,000, but there were less under chloroform. The reason why ethyl chloride was administered was because it was a short operation. Robert Davis Collins, house physician, agreed with the preceding witness that three cubic centimetres was a careful dose. The direct cause of death was poisoning from ethyl chloride, but the poor condition of the child had a serious effect. The jury returned a verdict of 'Death by misadventure,' and attached no blame to the medical authorities."

* * * *

L.H.H.

DOCTORS HAM and MILLER NEATBY have resigned their posts as Assistant Physicians to the London Homœopathic Hospital. Consequently there are two vacancies at present. The Children's Ward is reopened, having been closed owing to an outbreak of scarlatina. When the *Receiving Ward* is constructed in the new wing we hope these periodic outbreaks will be no more.

* * * *

The Modern Use of Opium.

THE May number of the *Practitioner* presents five papers on the various uses of *Opium* in modern therapeutics, and a sixth paper on *Chronic Morphinism*, perhaps by way of antidote. Most of the writers laud the drug as one of the greatest

of Nature's gifts, although the dangers attending its use are not ignored. Surely this emphasises the weakness of old-school medicinal practice, that a drug which confessedly cures nothing, and is at best merely a palliative, should occupy a position of such supreme importance as is here given to *opium*? "Blessed be opium; what should we do without it," seems to be the leading motive of these papers.

* * * *

Dr. Burney Yeo on Opium.

NEVERTHELESS, we gladly admit that progress has been made of late years in defining the cases in which *opium* may be safely prescribed—though seldom advantageously, in our opinion—and distinguishing those in which it can only be used by endangering the patient's life. Dr. Burney Yeo, whose paper is very able and readable, mentions the death of a young adult, suffering from typhoid fever, who was killed by the rectal injection of a dram of the tincture. Another fatal case is noted, caused by half a grain of the extract, given to relieve asthma in a case of chronic nephritis. In spite of these disasters, and of the terrible risk of inducing the *morphia* habit, Dr. Yeo recommends its use in a long series of acute and chronic disorders, from angina pectoris to the cure of a common cold, and in acute rheumatism as well as in spasmodic asthma and bronchitis, with, however, a caution in aged persons.

* * *

The Dangers of Opium.

THE paper on *Chronic Morphinism* is by *Dr. Dixon*, of King's College, and he gives credence to the melancholy fact that victims of this vice have usually learnt it from doctors' prescriptions, and are not infrequently doctors and chemists themselves. It is a serious responsibility for those who ridicule the homœopathic uses of drugs, that their crude attempts to suppress pain may end in ruining the patient morally and physically. We have also looked in vain, in these six pages, for recognition of the harmful effect on the progress of a case of the use of *opium*. Beyond admitting that it locks up all the secretions, and hence should be avoided in gout, there seems little knowledge of the fact that although pain, cough, &c., may be temporarily suppressed by its use, the duration of every case

in which *opium* is given will be prolonged. Nature's curative forces—stimulated only by homœopathic remedies—are paralysed by *opium*, and the whole system upset and thrown out of gear, from which it takes time to recover and to permit the progress of cure to resume its course.

* * * *

The Homœopathic Use of Opium.

IT is only by strict adherence to the law of similars that such potent drugs as *opium*, *arsenic*, *mercury*, and others, can be safely or advantageously employed in disease. So used, there need be no fear of killing instead of curing our patients. But so long as the doses employed in general medicine are only a little reduced from the amounts needful to produce symptoms of poisoning, accidents, which may prove fatal, must occasionally occur. The papers we are considering give only one example of a use of *opium* which is undoubtedly homœopathic, and that is its use in small doses to relieve vomiting and pain in gastritis and gastric ulcer. We gladly endorse its value and safety in this instance.

* * * *

A Proving of Quinine Sulphate.

WHILST Hahnemann's exhaustive and classical provings of *cinchona bark* have placed its homœopathic use on an imperishable basis, we have few and scanty provings of its alkaloid—*quinine*. It is, then, with interest that we notice a *Proving of Quinine Sulphate*, by *Dr. Fritz C. Askenstedt, of Louisville*, in the *Hahnemannian Monthly* for April. This is one of the best provings we have ever seen. It is thoroughly up to date in every sense, and the author being conversant with all the modern methods of chemical and physiological research, provides analyses of the excreta and blood examinations complete in every particular. It is well worthy of careful study, and throws light on several obscure points in the drug-action of *quinine*.

* * * *

What Quinine Does in the Body.

As the falling apple suggested the law of gravity to the genius of Newton, so from his experiment with *cinchona bark* the fact of homœopathy flashed into the mind of Hahnemann. Since then, that *quinine* as well as *bark* will

produce definite febrile symptoms in healthy persons has been repeatedly shown. In this proving of Dr. Askenstedt's, a sub-normal temperature, with diminished oxidation, slow pulse and headaches appeared, resembling the interfebrile period of malaria. The poisonous effect of large doses was exhibited in the profound metabolic changes induced, shown chiefly by a great excess of uric acid excreted, and by the very rapid reduction of the red blood cells, attended by a corresponding increase in the elimination of chlorides.

* * * *

Quinine and Chronic Bright's Disease.

AMONGST several points of interest to homœopaths in this proving of *quinine*, we especially note the following, as pointed out by the author :—that the total symptoms produced after some days of the proving manifested a striking similarity to the symptoms of *chronic interstitial nephritis*, in the excessive flow of urine, containing an absolutely and relatively small amount of phosphoric acid and urea, with excess of uric acid, a rapid loss of red cells with subnormal temperature, slow pulse and headache. Adding to these amaurosis and albuminuria (which are well-known results of *quinine* poisoning), we have—as Dr. Askenstedt suggests—"a classical picture of interstitial nephritis which merits thorough investigation."

* * * *

British Homœopathic Association Lectures.

WE hope our colleagues will take full advantage of these Lectures. Dr. Dyce Brown lectures on Gynæcology, on Mondays, at 5, and Dr. Wheeler on Respiratory Diseases, on Fridays, at the same hour. These lectures are delivered at the Association's Room, in Regent Street. There are also Clinical Demonstrations at the Hospital, on Wednesdays, at 5.

Original Articles.

SOME ASPECTS OF ABDOMINAL PAIN IN WOMEN.[1]

By W. CASH REED, M.D., Liverpool.

Syllabus.

Introduction :—

(1) Pain in General.
(2) Pain and Temperament.
(3) Pain and Education.
(4) Pain as an Index.
(5) Pain may be Salutary—Instances.

Estimation of Pain.

Referred Pain.

Sections :—

(1) Pain Due to Tired and Stretched Muscular and Fibrous Structures.
(2) Rheumatism in Relation to Pelvic Pain.
(3) Gonorrhœa.
(4) Septic Lesions.
(5) S.W.[2] Corner Pain.
(6) Pain in Abdomen which is not manufactured there.
(7) Syphilis—Three Cardinal Points.

Introduction.

Gentlemen,—I propose in the following pages to deal with some aspects of pain in the abdomen in women, with the object of indicating certain general principles, and also of pointing out some pitfalls into which one is liable to fall, if imperfect examination and diagnosis be made. I have found it impossible to deal with the subject of treatment, except incidentally and with the object of knitting together otherwise fragmentary data. The reason lies simply in the fact that the compass of this particular paper does not admit of its consideration to an extent which would be really useful.

The subject of pain is such a vast one, for it is almost as wide as the science of medicine itself, that I should hesitate in

[1] Read before the Liverpool Branch British Homœopathic Society, April 11th, 1907.

[2] "South-West," the region of the appendix, *i.e.*, the right inguinal and neighbourhood.

this short paper to deal with it at all were it not that I intend to narrow its limits to quite a small area.

Thus I propose to deal with a few only of the causes of pain which are situated in the female abdomen, though on the subject of pain in the abstract I shall generalise a good deal.

As to the cases to be brought to your notice, I have selected such instances as are illustrative from clinical experience entirely of recent date.

Before particularising, I wish briefly to speak of (1) *Pain in General*, or rather such aspects of it as are forced upon the attention of all medical men sooner or later. As we listen to the patient's tale of woe, the mind falls automatically into an analytical frame, and perhaps equally into a judicial one. Having analysed the patient's complaint, and selected the chief points of importance from a confused mass of evidence, the latter has again to pass in review with reference to minor points of subsidiary importance. The process of reasoning is exactly opposite to that of the Text Book, which labels the disease and then describes its symptoms. This plan has always seemed to me somewhat addling, though I do not presume to say it can be avoided. Perhaps it is necessary; at any rate it is the *form* of academic teaching of medicine, as distinguished from that of practical teaching. The disease is embodied in the patient who has no difficulty in acting as his or her mouthpiece, and due allowance having been made for irrelevant matter, the listener may now label the disease.

(2) *Temperament.*—No scheme, however, as we all know, can be taken too literally, for the *personnel* of the narrator must be estimated, and this is no easy task when we see him or her for the first time. If we omit the personal equation we are liable to be hopelessly led astray. Speaking broadly, there are two types of patient which puzzle me the most, viz., the *histrionic* and the self-centred. They both exaggerate frightfully, but from perfectly different motives, neither of them laudable, but neither actually vicious. The former exaggerates from that state of mind which sees all life in dumb-show, to whom, "All the world's a stage," but they the only "players." There is frequently observed in this class of patient a quick sympathy and a kaleidoscopic change of mental attitude, so that the scene of suffering which they are depicting changes

while you look at it. This sympathy sometimes takes the form of self-pity, and the change of mental attitude is due to a sudden sidelight which has shot athwart their vision.

As to the second (the *self-centred class*), they require more patience. They are those who have an overweening sense of the importance of detail, and who have perhaps been unfortunately told that such and such an organ is affected, mostly the ovaries, sometimes the uterus. Now, "the fat's in the fire" with these patients. Their minds are overmastered by the particular organ at fault. They have, in short, uterus or ovaries "on the brain." The *ipsissima verba* of the doctor have done infinite harm, and the next man has a Herculean task to find another mental objective. It is well to record patient's exact words in reply to your questions. They are sometimes remarkably illuminating. I well remember the mother of a girl, wishing to indicate that the latter was suffering from a cold sensation from the anterior nares to the pharynx, described it thus in Devonshire fashion, "Her nose is like a piece of ice from yur right 'ome to yure." Again, a well-known surgeon of St. Bartholomew's, Mr. Lockwood, tells somewhere how a man in the out-patient department described his sufferings as "crampy veins"—this is illuminating to a degree. It is, I think, Sir William Bennett who insists upon the close relation of so-called cramps and varicose veins, and instances of this at once occur to me, and they will to all.

Pain, from a purely scientific or physiological point of view, I propose scarcely to touch upon, the subject is so vast. Yet I can hardly dismiss this aspect without briefly alluding to pain as an Index of Disease, and pain as an Expression of Intelligence, for in thinking over my paper these two points of view have come conspicuously before me. To take the latter first :—

(3) *Education.*—In a very interesting book recently published, entitled "Savage Children," by Mr. Dudley Kidd, the following passage occurs. The author is describing the children of one of the South African Tribes, and he says :— "Savage children are evidently less sensitive to pain than ours are, and are strangely slow in locating it. A grown-up Kaffir assured our author that he could well remember suffering from headache while as yet he had no idea where the pain was, and

would have believed anyone who had assured him that it was in the roof of his hut instead of in his head. Naturally, therefore, they are strangely unsympathetic about pain, and the same black man declared that as a child, though he had continually seen pain inflicted he did not know what it meant, nor did he realise the significance of a threat until one day when, for the first time, his father struck him." This passage needs no comment, but it indicates a very interesting field for observation anent moral and intellectual culture in relation to the perception of pain.

With regard to pain as an (4) *Index of Disease*, it may be *Salutary* and thus useful, though few of us would admit that the pain of toothache, *e.g.*, was a happy inspiration on the part of Nature for the purpose of commending a special molar to the dentist's delicate attentions! Yet pain may be salutary, as I shall show immediately, although it seems absolutely useless, for it cannot, like electricity, be chained and stored for use in the arts and manufactures. We have yet to invent an instrument, similar to the sphygmometer, which shall record the pangs of the sufferer, and give a tracing of the degree of pain which at a given moment he may be suffering from; otherwise with what mathematical precision we could apportion an anodyne. Such a hypothetical instrument, I submit, might be called an algometer. I believe it was Matthews Duncan who once referred to this subject of measuring pain, but he called his imaginary instrument an odynometer.[1] Is there, then, no standard of pain? In a large section of cases in which the pain is *acute*, I certainly think there is. There are three cardinal symptoms which indicate severe pain in a given case, whether the patient be histrionic, imaginative, self-centred, or, in short, whatever be his or her temperament; viz. (1) vomiting, (2) feeble pulse, and (3) collapse. Thus we have a tripod of considerable utility in dealing with degrees in acute pain.

To revert, however, to the statement that pain may be *salutary*. Let me prove it by an instance or two in which its absence as an index may be disastrous. In locomotor ataxy the sensation which indicates a distended bladder may be absent, or markedly diminished, and we have all probably

[1] ἡ ὀδυνη.

heard of a distressing sequel in such a case. Again, impaired nutrition of a cutaneous surface, as, *e.g.*, by urine in the aged, accompanied by blunted sensations, may and often does lead to bed sores. Thus the intelligence of the nurse must take the place of sensation in the senile, and here many a nurse has found the fulcrum of a lasting reputation. Lastly, injury to a joint enforces rest, and the pain of pleurisy or peritonitis does so also as regards the structures involved, in order to curtail an extension of the inflammatory process.

Another point must be mentioned, viz., the

Estimation of Pain.

I have already referred to it when speaking of pain in general, but should like to particularise. I would lay it down as an axiom that in the very young the estimation of pain is always genuine. I know that a child, *e.g.*, with a tracheotomy tube inserted, may work itself into a *temper* from discomfort and annoyance, and general disgust with everything and everybody, including its nurse, though she be the embodiment of every virtue, but this is not pain. A child, however, who complains of what is styled "growing" or "rheumatic" pains can never be disregarded, for its plaint very often means tubercle, and tubercle, moreover, in a stage which is curable.

Referred Pain.

The subject of referred pain almost demands a paper to itself. That in the knee in hip disease, and in the penis from vesical calculus, and in the testis from calculus in the ureter, are all well known. My own recent experience in this class of case leads me to say a word on two or three instances, which I have found most interesting and instructive. Sciatica is not usually associated with uterine flexion; yet it frequently is so. For a flagrant instance, I am indebted to Dr. Hynd, of Wigan, who had a case of severe sciatica in a school teacher. The pain had lasted for upwards of a year, when the girl, failing to get relief from her medical man, consulted Dr. Hynd. The latter at once thought it of pelvic origin, and sent the girl to me. The uterus was found to be acutely retroverted, and we decided to give an anæsthetic and to rectify matters. This was done at home, and the patient was permanently cured from that moment. Again, sciatica and sarcoma in the pelvis, if of

infrequent occurrence, fail sometimes to be associated in the practitioner's mind. Yet the connection is so conspicuous that it is infinitely worth while to remember it, and thus avoid a pitfall. Again, in so-called sciatica we may wisely search for a gluteal abscess due to tubercular bone, where pus has welled through the sciatic notch. Such an observation may be of the greatest utility.

SECTIONS.

Perhaps the commonest form of pelvic pain in women, especially amongst the poor and under-nourished, such, *e.g.*, as form the bulk of our out-patients, is :—

(1) *Tired and Stretched Muscular and Fibrous Structures.*—A homely illustration will serve best to illustrate my meaning. I was accustomed when in Plymouth to see women only on Tuesday evenings at the out-patient department of our hospital there. The class of cases I now refer to would put the situation in a nutshell, something after the following formula. To the familiar query, "Well, how are you?" the answer would be, "O, I'm very bad to-day, though I was better on Sunday and Monday, but then you see I was washing yesterday, and that never agrees with me." Here is a hint thrown in gratuitously to the soap manufacturers, combine or otherwise, for a telling advertisement. The materials are at hand! The artist "does the rest!" Muscles in women are weak, and after child-birth often subinvoluted. The nerves are sensitive, frequently from want of sleep, and this class of case is often anæmic. These patients frequently feel quite well in the morning, and fit for the daily arduous round, but after they have been on their feet for a short time the old familiar pain returns. It is referred to the sacral region, frequently between the shoulders, to the hypogastrium and down the thighs. The *treatment* is obvious, viz., rest, but this is often of course impossible. I used at one time frequently to order these cases a poroplastic jacket, beautifully made by Cockings' representative in Plymouth, and to whom I often send now. But after all, this treatment only meets the case of a comparatively small portion, and is at best a makeshift, though a most comforting one. Perhaps the best is to give these patients a pessary, for it supports the tired and stretched pelvic floor, and this part of

the muscular system is the one most urgently needing help. The medicines I have found most useful are *arnica* and *actea*, and as a diet, iron.

Closely allied to this first division of my subject is (2) *Rheumatism*, in its relation to pelvic pain, and I shall say a few words in the second place under this head. The late Dr. Ord, of St. Thomas's, was, I believe, the first who conspicuously insisted upon the fact that chronic rheumatism in women could frequently be cured by treating catarrhal conditions of the uterus and cervix. Rheumatism is a toxæmia, and is frequently absorbed *via* the throat, as in tonsillitis; by the urethra in the form of the gonorrhœal variety, and by the uterine cervix in abrasion and breaches of continuity in that structure. I believe that rheumatism in women is frequently seen clinically in the form of rheumatism of the pelvic ligaments. Two interesting cases were recently in the hospital, and will serve to illustrate what I mean. One is a patient of Dr. Compston's of Crawshawbooth; he asked if anything could safely be done to repair an extremely bad tear in the anterior lip of cervix, extending right up to the floor of the bladder. This tear had occurred in the last confinement. The apex of the tear, I may remark, was extremely sensitive, and when touched caused great pain. Just prior to coming into hospital, Dr. Compston had ordered her to bed on account of some chest lesion, and whilst she was steadily recovering from that, but still in bed, an attack of acute rheumatism occurred. When the patient came to hospital, I stripped the bladder from the deeply torn cervix, repaired the latter and restored the former. It happily turned out a success, though densely cicatricial avascular tissue is not ideal for primary union. Of course the rheumatism may have entered the system by some other channel than the cervix, but I submit that if the cure is now complete, and no other attack of rheumatism occur in this comparatively young woman, there is presumptive evidence that the materies morbi entered *via* the cervix.

The next case is one in which I do not suggest that rheumatism entered *via* the cervix. The point here is the pelvic rheumatism *per se*. A little girl, aged 13, was distinctly ill. There was constant pain referred to McBurney's point and distinct tenderness there, and a temperature which I had

verified during a period of some weeks, while she was an out-patient, of one to two degrees above normal. It may be asked why this child was not at once admitted to hospital as one of appendicitis. The reason is that she had already been an in-patient under one of our colleagues, who, I believe, after the most careful investigation, could not satisfy himself that true appendicitis existed. When the child was admitted for the second time, I was equally in the dark as to the cause of the pelvic pain. It was not now continuous, and the temperature had become normal. In order to make a diagnosis in this occult case I now examined her *per rectum*, under an anæsthetic. The uterus was, of course, infantile, and was about the size of a filbert. The right ovary was very easily felt, and was very distinct. It was, in fact, larger than the uterus. The left ovary could not be felt. On examining McBurney's point, the tendon of the psoas muscle felt like a ridge and slipped about backwards and forwards under the finger. With this exception, the evidence in this region was negative. Before passing on to the crucial point in the case, I wish to say, with reference to the examination *per rectum*, that did the opportunity arise more frequently for examination of a child of this age, I strongly suspect some such want of correspondence in the size of the adnexa would be found more frequently. I submit that here we have a transition in the developmental process which, did we better understand it, would throw light upon that obscure class of case in the adult which we call "infantile uterus."

A week or so after this examination, this little girl's temperature rose, and she had an attack of rheumatism in her left wrist, with—and this is most interesting—a subsidence of the pain in McBurney's point.

(3) *Gonorrhœa.*—It would be idle longer to delay reference to what is, after all, by far the commonest cause of pelvic pain in women, viz., gonorrhœa. If this could be eliminated, women would be relieved from a thraldom which is simply appalling. All men who work at gynæcology, especially in such great cities as this, must frequently be sick at heart at the suffering inflicted upon the innocent by those who enter upon marriage with an incompletely cured gonorrhœa. I do not, of course, mean that such a compact is necessarily vicious; it is

often a matter of ignorance only. I have no desire to moralise, and leave that to abler and better men in another field. I merely state the impressions of a gynæcologist in the slums of a great city. To imply, however, that gonorrhœa was more prevalent amongst the poor than the rich, would probably be a hideous injustice.

I saw amongst some old bric-a-brac recently an old oak sideboard, on which was engraved this motto, "Make ready the spindle and shuttle, and God will supply the flax." An apt antithesis came to mind, namely, "Make ready the speculum and caustic and the Devil will supply the patients."

Before proceeding further to consider pelvic pain due to gonorrhœa, it is necessary to generalise a little, or there will be a danger of confusing things which are essentially different, though they may occurr in one and the same patient. I refer chiefly to septic pelvic lesions. This is a big subject and I only touch its fringe. When speaking of septic lesions, I mean conditions quite independent of the gonorrhœal virus. The mind of a gynæcologist is liable to be obsessed by gonorrhœa in consequence of its extraordinary prevalence; yet he must sometimes, if I may use the term in this connection, seek to depolarise his mind from gonorrhœa altogether. This is specially necessary when dealing with lesions commonly known as septic.

(4) *Septic lesions* of the pelvis are common enough, though I believe far less so than formerly. This, of course, is due to the strides made in teaching practical antiseptic midwifery both to students and midwives. It may provoke a smile to see a student place his hands in a corrosive sublimate solution whilst he slowly counts five. But it's up-to-date science all the same. Probably, too, india-rubber gloves have saved many a woman's cellular tissue from infection, though I am still old-fashioned enough to look upon the latter somewhat in the light of a fetish. Septic lesions of the pelvis are due to trauma, and are dependent upon septic fingers or instruments. The organisms found in these cases are the strepto- or staphylo-coccus. They are introduced from without and are elaborated within the organism. A well-known red herring is sometimes trailed across the path to confuse the issue, viz., sewer gas. I do not plead immunity from calling in the aid of this malodorous

fairy, but it is best to admit at once that in sewer gas poisoning, which, of course, is well known in the puerperium, one does not find the strepto- nor the staphylo-coccus, so at least I believe. In pelvic pain due to a resolved pelvic cellulitis and peritonitis, menstruation is excessive, and the pain is very great, and the latter is due to the implication of the peritoneum. In the intervals of menstruation there is a muco-purulent discharge. The treatment is largely surgical, for foci of infection remain in the endometrium, and from these a certain amount of absorption takes place through the lymph channels and is carried to the adnexa; thus the inflammation is kept up. Therefore, curettage and cauterisation and destruction of these foci is indicated.

(5) *Peri-Typhlitis.*—With regard to the subject of pain in the S.W. corner of the abdomen, a citation of the two following cases will be of interest. They serve to emphasise the great importance (when contemplating pain in this region) of not too hastily rushing to the conclusion that it is infallibly due to inflammation of the appendix. I know of nothing which expresses better the attitude of mind which too readily assumes the relation of cause and effect here, than to speak of it as a mind obsessed or besieged. We often speak of a thing being "upon the nerves," and we know exactly what is meant. I think appendicitis is liable to "get on one's nerves," and it needs a level head, a due sense of proportion, and a wise generalisation of facts, to give a sound judgment in a given case. I am not, of course, speaking of cases in which operative delay would mean gangrene and abscess, perhaps, in a few hours. In short, all cases of fulminating appendicitis are entirely excluded from these observations. In the cases I am about to refer to, the symptoms were those of appendicitis, and which doubtless existed *inter alia*, but as a factor, and though an extremely important one, still only a factor, in the group of signs and symptoms. Miss X., a patient of Dr. Whitaker's, at Waterloo, aged about 30 years, had an attack of peri-typhlitis last summer when away from home. She was then attended by the practitioner on the spot. The present attack commenced with very severe pains in the abdomen. The temperature fluctuated between 99° and 100°, and the pulse was correspondingly rapid. The bowels were costive, but were not much

distended, and the pain was severe in the right groin and thigh, also in left side in region of descending colon. The face was much flushed and the patient was obviously very ill. When asked to locate the pain, the patient placed her hand in the latter region, not over the appendix nor (which was significant to my mind) upon the epigastrium, for so-called "stomach ache" often really spells appendicitis. We examined carefully by the rectum and found a mass which was situated about the middle line, and this was tender and hard. I suggested that we should, contrary to ethics in a single woman, examine *per vaginam*. This we did, and found that the lump was unmistakably a retroflexed uterus. It was painful, especially if in the least tilted, and there was no difficulty in diagnosing a fairly extensive cellular inflammation around it, in other words, a parametritis. Dr. Whitaker took specimens of the blood and there and then estimated with much accuracy the leucocytosis. The count was as follows :—

January 8th, 1907, at 2 p.m., Leucocytes 18,000.
" " 10.30 p.m. " 19,660.

Here was a difficulty in view of above rendering, for as is well known a rapid rise in the proportion of phagocytes indicates operation. In view, however, of the totality of the above signs, we decided to wait for twenty-four hours. We continued *bell.* and *merc. cor.*, and ordered an olive oil injection to be placed in the rectum and retained, and a saline aperient to be given in the morning. The following morning Dr. Whitaker telephoned that there was no need to come as the patient was very greatly better; at 10 o'clock this morning the leucocytes were 12,000, and on the following day at the same hour, 5,200. I have not seen her since, but Dr. Whitaker informs me that the recovery, though slow, has been steady, that the parametritis has become more and more circumscribed, and that the peritonitic inflammation has disappeared.

The second case in this section which I wish to bring before you is that of a lady, also of about 30 years of age, and who was under the care of Dr. Hynd, of Wigan. The history was that of a week or ten days of vomiting, with a temperature that oscillated between 100° and 102°. There was persistent pain in the abdomen, chiefly on the right side. The tongue was almost clean, but the vomiting was so great that the patient

could retain merely a little orange juice. The abdomen was tender, bowels not much distended, but over an area of about four inches in diameter in S.W. quarter of abdomen there was a hard, boggy swelling, dull on percussion and very tender to touch. Its outline was fairly obvious above, but below it merged imperceptibly into Scarpa's triangle, leaving the fold corresponding with Poupart's ligament obliterated. The patient looked very ill. The chief cause of suffering was intense pain on defæcation; so agonising was this, that the doctor had been obliged to keep the patient under the influence of morphia. Before this was resorted to, her screams alarmed the whole neighbourhood. A rectal examination, verified, as in the last case, by a vaginal one, revealed a diffuse swelling, and, as in the last case, also a retroflexed and tender uterus. This examination was not very thorough as the patient was so intensely tender. I thought we had to do with a pelvic cellulitis, probably already broken down, but so far not actually pointing in any of the three usual situations, viz., above or below Poupart's ligament, or in buttock through the sciatic notch. I advised the immediate removal of the patient to a private ward, either in the Wigan infirmary or to one in our own hospital, with a view to operation, which it seemed hazardous to delay. The day but one after, she travelled by road from Wigan to Liverpool in a horse ambulance. Contrary to expectation, she did not suffer from transit. The temperature had even sunk and the pulse become slower. The subsequent history I may condense. The phlegmon gradually subsided, the pain on defæcation lessened, and pulse and temperature became normal. A week after she could take and digest solid food, and only a very slight swelling then existed. One very curious feature in the case, and which I have not hitherto seen marked to anything like the same extent, was this, whenever the tender swelling in S.W. quarter was percussed or otherwise manipulated, an involuntary contraction of muscular fibres of abdominal wall would set in, very hard and tender. It was sausage-shaped, with the long axis reaching from the middle of Poupart's ligament upwards and outwards in the direction of and beyond McBurney's point. As the internal structures became less sensitive, this contraction became less and less marked, and finally subsided. This patient, I should observe,

was also treated by *bell.* and *merc. cor.* I have no doubt the case was one essentially of pelvic cellulitis, involving especially the region of rectum and right ovary. The signs and symptoms, however, closely resembled those of appendicitis. I may add that before the patient left the hospital, under an anæsthetic it was ascertained that a large and prolapsed right ovary existed.

Gentlemen,—My paper, I fear, is getting rather long, but I have endeavoured to keep it from discursiveness, and I shall now draw it towards conclusion by referring to two or three matters concerning abdominal pain which have greatly struck me, and which I am anxious to pass on, in case they may be of service to others.

(6) *Pain in Epigastrium which is not manufactured there.*—I wish now to refer to such pitfalls in this connection as in our less experienced days we fell into, and might again unless forewarned. The most common cause of pain in epigastrium is, of course, some form of gastric disturbance producing hyperæsthesia. Gastric mischief, however, of all kinds I am putting entirely out of count at present.

There are four conditions which give rise to pain in the epigastrium which is not manufactured there, and have nothing to do with the stomach: (1) Biliary colic; (2) Appendicitis; (3) Caries of lower dorsal vertebræ; (4) Pleurisy and pneumonia.

As to the first, biliary colic, the subsequent history of the case will clear up any ambiguity.

As to the second, appendicitis, I have learnt never to fail to investigate cases of frequently recurring "stomach ache" in the young, especially in the young adolescent, in the light of possible appendicitis. What happens is this: The patient complains of stomach ache, probably of vomiting also, and on being asked to locate the pain does so definitely in the epigastrium. There may, or may not, be a rise of temperature, probably there is to some degree. By-and-by this pain subsides, and gives place to the typical pain in S.W. corner of abdomen. Probably in all such cases as I have described there is really pain at both sites, but that in the epigastrium is so much the more severe that it overmasters the other, and it so falls out that as the greater pain subsides, the patient for the first time becomes aware of the pain at McBurney's point.

Third, caries of the lower dorsal vertebræ. The fallacy here is so well known that I need do little besides mention the fact in order to make my list complete. The pain is conducted along the course of the spinal nerves from the site of mischief, but is felt where the nerve endings are distributed, another instance of the puncta dolores of the older writers.

Fourth, pleurisy and pneumonia. An acute attack of either the one or the other, or a combination of both, is not infrequently associated with very severe pain in the epigastrium. The symptoms are so acute, and the pain so severe and localised, that mistakes have been made on the assumption that the trouble was an acute abdominal one, and the abdomen opened, with, of course, negative result. There are, of course, certain indices which we might suppose would prevent the error. The pulse and temperature failing to give a definite clue, it might be assumed that the character of the respiration would at least act as an index, yet it has failed to do so in the most competent hands. The inference is that in all cases of acute abdominal pain, especially in and about the epigastrium, we ought to make a point of very carefully examining the chest. In such case, to use an Irishism, we may find that the mischief is after all not in the abdomen, but in the thorax.

I am inclined to include another thoracic condition under this head, and to refer to pericarditis. If the latter is associated with diaphragmatic pleurisy, I submit that the pain is largely in the epigastrium. One point, however, I am quite sure of, and that is the very curious one, viz., that pericarditis often induces very severe pain in the right shoulder.

As regards (7) *Syphilis*, a few words must suffice. Experience teaches me that, apart from the outward and visible signs so well recognised of the disease, there is a well-marked triple index of its underlying existence in a case whose primary symptoms are not suggestive of its existence. I am supposing a case in which no obtainable history of syphilis is forthcoming. There is nothing typical in throat or skin, and yet the patient is obscurely ill. I am, of course, excluding cases in which there are para-syphilitic phenomena, *e.g.*, tabes dorsalis, or syphilis of brain, in other words, remote or more chronic forms of the disease.

The three points which I have learnt to rely upon chiefly

in the diagnosis of cases in which I believe syphilis to be in the background, and yet one cannot demonstrate it until *kali. iod.* has been given, when the effect is often dramatic, are :— (1) A temperature of the moderately hectic type ; (2) anæmia, in which hæmatinics are useless ; and (3) pains, worse at night.

Thus, gentlemen, I have endeavoured to piece together some notes on a big subject, and shall be fully rewarded if my paper is provocative of an ample discussion.

DUODENAL ULCER.

By the SENIOR EDITOR.

During the last half of 1906, many valuable papers have appeared both in English and Scottish Journals on the subject of duodenal ulcer. Time was when this was thought to be a *rare* condition, and to be usually the result of burns, involving a considerable part of the surface of the body. Now it is known to be by no means uncommon. The pain is peculiar : It usually occurs from two and a half to three hours after food, and is relieved for a time by the introduction of food into the stomach. Pain of this character is regarded as almost pathognomonic of ulcer of the duodenum. It is much more common in men than in women, and usually occurs about the middle period of life, and is preceded by the acid form of dyspepsia (*hyperchlorhydria*). This is regarded as a *neurosis* of gastric secretion, usually depending on much worry and mental strain in overworked business and professional men. Another ætiological factor is arterio-sclerosis.

The ulcer practically always occurs somewhere in the first two inches of the duodenum, and well above the entrance of the bile and the pancreatic ducts. One wonders whether this has anything to do with the fact that both stomach and duodenum (the first part at any rate) are developed from a common origin, viz., that part of the primitive intestine known as the "foregut." The ulcer is usually located on the upper portion of the anterior wall.

The pain usually consists of a deep-seated tenderness in the epigastric region well to the right of the middle line, with

rigidity of the upper part of the right rectus. It is severe, cramping and neuralgic; it begins in the right hypochondrium, and may pass across the abdomen from right to left (note *lyc.*), or go round towards the back to the lower dorsal region, where "tender points" may be met with.

Various explanations are given of these phenomena: the acid contents of the stomach are neutralised for a time by the introduction of fresh food; the pain is caused by the passage of the acid chyme over the surface of the ulcer; or it may be due to a localised peritonitis; or to cramp or spasm of the pylorus when the ulcer is situated close to the sphincter. When once the acid chyme has passed the sphincter closes, and very soon the alkaline fluid of the duodenum bathes the surface of the ulcer once more and the pain is eased. In addition to pain there may be profuse hæmorrhage, which may (and usually does) pass by the bowel (*melæna*); or the blood, if the bleeding is very profuse, may regurgitate into the stomach and be expelled by vomiting (*hæmatemesis*). The pain must be distinguished from hepatic colic, as well as from the "gastric crises" of *tabes dorsalis*. In hepatic colic there is usually vomiting, and *calc. c.* 30 often has a wonderful power over the pain. Vomiting is not common in duodenal ulcer. Always examine *per rectum* for intussusception, appendicitis, and hernia.

Acute duodenal perforation may simulate appendicitis; this happened in 19 of Moynihan's 51 cases. The fluid from the perforated gut seems to pass downwards along the outer side of the ascending colon as far as the brim of the pelvis. Pain may also be felt in the region of the appendix in cases of perforated gastric ulcer situated on the posterior wall of the stomach. In women we have further to be on the look out for diseased conditions of the right ovary and tube. Nor must one forget the possibility of *pneumonia*. This disease sometimes begins with shivering and vomiting, with severe gastric or abdominal pain referred to the region of the umbilicus; such referred pain may even cause unilateral or general rigidity of the abdominal walls. Such a case is also apt to be mistaken for one of appendicitis. We must further be on the watch to distinguish it from inflammation of the pancreas and thrombosis of the portal vein.

It is interesting to compare duodenal ulcer with gastric ulcer :—

DUODENAL ULCER.	GASTRIC ULCER.
Pain several hours after food, relieved by eating again.	Pain, in many cases, as soon as food is introduced into the stomach.
Vomiting not common, unless blood regurgitates into stomach.	Vomiting soon after eating, and this relieves the pain.
In middle-aged men.	In young women.
Often fatal from profuse hæmorrhage.	Very rarely fatal, even though bleeding is profuse and frequently recurring.
Treatment.—After *one large hæmorrhage*, gastro-enterostomy and saline transfusion.	*Treatment.* — Dietetic and hygienic, with rest in bed. In rare cases, gastro-enterostomy.

In severe abdominal mischief the expression is usually drawn and anxious, but do not forget the lethargy, the delusive calm, of gangrene. Always carefully consider the *pulse-temperature ratio.* Here the pulse rate is even more important than the temperature. If the pain disappears while the pulse keeps up, or rises, the outlook is *ominous*, but *most ominous* of all should the rigid belly become distended ; for tympanites in acute abdominal disease, especially with relaxed sphincter and ballooned rectum and "facies Hippocratica," is of most serious import.

In acute pain in the abdomen with sudden collapse, it is well to have in one's mind, and at one's *finger ends*, the most likely possibilities—

(1) Perforation of the stomach.

(2) Perforation of the duodenum.

(3) Embolism of superior mesenteric artery (note probable symptoms of acute intestinal obstruction, the bowels being constipated ; but examine for cardiac lesions, such as mitral stenosis, or malignant (ulcerative) endocarditis).

(4) Acute hæmorrhagic pancreatitis. In this there is usually constipation.

(5) Rupture of an extra-uterine gestation—usually about the sixth week—with signs of internal hæmorrhage.

(6) Rupture of hydatid cyst of liver.

(7) Affections of ovaries or tubes, usually in young women, *e.g.*, ruptured pyosalpinx, torsion of pedicle of an ovarian tumour.

(8) Rupture of abscess of appendix vermiformis.

(9) Kink in ureter of floating kidney (*Dietl's crisis*).

(10) Intussusception, twist or kink of the gut, internal strangulation of any kind.

(11) The colic of acute indigestion.

(12) Acute inflammation of the subserous peritoneal tissue.

Such are a few of the more common causes. In *intussusception* the pain is forcing and paroxysmal, and the patient says he would be better if he could get his bowels open, reminding one of one of the leading symptoms of *nux vomica*. It is surely unnecssary to add that in such conditions *narcotics* must be avoided; they can only do harm, and they stupefy the doctor even more than the patient!

To use narcotics under such conditions, reminds one of the misguided efforts of *kind friends* in cases of a ruptured varicose vein of the leg; they place the patient in a chair, and then heap rags on the bleeding point, and as fast as the blood shows through, on goes another rag. All that this does is to *hide* the blood while the patient is bleeding to death. So with narcotics in acute abdominal conditions, the doctor who uses them no doubt, like the friends, means to be kind and to save the patient pain, *but it is a kindness that kills.*

But does *pain several hours after eating, relieved by taking food again, always* mean duodenal ulcer? It is impossible to say; but if it does then we have often cured duodenal ulcer, for it is by no means uncommon to meet with pain of this character in one's ordinary daily practice. Many medicines appear to meet this condition, but especially *anac.*, *chel.*, *graph.*, and *petrol.*, with several others, such as *kalm.*, *lach.*, *med.*, *nat. c.*, &c. Hence, if we meet with pain of this character and with this modality, we should examine one or all of these medicines in the *Materia Medica* till we find the *simillimum*, which may cure the whole condition and prevent fatal hæmorrhage. But if not, after *one large hæmorrhage*—as evinced by sudden collapse, pallor and gasping (air-hunger), and passage of a large amount of blood by stool—we think the

time has gone past for temporising, and that the surgeon should step in at once and perform gastro-enterostomy, if necessary transfusing saline solution, both before, during and after, in *large* quantity—say from six to ten pints or more. But it is no use transfusing unless one is prepared at once to operate, as transfusion alone will probably determine another hæmorrhage.

But does not operation show a wavering faith in homœopathy, and a total want of faith in the powers of the indicated remedy? By no means. In the case in question it is not a *disease* that kills the patient, but an *accident*, and a *surgical* accident, as truly so as if a knife had been plunged into the common femoral artery, or a varicose vein had burst. You cannot find "*the simillimum*" for a surgical *accident*, indeed, there cannot be such a thing. But if the bleeding has stopped, will not this give time for likely remedies to act and seal up the opening in the artery? Such a course, in my opinion, is quite unjustifiable; though some advocate temporising till a *second* big hæmorrhage occurs, which it is pretty sure to do if one big hæmorrhage has already occurred. But why wait for the second? The stopping of the first is as deceptive and dangerous as the so-called "lucid interval" that occurs between rupture (from injury) of the middle meningeal artery and the onset of fatal compression. In consequence of the loss of blood and the collapse, the heart beats very feebly, and a blood clot forms in and over the ruptured spot. But by-and-by the heart recovers its force, before sufficient time has elapsed for the clot to become organised, the clot is driven out, and hæmorrhage begins anew, which very likely may prove fatal. Therefore the "lucid interval," whether in cerebral or duodenal hæmorrhage, should be used, not for idly waiting to see what will "turn up," but for active interference to secure the bleeding ends in the one case, or to perform a gastro-enterostomy in the other.

Since writing the above, however, I am bound to confess that I have seen two patients who, from the history they gave, in all probability have been the victims of duodenal hæmorrhage, one some years ago, the other more recently. This latter is a dispensary patient, living in the country; I have explained the matter to him and warned him what to do in the event of another attack. At present he seems to be doing

well upon *petrol.*, the pain and discomfort having almost disappeared.

When a physician, who is a homœopath, hears of duodenal ulcer, his mind automatically calls up a mental picture of *kali bich.* and *uran. nit.* I have said nothing about these medicines, as they do not seem to me to have any special relation to the condition in question. Whether they would be useful in duodenal ulceration, the result or concomitant of burns, I do not know.

As regards the use of *kali bich.* "in dyspepsia, Lippe finds it indicated when there is a feeling as if the digestion stopped after a meal eaten with relish, and the food lay like a load; and it differs from *nux. vom.*, which has similar symptoms, in that the *kali bich.* symptoms *come on immediately*, while those of *nux.* only one to three hours after the meal. Lippe finds it also curative in the dyspepsia of beer-drinkers, and in round ulcers of the stomach, which I can confirm. The same is said by Dr. Clifton, who also gives as indications in dyspepsia, the state of the tongue, the dislike to water and to meat, morning nausea, taste in the mouth, pressure and weight rather than pain in the stomach, as if the food lay undigested, as these are defined in the pure symptoms. In an illustrative case by Dr. Clifton, in which the above symptoms were present, and in addition rheumatism, worse when the gastric symptoms were better, he effected a cure with *kali bich.* 6 and 3, after many other medicines had failed."—*Monthly Homœopathic Review*, March, 1873 (quoted from Dr. Drysdale's Monograph). From this it would seem to be indicated in ulceration of stomach rather than in duodenal ulceration, though from their community of descent one might assume it would affect both these parts of the alimentary canal. In the experiments performed on the lower animals, the duodenum was even more constantly acted on than the stomach, to the extent of intense inflammation and even ulceration.

In reference to *uran. nit.* we quote from Dr. E. T. Blake's monograph.

"This remedy will probably rank high in the treatment of gastric ulcer.

"Either this drug, or the *bichromate of potash*, should be given to ward off the tendency to death after severe cutaneous

burn, which was observed by Curling to be accompanied by duodenal ulcer.

"What *chamomilla* is to acute duodenitis, this drug and *kali bichromicum* may prove to be to the chronic condition.

"Ulceration of the stomach has been produced in three out of ten rabbits; this seems to be a specific effect, for it appeared in those cases where the drug was introduced *under the skin of a distant part of the body.*

"The ulceration was near the pylorus; and in the non-ulcerated rabbits there was some deviation from health in the lining membrane of the pyloric extremity of the viscus.

"If Curling's observation be a true one, we should expect that this salt and the *bichromate of potassium* would have the power of averting the fatal tendency of extensive, cutaneous burn, from their evident specific power in producing ulceration of the duodenum, combined with marked general prostration."

The pylorus was diseased in nine rabbits and one cat out of a total number of nineteen animals experimented upon; and there was pyloric ulceration in three rabbits and one cat out of the same number.

We have always distrusted experiments on the lower animals. It is of no earthly value to me, in treating a case of supposed duodenal ulcer, to know that such and such a drug has produced a duodenal ulcer in a cat or rabbit, unless (1) I am assured that the effects would be the same in the human animal (which by no means follows); (2) that this particular drug is the only one in creation that can produce duodenal ulcers; or (3) if there be more than one, unless I know the *subjective symptoms of the prover*, whereby I may be able to differentiate each drug having this power the one from the other, till I find *the* one that agrees most perfectly with the clinical picture presented by my patient. Hence it is that experiments on the lower animals can never be satisfactory, and will only lead to confusion and disappointment.

THE LOCAL NON-OPERATIVE TREATMENT OF SUPPURATION OF THE MIDDLE EAR.

By DUDLEY WRIGHT, F.R.C.S.

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THAT local measures are not the Be-all and End-all of treatment in suppurative disease of the middle ear is not infrequently brought home to one by the rapid cure of a case which had resisted all previous treatment, following shortly upon the exhibition of the indicated homœopathic remedy. In such instances it is almost certain that a constitutional dyscrasia is at work which has been attacked by the remedy; and that a cure can in this way be produced without having recourse to more than ordinary local cleansing measures is, no doubt, within the experience of most practitioners who are in the habit of prescribing according to the law of similars.

At the same time matters are often hastened, even in simple cases, by the proper use of local measures, and, in complicated cases, the latter are often essential to the attainment of a cure. It is, therefore, with a view to giving some information on this subject that the following notes are penned. And since the question is so often asked, which is the best method of applying local treatment? it will be well to deal with this subject first.

Syringing, the usual method employed, is not without its dangers in inexperienced or careless hands, and the insufflation of powders is, under certain conditions, likewise attended with some risk. If the patient can be regularly seen by the practitioner there is less objection to either of these plans, but as a rule this part of the treatment has to be left in the charge of some relation or friend of the patient, and in such cases it is well that instructions should be given to carefully mop out the ear with cotton wool and to introduce the desired antiseptic solution in the form of drops, which may be done by means of a proper dropper, or, in the absence of this, by means of a fountain pen filler, which forms a handy instrument for this purpose. The patient should bend the head to the opposite side whilst the drops are being put in, and remain

in this position for a few minutes afterwards, so as to allow them to come in contact with all parts of the cavity. This action is assisted by the patient inflating the ear by Valsalva's method whilst the head is in this position. In a certain number of cases the discharge persists so long as fluid applications are made. In these the dry plan succeeds, and often rapidly tends to a cure. This is effected by blowing into the ear, after previous cleansing with some antiseptic lotion, a quantity of *boric acid*, or other sterilising powder.

The drawback to this method is that at times the discharge is dammed up in the tympanum and thus finds its way into the mastoid cells, and grave complications are apt to follow. It is, I believe, this sequence of cerebral or mastoid involvement caused by the shutting up of discharge in the drum cavity by powder, or, in other cases, by inspissated pus, which has led to the fallacious idea in the lay mind of the danger of stopping a discharge from the ear. Obviously this kind of "stopping" of the discharge is very different from curing.

It is quite possible that the use of some dry powder is more likely to lead to asepsis in the ear passage and drum cavity than the introduction of antiseptic lotions, and were it not for the above-mentioned risk, the former method would possibly supersede the latter. Can we, then, say under what conditions the risk of complications is present, and thus have some guide to the unsuitable cases for this form of treatment.

It is probable that the risk is the greater the smaller the perforation in the drum head, for in small perforations, especially those seated high up on the drumhead, there is more likelihood of the discharge being blocked up by a quantity of powder being introduced into the meatus, as well as a minimum chance of the powder reaching the seat of the discharge and acting beneficially upon the diseased mucous lining of the tympanum. This being so, it is clear that the most suitable cases for this dry method are those with a large perforation, where a considerable surface of the middle ear is exposed, and where the possibility exists of introducing a quantity of powder to the seat of the disease.

The Homœopathic *Materia Medica* contains many substances, mostly derived from the vegetable kingdom, which when suitably prepared and selected according to recognised

indications, can be used locally either as fluid or powder with much benefit. When used in powder form, a convenient method is to mix equal portions of the tincture of the drug with *boric acid* and evaporate to dryness. The resulting powder will have the specific effect of the drug in addition to the antiseptic virtues of the *boric acid*. *Calendula*, *hydrastis* or *hamamelis* can be used in this way.

The following are some of the most useful remedies for local application.

Alcohol.—This, besides having an antiseptic action, abstracts fluid from the tissues. In this way granulations and polypi are often got rid of. In cases where the discharge is watery and persistent, and the mucous membrane of the middle ear has a pale, fleshy look, alcohol drops are of great service. It is not good to commence with pure spirit, but to dilute it and gradually increase the strength from 40 per cent. It may be used as a vehicle for other antiseptic drugs, such as *resorcin*, and *boric* or *carbolic acid*. The first of these three in 5 per cent. strength is most useful in cases of unhealthy granulations.

Hydrogen peroxide.—This is a valuable application in certain cases where there are cholesteatomatous or other hardened masses in the canal, as it breaks them up and renders their removal with the syringe more easy. Some object to its use on the score that the effervescence caused by its coming in contact with pus may carry some of the latter into the mastoid antrum and induce an attack of mastoiditis. I have not experienced any such trouble, and I have largely prescribed this preparation in chronic middle ear suppuration, especially where the discharge is thick and adhesive, and the perforation small, for in such cases the danger of pus finding its way into the mastoid antrum is reduced to a minimum.

Boric Acid.—This substance, either in the form of a powder or as a solution in water or alcohol, is largely used for the cure of aural suppuration. It finds its chief sphere in cases with much congestion of the mucous membrane and some fœtor of the discharge. In such cases it is better to use it without alcohol, reserving this latter preparation for cases where the tissues are pale and œdematous, and require the shrivelling action so characteristic of alcohol.

Alum.—This may be an astringent, styptic irritant, or caustic, according to the strength used. From two to five grains to the ounce it is useful when the lining membrane of the tympanum is ulcerated, or if there are flabby granulations which easily bleed when touched. If there is any tendency to eczema this remedy should not be used, as it may irritate the skin, or provoke an eruption, or cause boils to appear in the meatus.

Sulphate of Zinc.—This is more deeply acting than the last mentioned, though its sphere of action is very similar. It may be used in the same strength, and will act upon granulations and even polypi in a satisfactory way. *Zinc* has a specific action upon suppurative processes, and it promotes healing in ulceration, as is seen in cases of ulcerated legs to which *zinc ointment* has been applied. This metal may be driven into the tissues from the positive pole of the galvanic current, and in this way the writer was able to cure a most inveterate case of suppurating middle ear which had resisted various other forms of treatment through a period of some years. The meatus was filled with a saturated solution of *zinc sulphate*, and a *zinc* terminal from the positive pole, insulated to within half an inch of its extremity by means of india-rubber tubing, was placed in the meatus and a current up to two milliampères gradually turned on for two minutes. Six sittings of this treatment entirely stopped the discharge. In making use of this method it is necessary to turn the current on and off very slowly, otherwise vertigo may be induced.

Nitrate of Silver is one of the most useful salts we have for local treatment of aural suppuration. It acts superficially, as it is rapidly decomposed and turned into *chloride of silver* when it comes in contact with the tissues. Unhealthy granulations or inflamed and ulcerated mucous membranes are rapidly brought into a healing condition by solutions varying from ten to 40 grains to the ounce. It is especially useful when the discharge is abundant and of a muco-purulent or purulent character, and if there is great sensitiveness of the lining membrane.

It is best applied by the surgeon, on a wool mop after the ear has been thoroughly cleaned out, and it should not be used by the patient as drops, as discoloration of the meatus and the auricle is almost certain to result from this method of

application. If used in the former way, there is no need to syringe out with salt solution, as is sometimes advised.

Argyrol and Protargol are two preparations of silver which can be used in the place of the *nitrate.* They appear to penetrate the tissues to a greater extent than the latter salt, as they do not become decomposed by the tissues. A 15 per cent. solution is a useful strength, and either preparation may be used as drops, as they do not stain the skin in the same way as does the *nitrate.*

Carbolic Acid.—This *acid* is occasionally of great service, for besides being a strong antiseptic, it is also an excellent caustic if applied in the crude state for unhealthy granulations and ulcerations of the middle ear with fœtid discharge. Besides this, when locally applied, it is a most excellent analgesic, especially when mixed with *glycerine,* as the *B. P. glycerinum acidi carbolici.* This dropped into the ear rapidly relieves cases of otalgia, and not only abolishes the pain, but also reduces the inflammation in acute tympanic catarrh of children. For rendering the drumhead insensitive preparatory to minor operations, equal parts of *carbolic acid, cocaine,* and *menthol* will prove efficient as an anæsthetic agent locally applied with a wool mop.

Two other acids, namely, *trichlor-acetic* and *chromic,* are useful agents for cauterising unhealthy granulations. The former is milder than the latter; it is, however, often more painful, though this can be overcome by means of *cocaine.* If *chromic acid* is used, it can be applied by means of a fine wool mop to the diseased area only, but care must be taken, after a few minutes, to neutralise it by a solution of *bicarbonate of soda,* otherwise it will penetrate deeply, and may cause serious after-effects. Another way of applying the acid consists in fusing a few crystals in the flame of a spirit lamp on a silver probe, and by this means the application can be more satisfactorily localised.

Bichromate of Potash as a lotion in the strength of 1 in 500, I have occasionally used for instillations in suppuration when there is some ulceration of the tympanic mucous membrane. It seems to be useful in cases where the discharge is more sanious than purulent, and in which there is present an accompanying nasal and naso-pharyngeal catarrh.

Hydrastis, as a local application in suppuration, does not appear to act very energetically. It is astringent, and is beneficial in congested conditions; but the universal astringents are usually more satisfactory and speedy in their action. It is, however, useful when combined with *boric acid powder*, as mentioned in a previous paragraph.

Perchloride of Iron.—This is one of the most satisfactory applications for polypi of the middle ear. The strong *perchloride tincture* is the preparation which should be used for this purpose. The growth should be made quite dry by means of a wool mop, and the *tincture* applied with a ring-ended probe. A second application may be required within a few days, after which the growth usually shrivels up.

Sanguinaria is another drug which has been used locally with success for the removal of polypi of the ear. It should be applied as the crude trituration. Its action is, however, uncertain, and not nearly so satisfactory as the *perchloride of iron.*

Clinical Cases.

By E. W. BERRIDGE, M.D.

(*Continued from p.* 289.)

CASE 12.—*Phosph., puls., sulph., graph., bar.-c., natr. m., niccol., coloc.*—October 20th, 1881.—Miss H. J., aged 36, consulted me personally, the treatment being subsequently carried on by correspondence. At the age of two or three she fell, and right occiput came in contact with a file; shortly afterward the hair fell completely off head, and a scab formed all over it. She was treated by a homœopath; but the sight soon began to fail, and eyes became inflamed. From age of three to eight she had great pain and inflammation of eyes, and though the wound on head healed, the scabs remained. One day she felt a severe pain in left eye, and heard a loud report in left forehead; after this left eye began to waste, while sight of right eye improved. Since then, no pain in left eye. Eight or nine years ago an allopathic oculist diagnosed cataract of right eye, with granular lids; he applied caustic to lids, causing much

pain ; since then sight has been weaker. In May, 1880, she consulted another allopathic oculist, who said she was going blind, and removed left eye. Then she consulted a third allopathic oculist, who diagnosed cataract, prescribing medicine and ointment; but eye became worse. Has had sixteen brothers and sisters, of whom twelve have died, almost all from phthisis. Present symptoms are cataract of eye, with slight film on cornea. Eye at times feels large, as if lid would not cover it, with heat and pricking in eye ; this enlarged feeling is generally worse when bodily tired, not affected by using eye. Myopia. Sees best in twilight, or when wearing dark glasses. With the attacks of pain, photophobia. For last six months, piles—generally internal—causing bearing-down pain in back. Constipation : stool only twice weekly, with constant ineffectual urging; during stool much pain from straining; after stool, prostration. Menses were regular, but since the piles they have become irregular, at intervals of from two to six weeks. During menses has severe pain, which a low potency of *pulsat.* relieves at once, but stops the flow. Menses have just ceased, having recurred after an interval of two weeks. Hair falls off.

Diagnosis of the Remedy.—Vision better in dusk. *Bell., bothr., calc. c., euph., nux.-m., phosph., silic., stram., sulph.*

Swelling of right eye. *Anath., apis., arg.-n., arn., eleis., gland., kali c., luesin., lyc., phosph., vesp.-cr.*

This comparison points to *phosph.*, which also has heat and shooting in eyes, though not specifically in right. It has also cured "sensation as if eye were swollen and pushed out of orbit." The remaining symptoms are fairly covered by this remedy, as well as by many others (471-6, 578, 586, 1890, 1892, 1918, 2032, 2299). I prescribed *phosph.* Cm. (F. C.), a few dry pellets alternate mornings for fourteen days.

November 7th.—Piles and bearing-down in back have ceased simultaneously. Constipation gone. Eye feels cooler and clearer, though used more than usual. Feels altogether much better in general health and spirits. *No medicine.*

November 28th.—No further improvement in eye; sometimes aches much ; when bad it feels too large for socket, and full of dust, with photophobia. Menses returned on 9th, after the disappearance of the piles, with dreadful pain in hypo-

gastrium, as if there were something inside her, "as hard, large, heavy, and cold as a milestone"; also pain in back extending to knees; this intense pain lasted five or six hours, then gradually ceased; the flow very scanty. Took no *puls.* this time.

Diagnosis of the Remedy.—Two remedies have abdominal pain like a stone during menses. *Cocculus* (296) has, "as if the inner parts were suffering from the sharp pressure of a stone." *Puls.* has (*Guiding Symptoms*, VIII., 609) "heaviness in abdomen as from a stone." Also *aloes* (470) has feeling of stone in abdomen when lying thereon; *ant. t.* (416) has abdomen feels stuffed full of stones after long sitting; *coloc.* (483) and *staph.* have pain as if intestines were squeezed between stones; *apis* and *cocc.* have pain in abdomen like sharp stones rubbing together ("Kent's Repertory"). But only *cocc.* and *puls.* have a similar symptom in connection with menses. As the patient's symptom was not "sharp pressure," but "heaviness," I selected *puls.*, and gave Cm. (F.C.) a few dry pellets every morning for seven days.

December 12th.—No return of piles or constipation. Menses appeared on 8th, almost to the day, but scanty, and only for two days; very little pain, and that chiefly in back; not a shadow of what she suffered last month. During menses much headache; a sort of fulness, as of rush of blood to head and face; worse the first day, gradually ceasing by end of second day. Sight has been "very fair since last medicine"; a more natural feeling about eyes. Says "the last medicine seems to have had the effect of *puls.*," though she knew not its name. *No medicine.*

January 9th, 1882.—For more than a week has been able to bear gaslight; all last winter could not look up in church, but had to close eyes all the time; this is not so now. On December 29th caught a terrible catarrh, chiefly affecting chest; burning in eyes, and felt ill all over. Took low potencies of *bry.*, *hepar.*, and *phosph.*, all in alternation with *acon.* Naturally such unscientific treatment did very little good, and she experienced more relief from a wet compress. The catarrh has now passed into its second stage. Has had a bad cough for last twelve days; worse at night when lying down, keeping her awake for hours; a hard, dry cough, tearing chest and shaking whole body. Pants at the least exertion. Scarcely

any discomfort with last menses, but more scanty than ever, and with the same fulness of head. Used sometimes to have epistaxis during menses, but this has not returned since treatment.

Diagnosis of Remedy.—Epistaxis during menses. *Acon., ambr., bry., calc. c., croc., laches., natr.-s., sabin., sepia, sulph., verat.*

Congestion of head during menses. *Acon., bry., calc. c., sulph., verat.* (and many others which have not the former symptom).

Of these five remedies, all have dry cough, and all, except *acon.*, have cough on lying down, and shaking cough.

Of the four remaining remedies, only *calc. c.* has tearing in chest during cough; though *sulph.* (2429) has the similar symptom, "shattering in chest on cough," and only *sulph.* has dyspnœa on exertion. Scanty menses belongs pre-eminently to *sulph.*; and while *calc. c.* has that symptom, profuse menses are far more characteristic thereof. Both have vision better in the dusk. I prescribed a few pellets of *sulph.* D.M. (F.C.) every morning for seven days.

February 6th.—After the first dose the cough ceased "as by magic"; took only one dose, as she felt she did not require more. Slept well all next night, which was "quite a treat." Has had no return of cough at all, and altogether feels perfectly well, except that the eye aches very often. Last menses more natural; less headache and more backache. *No medicine.*

February 10th.—Feels perfectly well, except that eye has been weaker for last few weeks; a sort of dazzled feeling, as though she had tried to look at the sun, and while it lasts a sick feeling in stomach, which is a new symptom. Very myopic. On left half of scalp hair falls off, and there is a thick coating, not sore except when removed; remainder of scalp is natural; this coating is constant, but worse at times; it accumulates again in a week or two after removal; left side of head never feels so natural as the other. Often has numb feeling in the whole left half of her. Has much nerve, and so pays less attention to little things, but sometimes has dreadful collapses, and then recruits herself by a thorough good cry all to herself, and so goes on; crying is her safety-valve, only it hurts eye.

Diagnosis of Remedy.—Relief from weeping. *Anac., aster., colch., cycl., dig., graph, ign., lyc., merc., nit.-ac., phosph., plat., tabac.*

Hair falls off. *Colch., graph., ign., lyc., merc., nit.-ac., phosph., tabac* (and others which have not the former symptom).

Scabs or scales on head. *Graph., lyc., merc., nit.-ac., phosph.* (and others which have not the two former symptoms).

Of these five remedies, *graph.* has pre-eminently left-sided numbness: (*Guiding Symptoms*) I prescribed a few dry pellets of *graph.* mm. 680 m. (Finckè) alternate mornings for fourteen days.

February 28th.—Feels perfectly well, except that she has had that strange feeling several times; no pain, only a sort of sick feeling after it has passed off. It comes on with a strange feeling passing over brain, especially on left side; then a dazed feeling before eyes, and it passes all down left side of body to toes; it comes on any time during day, and she just drops down on the nearest seat, and it passes off. If she can have a good cry, she gets over it so much the sooner; if she cannot cry, this sick feeling continues for an hour or two. Sight and head much the same. Last menses were more comfortable and natural than she can ever remember. *No medicine.*

March 23rd.—Eye often aches, especially when tired or worried. Menses returned last week, but only for one day, with much pain in body and down knees.

Diagnosis of Remedy.—Menses lasting one day. *Bar.-c.* (scanty), *mercurialis.* I selected the former remedy, because it has (in the same symptom) scanty menses, and is an antipsoric. I prescribed a few dry pellets of *bar.-c.* Cm. (F.C.) alternate mornings for fourteen days.

Subsequently (date omitted in case-book) reports eye unchanged, but otherwise feels well.

November 12th.—Has been ill for over two weeks; improves a little for an hour or two, then worse again. Thinks she has taken cold. Frequent chills, even in bed. First had pains in most of joints, and particularly in lower part of back. Took a low potency of *rhus.*, and is now comparatively free from these pains; but for the last four days the pain has been in the entire head and back of neck, sometimes almost unbearable; has to hold head as tightly as possible, especially when

coughing. Short, dry cough on lying down. Head feels as if it would burst; cannot bear even to walk, it shakes the head so. Very thirsty. Has to press head with hand when writing. Eyes feel like fire-balls; even the remains of the left, which had been enucleated. Has taken *acon.* and *bry.* in low potency without benefit.

Diagnosis of Remedy.—Pain in head from coughing, relieved by pressure. *Natr. mur.* (254) *nicc.*, *nux. v.* (both from "Lee's Cough Repertory"), and *Sulph.* (334, 336).

Pain in head from writing. *Natr. mur.* (and others which have not the former symptom). This remedy corresponded well to the other symptoms (237, 238, 263, 420-5). I prescribed *natr. mur.* Cm. (F.C), a few pellets dissolved in water, and a spoonful of the solution thrice daily for six days.

November 17th.—Commenced medicine evening of 13th. To-day has been able to work all day, "and proper work, too"; all last week it was about half-an-hour's easy work, then an hour's rest. Is quite surprised how well she feels. She felt the curative effect in about an hour after the first dose; the pain gradually began to go from the back of neck right over head, but it lasted longest in eyes and temples. Cough very much better. *No medicine.*

November 20th.—Much better; head feels quite free from pain. Has a bad, dry cough, deeper and harder than before; it prevents her from sleeping long at a time, and is much worse at night. Nevertheless, feels much better generally. Twice last week lost much blood from nose, after which felt better and lighter altogether; this occurred at time of menses, when she had much pain; and, instead of taking its natural course, the blood seemed to rush to head; no similar trouble for a very long time. Eye feels comfortable again. *Puls.* Cm. (F.C.), a few pellets dissolved in water, and a spoonful of the solution thrice daily for six days.

November 29th.—Cough does not wake her at night, otherwise it is about the same; very bad on lying down, quite exhausting. The old sleeplessness has returned, and she cannot sleep after 4 a.m. *Puls.* mm. (Finckè), a few pellets dissolved in water, and a spoonful of the solution thrice daily for six days.

December 9th.—Cough about the same, in paroxysms

during day, and always on lying down by day or night. Menses have returned without the slightest pain, which never happened before. Otherwise feels quite well and strong.

Diagnosis of Remedy (from the past symptoms, the present not being sufficiently characteristic).—Headache from coughing, relieved by pressure. *Natr. mur., nic c., nux. v., sulph.*

Of these, *natr. mur.* was ruled out, as it had been recently prescribed, and had finished its work; *nux v.* was contra-indicated, because its symptom was connected with whooping-cough and vomiting, which did not exist in the patient; *sulph.* was not the *simillimum*, as its symptom was stitching in forehead. *Nicc.* has "violent cough; must sit erect and hold head with both hands." I prescribed *niccolum* 200, a few pellets dissolved in water, and a spoonful of the solution thrice daily for six days.

January 12th, 1883.—Reports that the *nicc.* quite cured the cough, and she feels perfectly well and strong.

June 18th.—Eye has been as bad as ever for the last five or six weeks; on waking in morning, it feels rough and hard like stone, just as if she had lain with it open all night, and the wind had blown into it; must keep it closed by holding lid down; over-exertion brings on the pain, especially anything that strains shoulders and neck.

Diagnosis of Remedy.—Eyes feel hard. *Cann. ind.* (124), *coloc.* (143). *Cann. ind.* was ruled out, because it is a part of a cataleptic condition with hallucinations, and also affected the entire brain as well as right eye.

I prescribed *coloc.* Cm. (Finckè), a few pellets dissolved in water, and a spoonful of the solution twice daily for six days.

June 30th.—Eye began to feel much more natural after second dose; cooler and softer on waking in morning, and sooner getting comfortable; it has improved so much that, with the exception of one morning, has been able to rise directly on waking, whereas formerly had to keep in bed an hour or two. Now eye feels very weak, but no other symptom. The bright weather seems too strong for it. No other symptoms. Has felt perfectly well in health for a long time. *No Medicine.*

August 6th, wrote: "My sight is so good that I do not think I require any more medicine. I have waited to see if

any of the old symptoms returned, but they have not. I am sure my sight is far beyond what my most sanguine hopes ever reached."

June 16th, 1884, wrote that she was quite well, and the sight very good. I saw a piece of fine lace which she had recently worked, and it was a triumph of needlework.

Comments.—(1) The first point to be noticed is the complete and permanent cure of cataract by homœopathy after allopathy had failed. Allopaths, when confronted by a remarkable homœopathic cure, usually fell back on the stale resources of doubting the diagnosis. Here no such plea can be urged, as the diagnosis was made by some of their leading specialists. An allopathic diagnosis in a severe or difficult case is always of value, as it places the subsequent triumph beyond all cavil.

(2) A favourite allopathic resort is the enucleation of a useless eye "in order to save the other." A damaged eye may sympathetically affect the other, and the latter may be temporarily improved by removing mechanically the exciting cause of the trouble; but the operation is unnecessary, and sometimes fails, as in the present case. Homœopathy will cure the diseased eye, if a cure be possible; if not, it will prevent the disease from attacking the sound eye.

(3) The folly of specialism in medicine, except for diagnosis in obscure cases, is here shown. Almost all that the allopaths could advise was local treatment, and all to no avail. Whereas this patient's symptoms were pre-eminently constitutional, as shown by the phthisical history; and remedies, selected from time to time according to the totality of the symptoms, restored health.

(4) On November 9th, 1881, menses returned after the disappearance of the piles, proving that the latter had been cured, and not merely removed naturally through menses relieving congestion. The rule in similar cases is, that if after the administration of a remedy the pain ceases before a discharge occurs, it is a cure; if the pain ceases only after a discharge, it is a recovery.

(5) It should be noted by those who doubt the power of the highest potencies, that the patient recognised the *puls.* by the curative effect of the Cm. Also, that whereas a low potency of *puls.* had always removed the pain, but stopped the

flow and failed to regulate, a very high potency relieved the pain more completely and permanently, did not stop the flow, regulated almost to the day, and also improved the eye.

(6) The comparative uselessness of routine domestic treatment is shown. In the first instance, *bry.*, *hepar.*, and *phosph.* were alternated with *acon.*, when *sulphur* was the remedy. On the second occasion *acon.* and *bry.* were given when *natr. mur.* was the *simillimum.* As might have been expected, they did little good. Homœopathy cannot be practised with only a small box of medicines and a "book of the words." Moreover, alternation is unscientific; remedies cannot be prescribed homœopathically in alternation unless they have been proved in alternation on the healthy.

(7) The report of January 9th, 1882, shows how a catarrh, under the action of the unhomœopathic remedies, merely advanced to its second stage, a severe cough. The invariable rule for catarrh is this: If the disease proceeds from head to chest, it shows that it is getting worse, and that the medicine has been wrongly selected. But if relief from the chest symptoms is followed by return, or temporary increase, of the nasal catarrh, it shows real amelioration, and the remedy should be allowed to act without repetition or change. Patients often, in the latter event, imagine that they have "caught a fresh cold," and take some remedy on their own account, thereby sometimes driving the catarrh back to the chest, and hindering the cure.

(8) On January 9th, 1882, *sulph.* was selected partly on a symptom that had ceased for some time. The record of past symptoms, which Bœnninghausen calls the *anamnesis*, is of value in the selection of the remedy, and is, indeed, the essence of Hahnemann's doctrine of the treatment of chronic disease. The more recent symptoms are, *ceteris paribus*, more characteristic than the earlier, but these must on no account be ignored; sometimes the only characteristic symptom of a case is one that has already passed away.

(9) The coating on scalp was removed, as shown by the final report, though the patient omitted to notice under what remedy it disappeared.

(10) Our failures, as well as our successes, should teach, and the older homœopaths should warn beginners how to avoid

pitfalls. I doubt whether the prescription of *bar.-c.* was advisable; it suited the few symptoms reported, but I think the *graph.* should have been allowed to act longer. The prescription of *puls.* in November, 1882, was an error. It was a *simile*, but not the *simillimum*, and so only relieved the menstrual trouble. As the patient "felt much better generally," the *natr. mur.* should have been allowed to act.

(11) The hard feeling of eye suggests *coloc.*, and possibly *cann. ind.* in glaucoma. I have again verified the *coloc.* symptom. Mr. E. (June 13th, 1898) had iritis of right eye, which felt hard subjectively. I prescribed *coloc.* 50 m. (F.C.) in water, a spoonful of the solution every six hours till relieved. He improved in a few hours, and later was cured.

(12) The record shows that on two occasions there was decided improvement after the first, and on a third occasion after the second, dose; the last time the symptoms so quickly relieved were those of the eye. The repetition of the dose was, therefore, unnecessary, though not harmful.

Dr. David Wilson used to say that he found ophthalmic cases required a more prolonged repetition of the dose, probably because of the impossibility of completely resting the eyes. But at the time he held this opinion he seldom used any other potency than the 200th. There are many cases of ophthalmic disease reported as cured by the highest potencies without such frequent repetition.

(To be continued.)

RENAL CALCULUS.

By K. P. GANGOULY, Chandernagore, Bengal, India.

Babu K. M. Hazra, a short, healthy young man of 22, suffered just one year before from an attack of renal colic. Under allopathic medicines and hypodermic injections, though the severity of pain was diminished, yet every now and then he felt pain over the region of the right kidney.

On February 3rd, 1907, he had another intense paroxysm of pain when I called. Temperature 99·4°, pulse small, extremities cold, nausea. He had an attack of gonorrhœa two

years before. Passed a piece of gravel the size of a lentil, with a quantity of blood, during micturition. A few days ago the patient was suffering from intermittent, although agonising, pain along the course of the right ureter down into the bladder, and into corresponding testicle. Urine only passed by drops, with cutting and burning in the urethra. It was scanty, but was loaded with mucus and white sandy sediment.

I prescribed him *nux. vom.* 30, three doses for the night. Next morning I saw the patient lying in the same state. I thought of *cantharis,* and some other appropriate remedies, such as *canab., lycopod., terebinth* and *thlaspi,* when at last the special character of the illness reminded me of the new Australian remedy, *xanthorrhœa arborea,* which I at once prescribed in 2x dilution, two drops a dose, four times daily. The next morning it was reported to me that the patient was much better, had voided urine more easily with increased quantity, the sediment also having diminished.

Rep. *xanth. arb.* 2x gtt., ii. each dose, t.d.s.

Next day there was no pain, and the patient felt quite well. Rep. medicine twice this, and the following day once.

I advised him to take the medicine occasionally for fear of relapse. The patient saw me after two months and said he was perfectly cured.

Lobelia purpurascens, another Australian remedy, which I procured from Messrs. E. Gould and Son, has given me great satisfaction in the treatment of influenza.

SOME EAR CASES.

By ARTHUR A. BEALE, M.B., C.M.

Anæsthetist and Clinical Assistant, Ear, Nose and Throat Department, London Homœopathic Hospital.

Case 1.—E. F., aged 32, January 17th, 1907. This patient was a bright-looking girl, who had previously followed the occupation of dressmaking at Peter Robinson's, but owing to business worry four years ago had a breakdown which affected her eyesight and started serious frontal headache, described as neuralgic in nature. She had very serious deafness, worse

on right side, which greatly inconvenienced her, and tinnitus resembling "the rushing of the sea" (this trying symptom had been her constant companion for seven or eight years). There had never been any discharge, and pain *nil.*

The watch test showed on the left, 4 inches, air conduction + ; on the right side, 2½ inches, bone conduction +.

Examination discovered on the *right side* membrana tympani pearly white, thickened, and the cone of light broken ; on the *left side,* more or less normal in appearance, but slightly retracted.

Treatment.—In all these cases I find a regulated diet most helpful, and in this case I ordered wholemeal bread, milk, fruit or greenstuff or porridge for breakfast. Meat and vegetables, or fish or poultry, varied with a vegetable soup, for dinner ; and a third meal with wholemeal bread and butter, fruit, or milk pudding, and occasionally meat or fruit, for about 6, at the same time cutting off what I have invariably found harmful : strong tea, coffee, spirits and malt liquors, salted fish and meat, confectionery and pastry, and all sweet and sugary things, together with white bread.

Regarding medicines, all the symptoms indicated *ferr. phos.,* and as there had been a clear history of anæmia I decided on *ferr. phos.* 6x. Politzer's bag used.

January 21st.—No noises ; says hears better ; no headache. Continue *ferr. phos.*

January 28th.—Has had no noises till yesterday, when they returned slightly. *Watch* test, right 8 inches, left 7 inches.

February 4th.—Headache better ; no tinnitus. Politzer. Continue *ferr. phos.* 6x.

February 11th.—Noises and headache returned for a time ; hearing better ; right 18½ inches, left 27½ inches. Repeat.

February 18th.—Says much better, noises gone, thinks hearing better. *Watch,* right 27 inches, left 32 inches. Politzer. Continue *ferr. phos.*

February 25th.—Says very much better, has had no noises since 10th ; no headache, feels better herself. *Watch,* right 38 inches, left 52 inches.

On examination the right membrana tympani almost transparent. Cone of light normal and unbroken, the malleus handle slightly prominent. Left side not so transparent but healthy. Continue *ferr. phos.*

March 11th.—Has had a cold, probably influenza. Watch shows depreciation of hearing, right 21 inches, left 19 inches.

March 18th.—Recovered hearing. Watch, right 38 inches, left 52 inches.

May 6th.—Feeling very well, no return of headache or noises; health excellent. Continue *ferr. phos.*

All through this patient has had the one medicine, *ferr. phos.* 6x, and we are both satisfied with the result.

CASE 2.—W. C., school teacher, aged 26, came to me on December 17th, 1906. Has had chronic suppuration of ear: now is dry. There is a perforation in the posterior lower quadrant which shows signs of healing. Complains of pain behind ear. This patient was put on a diet similar to Case 1. *Capsic.* 3.

December 31st.—Since coming the pain behind ear better, but has had great pain in the ear itself. The meatus is full of curdy pus: there has evidently here been a history of fresh suppuration and bursting of the membrana tympani. *Bell.* 3x.

January 17th.—No further discharge.

January 31st.—Meatus quite clean and free from pus. There is a large opening in the drumhead. Continue *bell.*

February 14th.—Has had more pain and tinnitus. *Sabadill* 3.

February 28th.—Has had much discharge and consequent deafness. Boric powder inflated, and for medicine *mer. cor.* 3x, t.d.s.

March 21st.—Less discharge, but has throbbing headache. *Bell.* 3x.

April 18th.—No more discharge, no pain for a long time, though still has headache. She complains of rheumatic pains. *Bryon.* 3x.

April 25th.—Very much better; no headache, no pain, no discharge, hearing excellent. Membrane clean and healing.

CASE 3.—V. C., aged 20. Sister to above. Also came to me on December 17th, complaining of discharge from left ear and deficient hearing; has constant headaches, worse in the evenings, which felt like knives cutting from vertex down through the temples.

Watch test: right normal, left *only on contact.* On examination, the membrana tympani shows thickening and granulation,

with perforation. Ordered inflation of *boracic acid powder* and *calend. Arsen. iod.* 3x, t.d.s.

This patient showed also general weakness, lateral curvature slight, and heart sounds muffled. *Diet* similar to the last.

December 20th. — No discharge. Watch on left side 6½ inches.

December 31st.—Very much better, no discharge. *Watch* heard, left 9¾ inches. Repeat *ars. iod.*

January 10th.—There is still the appearance of granulations, but no discharge. Hearing, left 18 inches. Politzerised.

January 17th.—Feels better, health very much better; heart sound normal. *Watch* 26 inches.

January 24th.—Hearing, watch 28 inches.

January 31st.—Still progressing, no discharge. Repeat *ars. iod.* 3x.

February 14th.—Watch test, 40 inches.

March 21st.—Has had throbbing headache at back of head and pains behind ear. *Bell.* 3x, 4 t.d.s.

April 4th. — Headache gone, hearing quite recovered. Repeat *arsen. iod.* Still under treatment.

I attribute a great deal of the good results in these cases to the regulation of diet, and especially the cutting off of Saccharine and ultra-starchy food, as white bread and confections. If the cases were very persistent I should feel great confidence in restricting the diet to all meat for a time, as a complete or modified Salisbury: this is not often necessary in these cases.

RECURRING ATTACKS OF ACUTE LOCALISED ŒDEMA.

By Dr. W. F. H. NEWBERY.

(*Continued from p.* 291.)

April 16th.—As patient lives quite near my house I told him if he had one of the attacks not to wait to see me at the hospital but to come to me at any time, that I might see the swelling at its height. I had not seen him for a fortnight when this morning he called between 8 and 9 a.m. His face presented an extraordinary appearance, both cheeks and chin

swollen out of all shape and the lips enormously swollen and everted. The swelling was not hard nor did it pit on pressure, but presented a sort of doughy feeling. Saying he felt nearly "heart broken," patient gave the following account of the attack: Went to bed about usual time, between 9 and 10, but did not get to sleep till past 11 o'clock. Shortly after this he awoke with sensation of slight swelling at tip of tongue, and within half-an-hour tongue was so swollen he could hardly move it; the swelling passed from the tongue to right side of the mouth, and then to cheeks and lips; was at its height between 5 and 6 a.m., and by the time I saw him the swelling was gone down "nearly one half." I told him to see me at the usual time at the hospital in the evening.

By 6.30 p.m. there was only a little swelling of both cheeks, hardly noticeable—rather more on left than right.

Patient tells me that he has been having these attacks *every Tuesday for the last eight weeks*, always in the face but not always in same place. He had not been up for a fortnight. Last Tuesday, after taking *apis* 3x, ♏ii., 4h. for a week, the attack was quite a slight one, lasting only about four hours altogether, and was confined to right cheek. The attack to-day (patient having had no medicine for a week) was as bad as any he has had for a long time.

At the suggestion of a colleague I asked patient if he had ever suffered from worms or had ever been abroad. The answer to both questions was in the negative.

Heart sounds are weak but clear. Apex beat in normal position. Water examined for albumen gave negative results.

The general aspect suggested *apis*, and as the attack of last week seems to have been modified by the medicine, it was repeated. *Apis* 3x, ♏ii., 4h.

April 23rd.—No attack. Rep.

April 30th.—No attack. Rep.

So far I have only attempted to diagnose the remedy. But I am neither "content nor happy," as the Senior Editor puts it in his article on Symptoms and Diagnosis. What is the etiology? and what the "pathological substratum." I have called the case "Recurring Attacks of Acute Localised Œdema," but œdema is defined as "swelling produced by the accumulation of serous fluid in the interstices of areolar

tissue, '*pitting on pressure.*'" But this swelling I have not found to "pit on pressure."

May 7th.—No attack now for three weeks.

May 14th.—This evening patient came into my room with the exclamation—"Never had such a face in my life as yesterday"! and gave the following account of the present attack. Went to bed as usual on Sunday, 12th. About 1.30 on Monday morning awoke feeling a little irritation on right side of mouth. Slept and woke several times between that and 5 o'clock, when the swelling had spread over the right cheek, but was not sufficient to prevent patient from going to work at usual time, 6 a.m. By the time he got to the shop the swelling was a good deal increased, and by 8 o'clock began to spread across the lips to the left side of the face, but did not go above either eye into the eyelids, as it did on the 16th ult., when I saw him. As usual, patient applied hot water several times. By 10 o'clock the swelling was at its height, and began to subside until by 1 o'clock it had quite left the lips. The swelling subsided much more slowly than usual. In previous attacks it has entirely gone in from 10 to 12 hours from the commencement, but to-day at 7 o'clock, 42 hours from the commencement, the left cheek is still slightly swollen. Patient is as much at a loss to account for the present attack as he has been to account for any of the previous ones.

There is nothing in patient's occupation, so far as I can ascertain, to account for the very curious phenomenon. He tells me that, about four years ago, he was at home under treatment for 17 weeks—14 weeks in bed—during which time he had four or five attacks of the swelling in different places, which the doctor who was attending him saw. *Apis* 30, discs ij. n. and m.

CASES FROM THE LONDON HOMŒOPATHIC HOSPITAL.

By J. ROBERSON DAY, M.D.Lond.
Physician for Diseases of Children.

Gavage in Athrepsia.

Dora F., aged 3 months, was sent up to the Children's Department of the Hospital by Dr. James Jones. The child had been prematurely delivered, owing to the mother having a pelvic deformity.

There was a history of difficulty in feeding, the child "could not keep anything down," and had been "fed with brandy on a feather." The head was constantly retracted, and it had been suggested that there might be brain mischief.

The weight on admission was 7½ lbs. The child had a cough and there was a good deal of snuffling.

On March 8th, the day of admission, *ipec.* 30 was prescribed and barley water and milk in equal parts, with a few drops of *bovinine* given in the bottle.

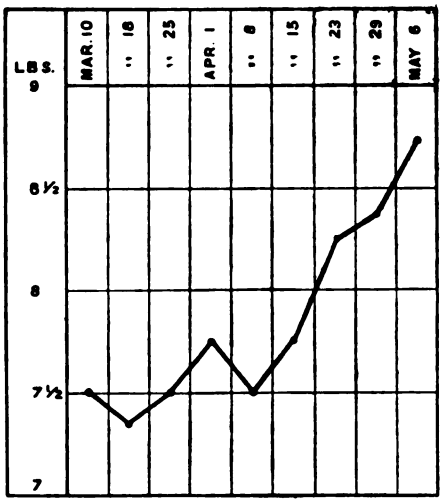
On March 11th the snuffling suggested congenital syphilis, and *syphilinum* 200 in weekly doses was administered. Subsequently it was ascertained that the mother of this child was attending the Gynæcological Department of the Hospital for syphilis. On March 26th *merc. v.* 2x, gr. iij. ter die, was prescribed.

On April 4th the child was still losing weight, and I decided to feed by gavage, and on April 5th this method of feeding was employed, 6 ozs. being given every 3 hours. During the first week of this treatment the child gained 8 ozs., and the snuffling became less, only a frothy foam collecting about the nostrils during sleep. We soon found that this artificial method of feeding left the child somewhat dissatisfied after its meals; it had been deprived of the luxury of tasting its food, and had not been able to suck. To meet this difficulty, I ordered a small quantity of the milk and barley water to be given in the bottle to suck, after the gavage. This had the desired effect, the child was satisfied with having something to suck.

The progress of the case was now uninterrupted, and the weight steadily and rapidly increased, as seen in the annexed chart.

Before the baby was discharged on May 8th, gavage was

discontinued, and the bottle was substituted, which it was now strong enough to take by its own efforts.



WEIGHT CHART OF D. F. Gavage commenced on April 5th.

Many such cases of snuffles have not the strength to suck and contend with the difficulty in breathing at the same time, hence they give up the attempt exhausted. This leads to wasting, and in a vicious circle the child is lost. I am persuaded we do not employ this method of feeding sufficiently often.

NITRIC ACID IN STOMATITIS.

Lucy S., aged 10, came on April 18th, 1907, with sore throat, foul breath, and ulcers on the tongue. The gums were very swollen. Everything caused pain when eating. The pharynx was follicular. The case was one of marked stomatitis in a dirty neglected child with pediculi capitis. *Acid nitric* 3x, ♏iij. every three hours, was prescribed, and a mouth wash of *calendula* and *chlorate of potash*. On April 25th she was very much better, all fœtor had gone and she was able to eat again.

On May 2nd she was quite well.

MERCURIUS CYANATUS IN ACUTE FOLLICULAR TONSILLITIS.

Fredk. E., aged 8½, came with feverish symptoms and follicular tonsillitis on March 14th, 1907. *Merc. cy.* 12, every two hours, was prescribed, and on March 18th he was much better. All the follicles clear, temperature normal.

Hospital Reports.

*** The Editors request that all correspondents will kindly condense their reports as much as possible, consistent with a smooth and effective rendering of the facts they wish to convey. Items of *merely local* interest should be omitted.

As there seems to be some misunderstanding in regard to this section, we would point out that there are two kinds of matter wanted for it:—

(1) News, reports of meetings, &c., which must be compressed into one, or at the most two, paragraphs of not more than ten or twelve printed lines.

(2) Reports of interesting cases occurring in Hospital or Dispensary practice, new methods of treatment, and all purely professional matters. These should be carefully, or, if needful, elaborately recorded and described. Each contributor will be allowed two pages of the REVIEW every month for this purpose.

Newspaper reports, unabridged, need not be sent. Such reports must be compressed and will come under (1) above, otherwise all such newspaper and unabridged reports will be laid gently, but firmly, to rest in the waste paper basket.—EDITORS, *B.H.R.*

LEICESTER COTTAGE HOSPITAL.

CASE OF SUPRA-PUBIC CYSTOTOMY.

C. J., aged 70, was admitted March 9th, complaining of having suffered from frequent and painful micturition for a year or more. At the time of admission, the urine was acid, of normal sp. gr., and contained a decided amount of albumen. On sounding, calculus was at once felt. For three days previous to operation an average of 45 ozs. of urine was passed. Examination of the heart revealed a soft V.S. murmur, but the patient was otherwise healthy. On March 13th Dr. Mason performed the operation of supra-pubic cystotomy in the usual way, the bladder being first washed out with boric acid solution and left moderately distended. Six calculi were removed, weighing altogether ¾ oz. They were not at all facetted but were all of the same shape, oval and flattened, the largest being 2·8 c.m. in length and 2·2 c.m. in width. The wound in the bladder was closed, and a soft catheter fastened in the urethra. On the fifth day leakage occurred at the wound and Colt's apparatus was applied. This worked most successfully, practically no soiling of the bed taking place, and no dressing being required. It was discontinued on April 6th, the wound being then healed, and all the urine passing *per urethram*. The urine was occasionally alkaline, and for this *urotropin* was given at irregular intervals with prompt result. The temperature never rose above 100·2. Dismissed April 13th.

E. C.

BIRMINGHAM.

A Case of Papilloma of the Bladder. Excision. Recovery.

S. C., aged 51 years, fitter, was admitted into the Homœopathic Hospital, on May 2nd 1907, with the following history. He had always enjoyed good health until Christmas last, when he noticed that his urine contained blood. This condition continued intermittently until admission, his urine recently having the appearance of pure blood. He has had no pain but has lost strength. He appeared a strong, well-developed man, not apparently anæmic, though on auscultation a distinct pulmonary (? hæmic) bruit could be easily heard.

On examination by the cystoscope a pedunculated growth was seen, the body of the tumour apparently floating from the pedicle, which was attached to the posterior wall of the bladder.

On May 3rd Mr. Billington opened the bladder by a suprapubic incision and removed the growth, and a small area of surrounding mucous membrane. It was an obvious papilloma attached to the bladder wall by a very narrow pedicle, half an inch in length.

A small drainage tube was inserted through the wound, and left in position for twenty-four hours.

On the third day urine passed *per vias naturales* only, and on May 14th the site of the incision had healed over.

The hæmic murmur could not be heard on the seventh day after the operation.

A Silica Case.

E. W., aged 23 years, presented himself in January, 1906, complaining of a discharge from the right eyelid and pain in the forehead.

Two years previously he had had an abscess of the (?) frontal sinus, which was opened at another hospital and had never healed.

On examination there was a fluctuating boggy swelling on the forehead in the middle line, some three inches in diameter.

Above the right eye and immediately below the supra-orbital ridge was a small sinus, from which watery pus could be expressed.

He was advised to come into Hospital for operation, but declined.

Silica 6x was then prescribed, together with as much open air as possible and a generous diet.

In February he presented himself again; the forehead swelling now measured one and a half inches across, and was comparatively shallow. The sinus was still discharging. *Silica* 12.

In April the forehead was hard and apparently normal, and the discharge very slight.

For his general debilitated condition *ars. alb.* 3x was now given for a month, at the end of which he resumed *silica.*

In January, 1907, the patient's mother came to say that he was apparently quite well, and had had no discharge or pain for five months. A. A.

PHILLIPS MEMORIAL HOSPITAL, BROMLEY.

SUDDEN DEATH IN A CHILD AGED 4½.

A FEW weeks ago I received an urgent message to go to see a little patient of mine, as the mother thought he was dead.

On arriving at the house, about a mile and a half from my home, I found the child dead, and although I had attended him since his birth I had not seen him for three months, his last illness being whooping-cough about last Christmas, and I could not certify the cause of his decease. The only history I could elicit from the parents threw no light on the case: the child had breakfast at 8.30, consisting of an egg, some bread and butter and milk, and nothing later; his mother left him quite well with his grandmother; at 11.30 he was walking down the garden holding the hand of his grandparent when his knees seemed to give way and he fell; she tried to stand him up, but he dropped down again; she carried him indoors, looking deathly white, and called in a doctor who was in the street at the time, but he pronounced life extinct.

At the *post-mortem* ordered by the coroner, the body was plump and well nourished, heart normal, stomach contained food almost digested; on opening the trachea the lower part and both bronchi were filled with the same fluid as was found in the stomach, namely, food not completely digested. The

child died of asphyxia, although nothing had escaped from his mouth or nose.

Intestinal Obstruction. Recovery Without Operation.

I was sent for to see an old trained nurse, aged 73, on January 16th. Found her in great pain, which she said was all across her abdomen; she had been ill for forty-eight hours, vomiting everything, even water; bowels had acted last on January 12th. I had her removed to hospital, gave *coloc.* 1x, ♏ 1 every hour. Temperature 97° F.; pulse 88.

January 17th.—Enema acted fairly well; vomits yellow bilious fluid; abdomen tender; very distended coils of intestine made out. Temperature 96·4° F.; pulse 98. *Berb.* 1x, ♏ 3 every two hours.

January 18th.—Very drowsy, vomited three times and once in night, tried to pass rectal tube without success, abdomen like a drum; no flatus passed since admission. Temperature 98° F.; pulse 112. *Opium* 1x, 5 drops every two hours.

January 19.—Temperature 97°; pulse 110. Still vomits, no flatus passed; abdomen very tight.

January 20th.—The same. Temperature 98° F.; pulse 100. Can only take water; tongue very dry and brown, less pain. Repeat *opium.*

January 21st.—Better night, vomit smells fæcal, abdomen still distended, but less tender; tongue brownish-orange, but less dry; during afternoon passed some flatus, the first time since admission, though vomiting continued. Temperature 97° F.; pulse 104. Injected ♏ 3 *morphine acet.*

January 23rd.—Slept a great deal, no vomit since injection. *Opium* 1x.

January 24th.—Sleeping well day and night, no action of bowels, but passes wind; abdomen much less distended; tongue moist. Temperature 96·4° F.; pulse 104.

January 25th.—Passes flatus freely, no vomit now; abdomen soft.

January 27th.—Very small bit of hard motion passed after second enema.

January 28th.—Bowels acted well after enema, and again later naturally (the first time since January 12th.)

January 31st.—Bowels have been acting freely four and five times daily naturally; abdomen now flat; tongue cleaning.

The patient's subsequent history was unimportant, she went home February 20th quite well.

It is now four years since the attack, and I saw her a few weeks ago and she told me she was keeping well, and had never had any trouble with her bowels since. H. W. T.

BRISTOL AND CLIFTON.

THE following abstract of the Annual Report of the Hahnemann Hospital and Dispensaries, Bristol, for 1906, will indicate the principal features of the year's work at that institution.

In each department of the work of the hospital there has been an increase in the number of patients treated compared with the preceding year; this applies to the number of in-patients, of private patients, and also to the number of visits paid to dispensary patients at their homes and to the out-patient attendances.

The amounts received in annual subscriptions and donations were both slightly larger than in 1905; but the subscription list is small in proportion to the needs and importance of the institution, and a special effort is to be made this year to secure a large number of new annual subscribers.

As mentioned on a previous occasion a special fund has been raised during 1905 and 1906, amounting to about £460, with a view to alterations and improvements in the equipment of the hospital. Some of the projected improvements have now been completed, including the construction of an electric passenger lift, an operating room, a balcony for patients needing open-air treatment, and a small mortuary.

The ordinary income and expenditure are about equal, and the institution is free from debt, there being a balance in hand of £10 10s. 7d. apart from the Special Fund. If the income from annual subscriptions is increased, it will enable more of the very poor to obtain admission to the hospital than hitherto.

From the medical point of view the year's work was very satisfactory. Among forty-five patients treated in the hospital there were only two deaths, one from diabetic coma, and one from chronic heart disease. There were nineteen operations, all of which were followed by recovery.

CLINICAL CASE.

SPASMODIC DYSMENORRHŒA.

REPORTED BY DR. J. HERVEY BODMAN.

LILY S., aged 28 years, single, attended as an out-patient at the Hahnemann Hospital, Bristol, on February 8th, 1907. She states that the menstrual periods have always been attended by severe pain. The pain is chiefly in the hypogastrium and groins, and is violent and crampy in character; it is often accompanied by vomiting, which seems to be caused by the severity of the pain; sometimes there is also diarrhœa. The menstrual discharge is scanty and dark in colour. The period recurs every twenty-four or twenty-five days. *Puls.* 30 t.d.s.

February 22nd.—Period has not come on yet. Rep.

March 1st.—The period came on a few days ago, and was much less painful than usual. Rep. *b.d.*

March 22nd.—Period came on again yesterday, twenty-four days after the previous one. There has been *no pain* or sickness this time. Rep.

May 10th.—Last period was three weeks ago; it was entirely free from pain. Rep. *mane.*

Remarks.—This case calls for little comment, as the indications for *pulsatilla* were clear, and its value in this type of dysmenorrhœa can be frequently verified. It is, however, noteworthy that after only six weeks of treatment a disorder of many years standing was entirely rectified.

Correspondence.

HAHNEMANN PUBLISHING SOCIETY.

To the Editors of THE BRITISH HOMŒOPATHIC REVIEW.

DEAR SIRS,—This Society has never yet been officially closed. I would like this to be done at our Congress meeting in September.

Could you arrange for half an hour for this purpose before the beginning of the official business? If so, please add to the Congress Notice in the Review, when you say the Congress business will be opened at 10 in the morning, something like the following :—

"A meeting of the Hahnemann Publishing Society will be held at 9.30, for the purpose of receiving the Secretary's and Treasurer's Report, and for the official closing of the Society."

Yours truly,

JOHN W. HAYWARD.

Hon. Secretary and Treasurer.

[We, as Editors of THE BRITISH HOMŒOPATHIC REVIEW, have nothing to do with the Congress arrangements, but we have sent Dr. Hayward's letter to the Hon. Secretary of the Congress, who informs us that he will arrange the meeting as Dr. Hayward proposes, at 9.30 a.m. on September 19th (the day of meeting of Congress).—EDITORS, BRITISH HOMŒOPATHIC REVIEW.]

PUHLMANN'S HANDBOOK.

To the Editors of THE BRITISH HOMŒOPATHIC REVIEW.

DEAR SIRS,—Since many Students who are enquiring into Homœopathy are perplexed in their selection of the best Text-book on the cardinal points and practical teachings of our School, I beg to commend to their careful perusal "Puhlmann's Handbook of Homœopathic Practice," published at Leipzig, by Walter Schwabe, the result of thirty years' close observation and earnest study, by Dr. Rohowsky, Dr. C. Heiinigke, Dr. Pfeil, &c. There is much pathological matter minutely explained in these pages. We find the dogmatic instructions blended with honest admissions of the value of high potencies, and the broadest views expressed concerning opposite opinions entertained by various members of our School at home and abroad, and this enhances the attractiveness of the work.

THOMAS SIMPSON.

Foreign Reports.

FRANCE.

THE banquet of the French Homœopathic Society took place on Saturday, April 13th. Many physicians, both from Paris and from other towns, came to the banquet in honour of Hahnemann.

The toasts were interesting: more especially was this the case since, during the past few months, Dr. P. Jousset, in *L'Art*

Médicale, has protested strongly against the physicians who use high dilutions, such as the 200th and over, as well as against those who claim that such doses may be dangerous, or that one dose may be sufficient to cure a case of disease.

After a speech by the president, Dr. Chancerel, who drank to the glory of Hahnemann, the triumph of positive therapeutics, and the unity of medicine in the future, Dr. Joussett started up, and with his usual ardour said, Fifty years ago the disciples of Hahnemann thought they were assured of victory. That this had not been realised was largely due to those who made use of excessively high dilutions; who said that one globule only was sufficient to cure a disease, nay, that it was even sufficient to smell it. Dr. J. P. Tessier had said that his school was taken between the allopathic anvil and the homœopathic hammer—the latter being more ferocious than the former. He hoped, however, that from henceforth these extravagances would cease to exist, and he drank to the future triumphs of scientific medicine as embodied in our *Materia Medica.*

Dr. Conan then rose to reply to Dr. Jousset. In his reply, he maintained an exactly opposite thesis, stating that the 1,000th dilution can be not only active, but may be dangerous in unskilled hands. He then read his toast, which consisted of an oration in praise of Dr. Jousset, saying that, although differing from him on many points, he was bound to confess him the standard-bearer of homœopathy in France, and at the same time the "yessierist" of all homœopathic physicians.

Dr. Conan's tactful speech was received with great applause, since he so gracefully paid homage to the old Master, in spite of his opposite views. Such meetings do much to cement that unity of brotherhood that ought to exist between all classes of Hahnemann's pupils. DR. PAUL TESSIER.

Reviews of Books.

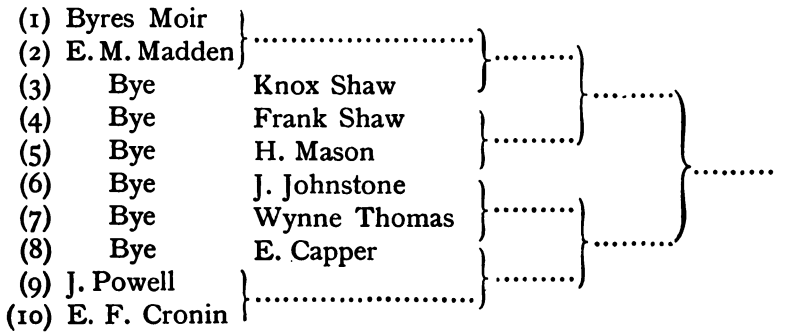
The Homœopathic Directory, 1907, or as it is now called the "*International Homœopathic Directory*," has just reached us. This useful publication has certainly become international in its character, and contains names and addresses of homœopathic practitioners in every part of the civilised world. Each

issue becomes more complete and gives names previously omitted. Confining our attention to the British Isles, and comparing the list with that given in the *Supplement to the Journal of the British Homœopathic Society*, we find that the *Directory* contains twenty-nine names that do not occur in the latter. Whilst omitting those members of the B.H.S. who have retired from practice or are resident abroad, there are twenty-three members of the Society whose names do not appear in the Directory—a difference of six. Honours are therefore pretty easy. We think it a pity that these members object to their names being seen in the Directory, and without wishing to tread on any corns, we venture humbly to suggest that an *entente cordiale* should be established, and the complete register of those practising homœopathically be allowed to appear in the Directory. The ethical principles which are supposed to stand in the way of this healthy amalgamation, seem to us hardly of sufficient importance to justify such an omission.

Notices, Reports, &c.

B.H.S. GOLF.

THE following is the Draw for the Golf Tournament, 1907 :—



First Round to be completed by May 31st.
Second „ „ „ June 30th.
Third „ „ „ July 31st.
Final „ „ „ September 30th.

H. W. T.

NOTICE TO CORRESPONDENTS.

*** *We cannot undertake to return rejected manuscripts.*

All MSS. should be in the hands of the Senior Editor by the 15th of the month at the latest.

AUTHORS and CONTRIBUTORS receiving proofs are requested to correct and return the same **as early as possible** to Dr. MCLACHLAN, 3, Keble Road, Oxford.

The Editors of Journals which exchange with us are requested to send their exchanges to Messrs. BALE, SONS AND DANIELSSON, LTD., 83-91, Great Titchfield Street, Oxford Street, London, W.

LONDON HOMŒOPATHIC HOSPITAL, GREAT ORMOND STREET, BLOOMSBURY.—Hours of attendance: MEDICAL (In-patients, 9.30 a.m.; Out-patients, 2 p.m. daily); SURGICAL, Out-patients, Mondays, 2 p.m., and Saturdays, 9 a.m.; Thursdays and Fridays, 10 a.m.; Diseases of Women, Out-patients, Tuesdays, Wednesdays, and Fridays, 2 p.m.; Diseases of Skin, Thursdays, 2 p.m.; Diseases of the Eye, Mondays and Thursdays, 2 p.m.; Diseases of the Throat and Ear, Wednesdays, 2 p.m., Saturdays, 9 a.m.; Diseases of Children, Mondays and Thursdays, 9 a.m.; Diseases of the Nervous System, Thursdays, 2 p.m.; Operations, Tuesdays and Fridays, 2.30 p.m.; Electrical Cases, Wednesdays, 9 a.m.

Contributors of papers who wish to have reprints are requested to communicate with the Publishers, Messrs. BALE, SONS AND DANIELSSON, LTD., who will make the necessary arrangements. Should the Publishers receive no such request by the date of the publication of the REVIEW, the type will be broken up.

All books for Review should be sent to the Publishers.

Papers and Dispensary Reports should be sent to Dr. MCLACHLAN, 3, Keble Road, Oxford.

Advertisement and Business Communications to be sent direct to the Publishers.

Communications have been received from Dr. BERRIDGE (London), Dr. K. P. GANGOULY (India), Dr. JOHN W. HAYWARD (Liverpool), Dr. SIMPSON (Birkdale), Dr. PAUL TESSIER (Paris), Dr. CAPPER (Leicester), Dr. ROBERSON DAY (London), Dr. BEALE (London), Dr. AVENT (Birmingham), Dr. J. HERVEY BODMAN (Clifton), Dr. DUDLEY WRIGHT (London).

BOOKS AND PERIODICALS RECEIVED.

International Homœopathic Medical Directory, St. Louis Medical Review, The American Physician, The Calcutta Journal of Medicine, Medical Century, The Medical Times, The Vaccination Inquirer, Le Mois Medico-Chirurgical, The Hahnemannian Monthly, The Chironian, The Homœopathic Envoy, The New England Medical Gazette, Pacific Coast Journal of Homœopathy, The Medical Brief, The Homœopathic Recorder, The North American Journal of Homœopathy, The Homœopathic World, The Indian Homœopathic Review, Universal Homœopathic Observer, L'Art Medicale, Revue Homœopathique Française, Revue Homœopathique Belge.

THE BRITISH HOMŒOPATHIC REVIEW.

JULY, 1907.

Editorial Notes and News.

Urotropine.

Is the use of this substance, in septic conditions of the urinary tract, homœopathic or allopathic? In the strict sense, of course, it is not homœopathic, inasmuch as it has not been "proved" on the healthy, so far as I know, so that it can only be prescribed on a *pathological* basis, since individualisation is not possible under those circumstances. It is regarded as a valuable diuretic, uric acid solvent, and genito-urinary antiseptic by the other school. It is used in cases of cystitis, and of nocturnal enuresis of children when due to the *B. coli.*, as well as to destroy typhoid bacilli present in the urine after the second week of the disease, or in other forms of *bacilluria, e.g.*, Dr. Stonham's case in our May issue. It must not be forgotten that the urine may contain millions of bacilli to the cubic millimetre, without pyuria or any symptoms of renal or bladder trouble. In such cases the urine has a peculiar, opalescent, sheeny appearance, and in the test tube gives a peculiar shimmer, quite characteristic of bacilluria—or at any rate sufficiently so to make one at once apply bacteriological tests.

* * * *

Action and Chemical Relations of Urotropine.

Is the action of urotropine merely antiseptic, or has it some specific—in other words *homœopathic*—relation to such septic conditions? We think that an examination of its chemical relations shows that it has such a *specific* relation to septic conditions. It seems to be closely related to some of the *ptomaines, i.e.*, nitrogenous bases produced during putrefaction in animal organisms after death.

Two typical ptomaines from human corpses are (1) *Putrescine*, which is tetramethylene diamine $C_4H_8(NH_2)_2$ (methylene = CH_2) and (2) *Cadaverine*, which is pentamethylene diamine $C_5H_{10}(NH_2)_2$. Now *Urotropine* is hexamethylene tetramine $C_6H_{12}(NH_2)_4$, and evidently a very near relative of the other two. The synthetical base *Piperazine* is also closely related to the ptomaines. Its composition is $C_2H_4(NH)_2C_2H_4$, and in most text-books of *Materia Medica* is named diethylene diamine (ethylene = C_2H_4). But it is an *imine* not an *amine*. No doubt it might be named diethylene di-imine, but we think a better name is tetramethylene di-imine, $C_4H_8(NH)_2$. In this connection it is interesting to compare *pryogen*, associated with the names of Burdon Sanderson, John Drysdale and Compton Burnett, and the "related and perhaps identical nosode" *septicæmin*. A good account of these will be found in Dr. Clarke's *Dictionary of Practical Materia Medica* (vol. ii., p. 931).

* * * *

Kala-azar (*Milroy Lectures*).

THIS is the epidemic manifestation of a fever endemic in extensive areas of India, which has spread slowly up the Assam Valley. The chief symptoms are persistent fever of an alternating remittent or intermittent type, which soon leads to cachexia. There is great wasting of the face, chest and limbs, but the abdomen is large and tumid, due to great enlargement of the spleen and sometimes of the liver. The *incidence* among the sexes shows little difference, but one-third of the cases occur in children under ten years of age. It does not readily attack Europeans. The infection seems to be more virulent during the cold season. The remittent type of fever shows two or three daily remissions (an important diagnostic difference from typhoid). The *spleen* is always much enlarged, the *liver* in about one-half of the cases. Death is frequently due to some complication. The parasite is found chiefly in the spleen, bone-marrow and liver, though no organ is exempt. It seems to belong to the protozoa, but exact knowledge concerning it is still wanting.

* * * *

Inflammation. Is Professor Bier, of Bonn, and his followers also among the prophets—I mean, followers also among the Homœopaths? An area in a state of *active congestion, i.e.*, acutely inflamed, is to be treated by means of *passive hyperæmia*, in other words, a passive hyperæmia is to be added on to an active hyperæmia, and in many cases with remarkable and unexpected results. True, the blacksmith and the cook know the benefit of holding a burnt or scalded hand *near* the fire, but of course that counts for nothing, as these people "that know not the law are accursed." We have personally tried this method of treating burns and testify that the effects are prompt, if the method is a somewhat painful one. Bier introduced his method as a means of treating tuberculous arthritis. It has been known for a long time to surgeons, but has recently been extended to the treatment of acute inflammations, such as whitlows, osteomyelitis, "acute necrosis," furuncles, puerperal mastitis, buboes, ulcers of the leg, and so on.

* * * *

Rationale. THE blacksmith will tell you that "the fire takes the heat out." In regard to Bier's method, we are told that the treatment prepares an unfavourable environment for the bacteria, especially from the presence of many migrated white cells, of a "truly active phagocytic power." The one explanation is just as lucid as the other. In using this method three points are important:—(1) The pain must cease or be markedly diminished in about twenty minutes; (2) The arterial pulse, distal to the bandage, must be unaffected; (3) The temperature of the limb must not be allowed to fall. The first tells us if the treatment is doing good; the other two if it is doing harm.

* * * *

Gastric Ulcer. SOME interesting observations have been made, and work done, in connection with the pathology of this affection at the London Hospital, by Drs. Charles Miller and F. J. Smith. Underneath the basement membrane of the stomach, and also above it, stretching up to the epithelial lining, are masses of small round cells of connective tissue type, which may be termed

"submucous tonsils" or "adenoid acini." They are not found in the newly-born baby, but are very numerous in the young, and diminish after the age of forty. They are specially numerous in the pyloric region—the usual seat of gastric ulcer. In all cases, they say, solution of continuity begins in changes in and around an adenoid acinus; the acinus becomes hyperæmic, inflames, swells up, and stretches the epithelial layer, and eventually causes its rupture. Under appropriate conditions this rupture may develop into an ulcer. Inasmuch, however, as *duodenal* ulcer usually occurs in middle-aged men, the cause cannot be identical with the above; for by that time of life, according to the above observers, the "adenoid acini" have begun to atrophy and disappear, like lymphoid tissue elsewhere.

* * * *

Human and Bovine Tuberculosis.

DR. NATHAN RAW, physician to Mill Road Infirmary, Liverpool, contributes to the *Journal of Clinical Research* the conclusions he has arrived at from his observation during the last ten years of over 4,000 cases of phthisis pulmonalis, and 1,500 cases of surgical tuberculosis, as well as 800 *post-mortem* examinations of tubercular cases. He considers that human and bovine tuberculosis are different varieties of a common species, and that the human body can be infected by both forms. He thinks that tubercle bacilli of the human type produce phthisis pulmonalis and ulceration of the intestines and abdominal glands, while bacilli of the bovine type produce tubercular peritonitis, tuberculosis of the lymphatic glands, lupus, and probably also tubercular meningitis and acute miliary tuberculosis. These two forms of tubercle are, he believes, antagonistic to each other, and in treating patients tuberculin from a bovine source should be used for phthisis pulmonalis, while tuberculin from a human source, such as is Koch's tuberculin R, should be used for bovine lesions such as lupus, tuberculosis of lymphatic glands, &c.

* * * *

Colloidal Solutions of Metals.

FOR some time past M. Robin and M. Netter, in France, have made use of infinitesimal doses of metals in the colloidal state, and lately Dr. Gisévius, junr., read an essay

before the Berlin Homœopathic Society on results obtained in his practice by dilutions made from colloidal solutions of gold, silver, and copper. Metals are obtained in a colloidal state by passing, by means of an electric arc, a spark between two layers of the metal plunged in water. An extremely minute division of the metal is thus produced. It is a question for us to consider whether metals can be reduced to as fine a state by these means as by the method of trituration employed in the preparation of insoluble drugs by the Homœopathic pharmacists. If, for instance, we could compare the state of division of gold or silver arrived at in the sixth homœopathic trituration with that occurring in a colloidal solution produced by the electric arc, which should we find to be the finer preparation? If it should happen that sub-division is as great, or greater, in the colloidal solution, it might be worth while to use these solutions as a starting point from which to make the higher potencies, and so save the laborious process of successive triturations according to the Hahnemannian method. We commend the elucidation of this question to the Research Department of the British Homœopathic Association. We think it could be determined with but little trouble and expense.

* * * *

New Anti-Opium Remedy.

ACCORDING to the *Kew Bulletin*, *Combretum sundaicum* is the name of a plant which possesses anti-opium properties. Dried specimens of it have been forwarded to Kew Museum by Mr. J. B. Carruthers, Director of Agriculture, Federated Malay States, and are to be seen exhibited in Case 52, Museum No. 1. It seems from an account by Mr. L. Wray that the medicinal virtues of this plant as an antidote to opium were accidently discovered by a party of Chinese woodcutters, who, when working in the jungle, ran out of tea, and as a substitute took the leaves of a jungle climber, dried them, and used them as tea in the ordinary way. This beverage made the men ill with a bowel complaint, but when the leaves were first roasted no ill-effects occurred. Then some opium dross, after being smoked, was mixed with the "tea," and the men continued drinking the mixture for a week or more. After this it was found that all desire for opium smoking had been lost. Friends of the men made known the discovery, and so the

news was spread. Establishments have been instituted for the treatment of the opium habit by means of the newly discovered drug, and at the one in Kuala Lumpur, from November 16th to 23rd last, about 396 patients had reported that they were completely cured. Branches are being established in different centres in the Malay States, and already the official monthly returns of the imports of opium show a decrease.

* * * *

Allopathic Use of Aconite and Veratrum.

How far the allopaths still are from the knowledge of how to use our drugs rightly, may be judged from the following extract from a recent article by Woods Hutchinson, M.D., appearing in the April number of the *Practitioner:* "The man who gives *aconite* or *veratrum* in a case of pneumonia, typhoid, or appendicitis, is pouring a second poison into the body of his unfortunate patient to suppress the resistance which it makes against the former. They make the patient more comfortable, and the doctor easier in his mind, for the time being, but what of the ultimate outcome? They lower the temperature, slow the pulse, but much after the fashion that a blow on the head with a club will quiet the struggles of a rioter resisting arrest, or a dose of *opium* will relieve the fatigue of a soldier on the march." We do not see the parallelism between the action of the club which quiets the rioter and that of the *opium* which relieves the fatigued soldier; but, letting that pass, we are not accustomed to witness the stunning effects of the former agent from our administration of *aconite* or *veratrum*. Perhaps we employ different doses.

* * * *

Doctor Durden's Pocket-book.

A copy of this little book, which has now reached its twenty-first thousand, has been sent to us by Gilbert and Hall, Homœopathic Chemists, Bournemouth. It is compiled by a well-known homœopathic practitioner, "Dr. Durden" being his *nom-de-plume*, and is a little paper-covered book which can be slipped into the waistcoat pocket, and is sold for threepence. For this modest sum the lay homœopath can obtain a great deal of useful information as to diet and general management of slight ailments, as well as a brief *Materia Medica* and

clinical index. The doses are in all cases given, and range mostly from ϕ to 3 x. It is a wonderfully good threepenny-worth.

* * * *

British Homœopathic Society.

THE ninth meeting of the Session was held at the London Homœopathic Hospital on Thursday, June 6th, 1907, at 8 o'clock. Dr. J. H. Clarke, the President, was in the chair. A paper was read by Dr. H. V. Munster, of Croydon, entitled: "A brief glance at the *Calcarea salts*, with special reference to *Calcarea phosphorica*, and cases illustrating its use." The paper aroused considerable interest, and there was a good discussion upon it, in which Dr. Deck, of Australia, took part. It was followed by a paper by Dr. Arthur Avent, of Birmingham, entitled, "*Aconitum napellus* and *ferrum phosphoricum*, a comparison," in which the respective spheres of the two drugs were described and illustrative cases given. Mr. Dudley Wright showed specimens of a cæcum successfully removed for malignant disease and of a prostatic adenoma removed by suprapubic cystotomy, and Dr. Neatby showed a multilocular cystic adenoma of the right ovary undergoing extensive mucoid degeneration, an early stage of the same condition in the left ovary, and microscopic sections of the specimen.

The first meeting of the Annual Assembly will take place on Wednesday, July 3rd, when the papers read will be under the Section of Surgery and Gynæcology. The second meeting, on Thursday, July 4th, will be occupied with the election of officers, &c., for the ensuing year.

* * * *

Personalia.

AT present there are as visitors to this country—Dr. Stephenson, of Dunedin, New Zealand, so honorably known in connection with his famous conflict with infamous professional ethics in his city; Dr. Deck, of Sydney, the father of the present house-surgeon to the London Homœopathic Hospital; and an old and welcomed colleague, Dr. Gerard Smith, of Tasmania, who has been engaged in keeping the flag of homœopathy flying to some purpose in that country. Dr. Fairlie, of Glasgow, the Travelling Scholar of the British Homœopathic

Association, has returned after a long and academically profitable stay in Chicago. Dr. Edith Neild, the daughter of our respected colleague Dr. Frederic Neild, of Tunbridge Wells, has also returned from Boston, Mass., where she stayed as holder of the Travelling Scholarship during the earlier part of the year, winning golden opinions from our professional friends in the Hub of the Universe.

* * * *

Homœopathy at the Royal Commission.

AT a recent sitting of the Royal Commission on Vivisection, our colleague, Dr. Burford, gave evidence at some length on the homœopathic method of proving drugs on the healthy human body, as preferable to the broken lights of the investigation of the properties of drugs on animals, to the entire exclusion of subjective sensations and mental symptoms. It is a most important matter that the vast and valuable scientific treasures in our possession should be made known, and the value of direct data as to drug action on the human body proven, as against the indirect and incomplete data obtained from a similar investigation on the lower animals. We hope later in the year to re-publish this evidence from the Blue Book, when this is issued. We are glad that such an opportunity to clearly state our scientific position in a Government publication was seized and utilised. We are emphatically of opinion that more opportunities of this kind should be taken advantage of, and our science made to emerge from its present obscure position. This line of action we would cordially press upon the attention of the British Homœopathic Society.

* * * *

An "Improved" Table Salt.

THERE is a very popular form of table salt, extensively used in restaurants and hotels, which is largely advertised under a certain name, and recommended as having especial nerve- and tissue-feeding properties owing to ingredients which are incorporated with the *sodium chloride*. We have long had our suspicions as to the safety of this preparation for general use, especially since several cases of insomnia induced by it have come under our notice. A leaflet issued by the Company advertising this preparation has enlightened our understanding

of the matter. The great convenience of this salt, apart from its supposed tonic influence, consists in its singularly non-hygroscopic properties, by which, unlike ordinary table-salt, each particle remains distinct and non-adherent to others, even in damp weather. We understand that this result is obtained by the presence of *magnesium phosphate*, in what quantity is not known. Certainly from a homœopathic standpoint the presence of this potent drug in any quantity is undesirable, and may well "give us pause" before using or recommending the substance.

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Poisoning from Bromo-Seltzer.

IN the *Journal of the American Medical Association* Dr. Robinson, of New York, relates an undoubted case of poisoning from the excessive use of this medicinal beverage. The victim was a married man with three children; he had taken bromo-seltzer for eighteen months in increasing quantities, beginning with a small dose for headache. The chief symptoms he exhibited were: sallow, cachectic complexion, tires very quickly; dyspnœa on slight exertion; coated tongue with offensive breath; no appetite, with constipation; the pulse varied from 90 to 96 when recumbent, jumping at once to 104 or 108 on standing; every sixth or seventh beat was intermitted. The habit was gradually broken with great difficulty; agonising headache and complete insomnia being experienced for some time; eventually a full recovery was made. Bromo-seltzer contains *bromides* and one of the *antipyretics*, which it may be is uncertain, but from the symptoms narrated above we suspect *antifebrin*. We are glad to know that though an attempt was made to introduce the beverage into this country, it met with very little success. We are sorry for our American cousins, who are said to largely indulge in its use, almost every city drug store having a tap on supply.

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Poisoning by Digitalis.

FROM foods and beverages rendered poisonous by way of "improvement," to drugs used with poisoning effects, is but a small step. And in this connection *digitalis*, in

our opinion, comes out *facilis princeps*. We believe that the number of patients hurried out of existence by the injudicious use of *digitalis* by their medical attendants is enormous. It is given in the hope of prolonging life by strengthening the heart, but in how many cases does it really do so? In the majority of cases its action is the exact opposite. Some slight fictitious sense of well-being or strength may be experienced at first, but after this a feeble heart rapidly exhausts itself from over stimulation, and the patient dies days or weeks sooner than would be the case were *digitalis* omitted. We assume in these cases that death is inevitable, but does not the same thing occasionally occur when the heart, if left alone, or treated homœopathically, would recover? We fear that this cannot be denied.

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Sudden Death from Change of Treatment.

It is a common event for patients gradually sinking from cardiac failure to try a change of treatment in the hope of prolonging life. When this occurs in those who have already been drenched with digitalis, and skilfully used homœopathic remedies are substituted, life is frequently prolonged, sometimes for years. But in the opposite case the results are usually disastrous. A flagging heart that has been accustomed to the gentle influence of homœopathically acting drugs, cannot stand the violent action of digitalis in the usual doses. Rapid exhaustion and death is the frequent consequence of such ill-judged changes. It occasionally happens to homœopathic practitioners that, yielding to the persuasion of sceptical friends, such a change is made, and the physican—under whose care all that drugs, carefully and scientifically administered, can do for a feeble heart, has been done—is dismissed. The result is usually a forgone conclusion. In two or three weeks a death announcement ensues. We have known several such cases, in which, had homœopathic treatment been continued, the expectation of life was several months at least. Digitalis poisoning terminated their histories shortly after they fell into allopathic hands.

* * * *

Digitalis Scientifically Employed.

SINCE Hahnemann's provings of the drug, the use of digitalis for homœopaths has been clearly defined, slow, weak, intermittent and irregular heart action being the guiding symptoms. To this condition it is strictly homœopathic, and will act in small doses. Possibly its use in larger quantities, as a diuretic in dropsical conditions, may also be homœopathic. Could provings of the drug be pushed to such an extreme, there can be no doubt that dropsy would result before death. This is an example of what Carrol Dunham defined as the *secondary drug-action.* Such a symptom, when it occurs in disease, can only be cured by larger doses of the drug which produces it. These are examples of the scientific and specific curative action of digitalis, and are in striking contrast to its indescriminate use *per contraria* in all cases of cardiac failure and disease.

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Western Counties Therapeutic Society.

THE second meeting of this Society for the year, was held in London by kind invitation of Dr. Burford and Mr. Dudley Wright, on June 5th, under the presidency of Dr. Ord. Dr. Burford read a paper on Extra-uterine Gestation, and exhibited some exceedingly rare specimens, one being of simultaneous double ectopic gestation in the fallopian tubes; another of extra-uterine gestation in which a five months' fœtus lay in the abdominal cavity, while the placenta was hermetically sealed in the tube; a third of unruptured tubal gestation of the fifth or sixth week, diagnosed as such and removed successfully by operation. In this latter case Dr. Wheeler had diagnosed the condition provisionally before it was seen by Dr. Burford. The paper was followed by a discussion, in which the President, Dr. Madden, Dr. Johnson, and Dr. Moir took part. A brief address was then given by Dr. Black on Food in some of its Clinical Aspects.

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Coal Eating by Women.

DR. MURRAY MOORE, in the June number of the *Homœopathic World*, gives the details of a case. Some ten or twelve years ago we had a somewhat similar experience. It was

a case of cancer of the uterus, and the woman used to sit, day after day, with the coal scuttle beside her, breaking lumps of coal and cinders into small bits with her fingers, and at the same time crunching up small pieces in her mouth and swallowing them. We looked upon this as a form of "depraved appetite," comparable to the eating of chalk and plaster, slate pencils, &c. We hoped much from this "modality," but our hopes were doomed to disappointment. We tried all the medicines we knew of having anything like this symptom. In *Guiding Symptoms* we find under "Desire for Coal," *calc.*, *cic.*, and *alumen* (in chlorosis), all verified by cures. In J. T. Kent's Repertory, under "Desire for Coal," the same three medicines; and under "Desire for Charcoal," *alum.*, *cic.*, *con.*, *nit.-ac.*, and *nux v.* In the Repertory attached to Dr. William Boericke's *Pocket Manual of Homœopathic Materia Medica*, we find under "Perverted Cravings—Charcoal, Coal, Chalk," &c., *alum.*, *calc.*, *cic.*, *ign.*, *nit.-ac.*, *psor.* In Boenninghausen's *Therapeutic Pocket Book*, *cic.* only is mentioned, and the same is true of the *Repertory to the Cyclopædia of Drug Pathogenesy.*

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Boenninghausen.

We are glad to see that Messrs. Boericke and Tafel have in press a book which will be termed the "Lesser Writings of C. von Boenninghausen," and which will include all the hitherto unpublished articles of that old veteran homœopath, and also those books of his which are now out of print. They will all be in one cover, and will be of most excellent value to the homœopathic physician. We hope a full and complete Repertory will, if necessary, be added.

Original Articles.

ON THE PRINCIPAL FEATURES OF EXTRA-UTERINE GESTATION, WITH ESPECIAL REFERENCE TO THREE UNCOMMON CASES.[1]

By GEORGE BURFORD, M.B.

Senior Physician for Diseases of Women to the London Homœopathic Hospital; Consulting Physician for Diseases of Women to the Homœopathic Hospitals at Bromley, Tunbridge Wells, Bristol, &c., &c.

MR. PRESIDENT AND GENTLEMEN,—Twelve years ago I had the honour of reading before this Society a paper on "Peritonitis," setting forth new facts and new conclusions as to the disease derived from my own clinical research. My paper met with a discriminating reception. To-day I find that the facts I then cited are admitted into the text-books as verifiable; that the conclusions I then drew are taught in the more advanced schools. I have often greatly regretted that the mass of original observations I had accumulated had not seen the light earlier, instead of waiting for other original workers in the same field to publish first their confirmatory but independent work. My own unpublished detail still lies as MSS. in one of my drawers.

I have not here to present new or unique observations made on the process of extra-uterine gestation—there have been no gross errors to delete, clinging like cerements round living facts, since the epoch-making work of Lawson Tait, to whom our exact knowledge of this pathological process is chiefly due. Before Tait's work, commencing about 1881, the main clinical points had been collected and presented in a single volume by Parry in 1876, and who unfortunately died in the same year in which his volume of investigation saw the light. The first known case of extra-uterine pregnancy was described by Albucasis in the eleventh century, and down to the succeeding centuries the real pathology and the effective treatment remained unknown until the Victorian era. Not until the early 'eighties

[1] Being a Paper read before the London Meeting of the Western Counties Therapeutic Society, on June 5th, 1907. Specimens were exhibited and diagrams shown in illustration of the paper.

was the first operation, deliberately planned for the correctly diagnosed condition, carried out—and how could it be? For the new information which enlightened diagnosis and justified treatment by operation, was gained by the new procedure of successful abdominal section. It is to the masterly and masterful genius of Tait—Tait, the great pioneer of successful abdominal section; Tait, the great unearther of clinical conditions previously jumbled and confused—that extra-uterine gestation has been classified as a comprehensible pathological process, and its treatment placed on the plane of satisfactory and adequate measures. It is the modern fashion to glorify Lister, but gynæcological operators owe as much or more to Tait, to whose transcendent genius a future generation will certainly render not poetical, but plain and unsophisticated justice.

And now to our prime theme. What is extra-uterine gestation? How does it come about? How may it be recognised and dealt with? To be precise, all forms of gestation other than in the normal uterine cavity should be styled *ectopic*, for there is one form—the interstitial form—which takes place in that part of the Fallopian tube that passes through the uterine wall, and in its growth really becomes an aberrant uterine pregnancy. This form is rare—so rare, that very experienced observers have found not more than one case in the whole of their operative work; and some not one.

The immense majority of ectopic pregnancies are tubal, and here again to Tait is the credit due for insisting on this. Only quite lately has it been demonstrated that primary ovarian pregnancy may occur—that is, that the ovum may be fertilised, and continue to develop in ovarian tissue. But this result is so rare, that its clear demonstration as a possibility has only been made after endless research work, and in a fractional percentage of ectopic-gestational cases.

To the tube, then, belong the honours, practically, of ectopic gestation, for primary abominal pregnancy—except in the ovary as already alluded to—is a primary abdominal myth.

What causes, what brings about, the implantation of a fertilised ovum on the tubal instead of the uterine wall? Frankly, we do not know. Tait considered he had solved the problem by postulating *à priori* "desquamative salpingitis," owing to

which the cilia of the tubal mucosa had been shed, and thus retardation of the ovum in the tube rendered likely. This was further made *à priori* probable, in that sundry lesions of the tube often preceded the occurrence of tubal gestation. But many recorded cases do not present the history of any antecedent pelvic symptoms; and in one of my own cases what pelvic ailment existed was on the other side to that on which the tubal gestation occurred. Moreover, Tait considered that the movement-direction of the tubal cilia was towards the uterus, thus physiologically opposing the ingress of the spermatozoa to the tube. But later investigation has shown that the ciliary movements are toward the fimbriated tubal end; so the theory of ciliary opposition is invalid. Another explanation of the theory spinners—library men, as I call them, as opposed to laboratory or ward-observation men—is that impregnation *always* occurs in the tube. But for this wild theory there is not an atom of valid evidence, so I must leave the explanation of the preference of the fertilised ovum for the tube, and not for the uterus, as an unsolved problem.

Take, however, this postulate as of prime importance: "the development of an ovum in the tube, at any part of it, commonly results in rupture of the tube." And so deadly is the usual issue of tubal rupture, that it has actually been proposed to consider tubal gestation as a malignant disease, on the ground that its usual tendency is towards death.

Now the varieties of ectopic gestation are as follows:—

Primary	{	Interstitial. Tubal. Ovarian.
Secondary	{	Intra-ligamentous. Abdominal.

When gestation takes place in the utero-parietal tube it is called interstitial. This is a most deadly form of ectopic gestation. The gestation sac widens and expands, throws the other parts of the uterus out of proportion, and finally usually ruptures into the abdominal cavity. This form of ectopic gestation is exceedingly rare. Specimens are to be unearthed in London Museums, but one may go for a lifetime and never see a case. Mr. Tait recorded one case that he observed in his practice.

But quite otherwise is it with gestation in the Fallopian tube in its free portion. Such are by far the most frequent of all ectopic gestations so much so that Tait insisted that all extra-uterine gestations were primarily tubal. This is, with the rarest exception, still sound teaching. Now, there is no acute pelvic condition in the feminine gender more potentially deadly than this of tubal gestation. Let us imagine the fertilised ovum implanted on some part of the tubal wall, and increasing in size as weeks elapse. One of a few alternatives now happens.

(1) *Rupture into the Abdomen.*—This is the commonest. At any time from the fourth to the fifteenth week, rarely later, the tubal walls are so thinned that expansion is no more possible, and the tube ruptures, the embryo being shot out into the abdominal cavity. Furious hæmorrhage may ensue, and the patient often sinks from its occurrence, unless abdominal section be promptly performed and the bleeding vessels tied.

(2) The patient may survive the syncope due to the first outrush of blood. In a few days the bleeding recurs, and again recurs, and the deferred lethal result accrues later on, the abdomen being found to contain pints of blood as the issue of repeated hæmorrhages.

(3) In another type of case the hæmorrhage is inconsiderable, the tear not occurring through the site of the placental attachment. The fœtus is extruded, and may continue to live and grow free in the abdomen, because its placental implantation is not detached. Sooner or later the fœtus dies, its nutrition not keeping pace with its requirements, and the fœtal mass becomes encapsuled, undergoing degenerative changes. Or it may be removed by operation prior to its demise.

The first specimen I have to demonstrate is from a case of extra-uterine gestation of this type.

CASE 1.—*Extra-uterine Gestation in which a Five Months' Fœtus was removed from the Free Abdominal Cavity.*—The patient was aged 27, having had one previous confinement some five years ago. From that time onward she had menstruated regularly till the absence of the usual period gave her the first indication of a commencing pregnancy. The gestation proceeded apparently normally for some three

months, when the patient's attention was attracted to a painful swelling in the left flank, with a decided tendency to increase. A month and a half later the pain had become so acute that hospital treatment for some three weeks was requisite to subdue its urgency, and to enable the patient once more to move about.

A few days after her discharge from hospital labour pains set in and continued for some days, during which time pieces of "flesh"—probably decidual masses—were noticed in the hæmorrhagic uterine discharge. Coincident with these phenomena was an attack of syncope, so severe as to continue for twenty-four hours. Before long she rallied, and so considerably as to be able to undertake a railway journey. Very soon, however, the former symptoms recurred. A sudden sense of violent movement in the side was followed by another and severer syncopic attack; and again the peculiar uterine discharge occurred, with "fleshy" pieces admixed. This attack lasted some three weeks, and concurrently with its cessation a new phenomenon, that of persistent backache of a bruised character was noted. Retrograde changes now appeared; the abdominal girth gradually lessened, the breasts ceased to secrete, and the previously swollen legs returned to their normal dimensions. Finally a menstrual period, after ten months' intermission, denoted that the changes incident to pregnancy were at an end.

Examination of the abdomen when the patient came under our observation indicated the fœtus lying free in the abdominal cavity. Operation disclosed commencing mummification in this fœtal mass, which was removed, the patient making an excellent recovery.

This case created some interest at the time, and found its way into German specialist literature. And only last year I received a long letter from a German investigator, asking many further questions by way of amplification of the foreign report of this interesting case.

(4) Another course lies before the expanding tube with the growing fœtus. If the area of least resistance is opposite the broad ligament, the folds of the broad ligament are opened out by the expanding gestation, and the rupture may occur into the potential cavity of the broad ligament itself. Here, again, the fœtus may either die and disappear, or the gestation

may continue, and even go on to term, escaping from the broad ligament as growth increases, or like a broad ligament cyst, continue to grow, with the expanding sheets of the broad ligament continuously enfolding it.

(5) Yet another and possibly most interesting of the alternative issues of a tubal gestation falls to be considered. We all know full well uterine abortion. Now its analogue, tubal abortion, occurs not infrequently, but into the peritoneum, not into the uterus. To our own countryman, Bland-Sutton, is due the credit of first bringing this prominently to the notice of English-speaking physicians. The tube does not rupture; the fimbriated end opens out gradually, and the endeavour at expulsion is accompanied by perpetual hæmorrhage from the bleeding vessels, constituting a hæmatocele in the cavity of the pelvis. Although the risk of hæmorrhage may not be so great here as in the case of rupture, the clot-mass may, and often does, suppurate from the easy passage of germs from the adherent intestine into a volume of pabulum virtually outside the organism.

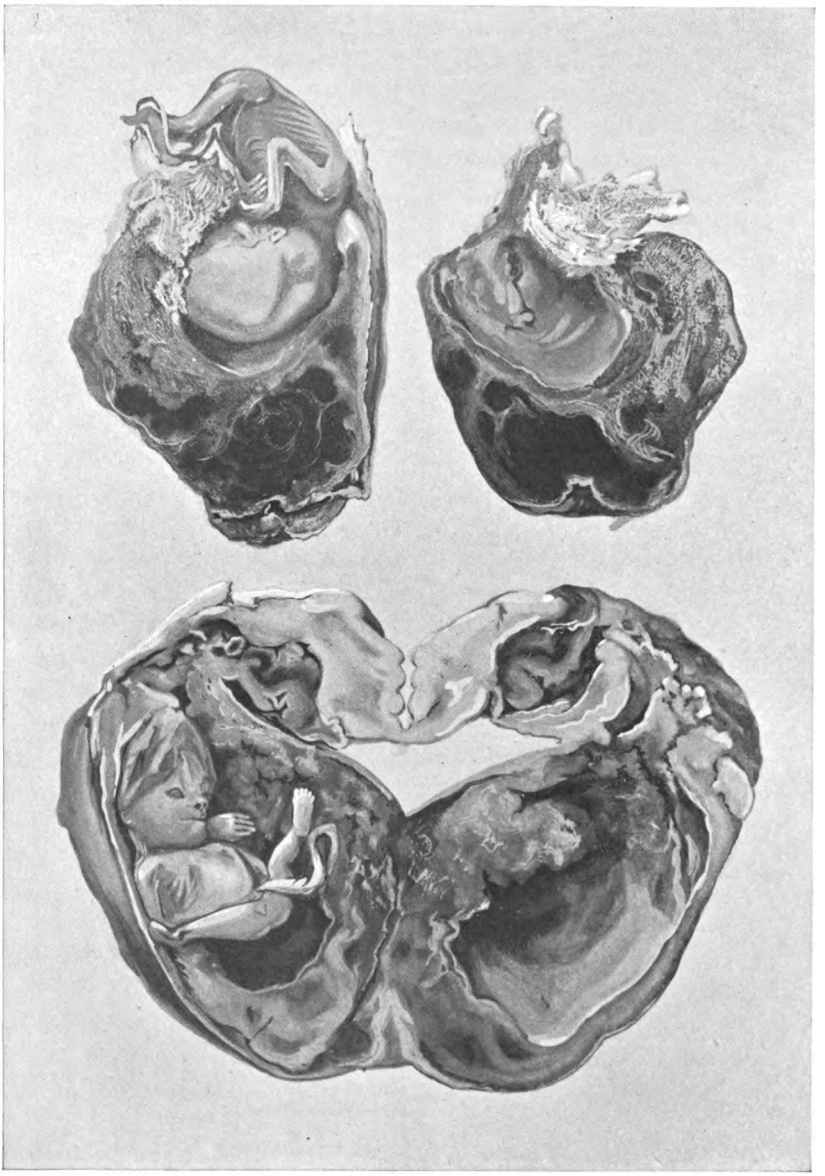
Of these varieties the second is the most frequent—rupture with repeated hæmorrhages. I now relate a case of this, which has also the character of presenting an extraordinarily rare double event.

CASE 2.—*Double Simultaneous Ectopic Gestation in the Fallopian Tubes: Operation: Recovery.*[1]—The case (specimen exhibited) was that of a married woman, aged 33, under the care of Dr. Sandberg, of Streatham. The clinical history showed that she had a normal parturition twelve years ago; two years later a premature labour occurred with adherent placenta. Several miscarriages took place in the ensuing years, and the last about three years prior to the present date. Since this latest miscarriage she had been perfectly regular, the last normal period commencing on September 7, 1904.

In October the menstrual period was wanting, and late in that month, and during November, a sanguineous daily discharge, now lighter and now darker in tint, had persisted up to November 28, the date of consultation. During this hæmorrhagic term she experienced constant pain day and

[1] From the *British Gynæcological Journal*, August, 1905.

TO ILLUSTRATE DR. BURFORD'S PAPER ON
"EXTRA-UTERINE GESTATION."



The upper drawing shows the right Fallopian tube, with fœtus *in situ*.

The lower drawing is that of the left Fallopian tube, much thickened by laminated clot: the fœtus is *in situ*.

night, sometimes with acute exacerbations. There had been no definite crises of collapse, and the occasional acute seizures of pain were readily and safely tided over. No shreds or membranous patches had been seen in the vaginal flux. Examination now showed diffused abdominal tenderness below the umbilical zone. The percussion reaction was ill defined, and no definite area of dulness was demonstrable. *Per vaginam* the uterus was drawn to the right side, not freely movable, enlarged, as in chronic sub-involution, and flanked by a diffuse inelastic deposit, mainly on the left side, distributing itself in less degree behind and to the right.

The diagnosis seemed to leave little to seek, and she was at once sent into hospital. The following day, while in bed, symptoms of internal hæmorrhage suddenly occurred, and the condition being critical, the abdomen was opened without unnecessary delay. A small quantity only of recent clot presented itself, while the pelvis was roofed over by dense omental and intestinal adhesions.

Breaking through these, some handfuls of clot and a good deal of fluid blood were removed, and an intimately adherent mass about the size of an orange enucleated with difficulty. This was the *left* gestation sac, and perpending from it was a fœtus still alive. Further search revealed a tubal swelling of less dimensions and of firmer consistence on the *right* side also, which on removal proved to be another gestation sac with another fœtus plainly visible. The most recent hæmorrhage had been from the left side. Transfusion to the extent of 2½ pints was carried on during operation. The patient made an unbroken recovery.

The specimens were submitted to the Clinical Research authorities for report, which was as follows: "These specimens obviously represent two ectopic gestation sacs with contained fœtuses. The right sac consists of the very much thinned-out Fallopian tube with the gestation sac in its ampullary extremity. . . . The fimbriated extremity of the right tube is opened up, and the opening measures about 8 mm. in the preserved specimen. . . . From this description it will appear that the specimen represents a tubal pregnancy which has been converted into a mole by hæmorrhage, and that hæmorrhage has probably also occurred into the peritoneum through the open fimbriated extremity.

"The specimen removed from the left side has much the same characters. It is a tubal mole, contains more than half its dimensions of blood clot and obvious chorionic villi, the rest of the sac containing the fœtus.

"From the measurements of the fœtuses of the two sides, 38 and 41 mm. respectively, it would seem that they must be of approximately the same period of growth, and if not actually conceived at the same time must have been very nearly so. The ages of the fœtuses corresponded approximately to eight weeks.

"The smaller fœtus is very macerated, and so may be regarded as having been at one time more nearly the same size as the larger one, which is quite well preserved."

Now the special and interesting peculiarity of the case is this: it appears to be the sixth recorded case in the medical literature of the world. At the same time that this specimen was exhibited to the British Gynæcological Society, Professor Schauta, in Vienna, was reading a paper on the varieties of tubal gestation before the Vienna Obstetrical Society.[1] Dealing *inter alia* with this form of tubal gestation—simultaneous conception in both Fallopian tubes—he mentioned that he had been able to find only four recorded cases in the history of the world. Professor Weinlechner, who was present, mentioned that he had had another, which brought the list up to five. This case, therefore, constitutes the sixth, and the specimen, therefore, is one of extraordinary rarity.

I now come to a brief enumeration of the early signs and symptoms of extra-uterine gestation. These are:—

(1) Where childbirth has previously occurred, some years have probably elapsed since the last normal pregnancy.

(2) There is usually a history of recent omission of the ordinary menstrual flow.

(3) Even as early as the fifth or sixth week after the last period a hæmorrhagic discharge often appears.

(4) Shreds and patches of decidual membrane are frequently found in the blood discharge.

(5) Irregular pelvic pains, sharp and colicky, may be complained of in the stage preceding rupture.

[1] *Centralblatt für Gynäkologie*, No. 2, 1905.

(6) On examination pulsating vessels may be made out in the vaginal *cul-de-sac* on the affected side.

(7) The uterus enlarges to a moderate degree, resembling in bulk a sub-involuted uterus.

(8) The uterus itself is empty.

(9) In Douglas' pouch, and developing to one side of the uterus, is the tubal gestation swelling.

The classical signs and symptoms of tubal rupture are as follows :—

(1) Suddenly, without warning, the patient is seized with acute abdominal pain.

(2) She rapidly becomes faint and collapsed, and vomiting usually occurs.

(3) All the signs of internal concealed hæmorrhage are present; the face is pallid, the lips blanched, the extremities chill, and, most important of all, *the pulse is weak and frequent, still tending to rise.*

(4) Consciousness is maintained, the mental state is passive, but the perceptive faculties are clear.

(5) Pelvic examination gives, as a rule, the indication of a recent intra-peritoneal effusion.

(*a*) The patient may continuously grow worse, and death ensue within twelve to thirty-six hours from the commencement of the attack. The earlier the rupture, the greater the risk of this rapidly fatal issue.

(*b*) In other cases the crisis of the attack may be passed and the patient somewhat recover, still remaining seriously ill. In a few days the symptoms are repeated, and to this, or to a succeeding attack, the patient often succumbs.

(*c*) Or the accompanying hæmorrhage may be limited in amount, the extruded embryo small, and the hæmorrhage not recurring; the whole mass may ultimately be absorbed without further untoward incident. This is stated to occur especially in cases of early rupture between the folds of the broad ligament. Or, after extrusion of the fœtus into the general peritoneal cavity, the embryo may continue to flourish in its new environment, even up to term; but, sooner or later, unless previously removed by operation, the fœtus dies, and the consequences of a dead mass in the abdomen then develop themselves.

Finally, I have to give some details of an uncommon case where the tubal gestation was diagnosed as such, and successfully removed by operation *before rupture.* That this is a diagnostic feat for which I may have some legitimate pride, is evidenced by the fact that Tait wrote, "I am of opinion that no authentic description exists of an unruptured tube-pregnancy." And again, "I have only seen one case before the period of rupture, but the question of the woman being pregnant never entered the mind of any one who saw her." (The case has recently been reported in full in THE BRITISH HOMŒOPATHIC REVIEW, so a very brief allusion need here only be made.)

CASE 3.—*A Rare Instance of Extra-uterine Gestation Diagnosed before Rupture and Removed Intact.*—The history was fairly clear. Married less than a twelvemonth, this lady had normal periods till December, 1906, except for a delay of fourteen days before the September period came on. When this delayed one appeared, however, it was perfectly normal in every way, and did not suggest an early miscarriage.

In January the period was missed, and about six weeks after its expected advent, comparatively slight hæmorrhage, irregular in its course, but never entirely ceasing, continued up to the time of consultation. Once and again a small clot had been passed, but no membranous shreds were at any time noticed, nor was the flow ever malodorous. Further, abdominal or pelvic pain had at no time been a marked feature.

Some two weeks after the commencement of hæmorrhage a consultation was held and the aspects of the case reviewed. Physical examination—a matter of considerable difficulty in this instance—indicated, from the somewhat enlarged and softened uterine organ, the probable occurrence of pregnancy but the clinical history did not quite tally with the usual symptoms of an early miscarriage. The possibility of an extra-uterine gestation was discussed, and it was decided to administer an anæsthetic, and, while clearing up the remaining points in the physical condition, to arrest the uterine hæmorrhage also.

Examination under anæsthetic clearly showed a soft elongated swelling apparently running parallel to the long axis of the uterus, and about the size of an English sausage.

The uterus was pushed over to the right. A careful review of the clinical history, together with the physical examination, confirmed us in the belief that we had here to deal with a veritable case of extra-uterine gestation. Operation confirmed the diagnosis : the swelling proved to be a tubal gestation on the left side, with no blood effusion as yet into the peritoneum. The gestation sac was removed, and the patient made an unbroken recovery.

Discussion.

Dr. Ord (President) thanked Dr. Burford for his admirable paper. He thought it an exceedingly happy circumstance that these rare cases, one being absolutely unique, should have fallen into Dr. Burford's hands. It was to the credit of homœopathy that the profession at large should know that such cases were as carefully studied and investigated by homœopaths, who specialised in them, as by others. He was pleased to hear the credit given by Dr. Burford to the late Mr. Lawson Tait for the pioneer work done by him in these conditions. He had known Mr. Lawson Tait well, and had submitted cases to him for operation in earlier days. One of these he had diagnosed as ectopic gestation, which was confirmed and successfully operated on by Mr. Tait twenty years ago. In the days when other operators were smarting under the inconvenience of the carbolic spray, Lawson Tait laughed at these contrivances, and cared nothing for germs. His idea was that it was the *soil* not the germs that mattered. If no decomposible matter were left in a wound, but only living tissue, the germs had no soil to suit them and did no harm. He considered that Mr. Lawson Tait was twenty years before his time; his opinions now were generally accepted. In thanking Dr. Burford for his paper, they must not forget to compliment Dr. Wheeler, who had, for the first time, succeeded in diagnosing ectopic gestation before rupture.

Dr. Madden corroborated Dr. Ord's references to the late Mr. Lawson Tait's work, but he thought that the fun poked by him at Lister's carbolic spray was hardly justified ; Mr. Tait attained the same ends by scrupulous cleanliness, the necessity for which was first pointed out by Lister, and he was thus able to dispense with the spray. Dr. Burford's specimens were of

extreme interest, and one was certainly unique. He congratulated the *Western Counties Therapeutic Society* on having such a paper presented to them; it was a great honour to the Society. Dr. Burford's paper would be a great help to members in identifying any similar cases they might meet with. He would like to ask Dr. Burford if the blue look in the vaginal mucous membrane, indicative of pregnancy, was also found in cases of ectopic gestation?

Dr. BURFORD replied that this was so.

Dr. JOHNSTONE said it was curious that the subject of double ectopic gestation had been revived three weeks before Dr. Burford's case by a Viennese Obstetrical Society, at which it was stated that only four cases had been recorded. Amongst several cases of the common variety, he had met with one very painful example, of a lady who, in apparently good health, felt sudden pain, and ectopic gestation was diagnosed by a specialist, who, unfortunately, operated *per vaginam*, with a fatal result in a few hours. Shortly after this he had a case taken with sudden pallor and abdominal pain, which was operated upon. In this a tubal gestation proved to have ruptured, the abdomen being filled with quarts of clotted blood extending up to the liver and spleen. She made an excellent recovery, and gave birth to a healthy child two years after. He had operated on two cases of supposed ruptured gastric ulcers in the London Homœopathic Hospital, one being *in extremis*, both of which turned out to be tubal gestation. Many men had met with such cases, but none had had the good fortune to meet with such a unique condition as Dr. Burford. Operation through the vagina was a mistake: it was impossible properly to control the hæmorrhage, which was the great danger in these cases. Hæmorrhage could be easily controlled in operation through the abdominal walls.

Dr. MOIR regretted that Dr. Burford had such a small body to present such valuable cases to. There was so much to be learnt from his papers. He recalled a previous paper in which, some years ago, Dr. Burford presented the valuable results of his studies on peritonitis. This also deserved to have enjoyed a larger field. It was a great disadvantage to be unable to present all the details of such cases, which would be of very great interest.

Dr. WHEELER said, with regard to the case of tubal gestation which Dr. Burford had credited him with diagnosing before rupture, that immediately afterwards a case had been recorded in the *Lancet* in which this had been done, making the second case recorded.

Dr. BURFORD, in responding, thanked the members for the cordial reception they had accorded his paper. He agreed with Dr. Moir as to the difficulty of including details of importance in a paper of this sort, without making it of inordinate length.

THE TREATMENT OF DYSENTERY.

BY J. CALL WEDDELL, M.D.,
SUNDERLAND.

AFTER perusing a recent article on the above subject in the *International Medical Review*, by Professor Plehn, of Berlin, I was struck with the cumbersome and laborious treatment suggested by him, and was led to refer back to one of my old case-books, to see if we could not produce results better, both as to time and recoveries, by homœopathic medicine.

The notes, which I have copied hereafter, justify, I think, my expectations, but it may not be uninteresting if a few quotations are made from the article in question to demonstrate what strides (!) are being made by members of the "Regular" school of medicine in this twentieth century.

First, he begins by stating that the two forms of dysentery "being a matter of localised processes in the intestine," produced by amœbæ (*A. hystolytica*) in the one variety, and bacilli in the other, "there are points of view common to both diseases regarding the treatment, the first aim of which is to destroy the cause of the disease by disinfecting the intestine." To carry out this object *calomel*, in heroic doses of thirty grains even, is employed in hot climates where the disease prevails. I remember, about thirteen years ago, being assured by a Medico from the West Indies that this was the one and only way of curing cases out there. Professor Plehn adds, "It is self-understood that cases of poisoning were, and are still,

of no rare occurrence, especially when the prompt relief of constipation is neglected." Who can doubt it? The much vaunted *ipecacuanha*, it would appear, has had to be deprived of its emetic properties, and even then is conspicuously uncertain in its effects. So also *simiruba*. So, in despair, he harks back on *calomel*, for "according to our own experiences, *calomel* still remains the most effectual disinfectant of the intestine." (!) Two tablespoonfuls of *castor oil* are administered to start with (he does not say whether repeated if not retained), then, after the effect of the oil has become evident, half a grain of *calomel* is given every hour for twelve doses—the patient is allowed a respite during nights—and this is repeated the two following days. The pain and purging are relieved in from twenty-four to twenty-eight hours in recent cases. "Perhaps this is explained by the fact that in exterminating the parasites by means of the sublimate formed by the *calomel*, the irritating formation of toxine is limited or may be done away with." The cure, however, is not yet completed, the patient must be kept in bed for three weeks at least, and during this time grs. vi. of *subnitrate of bismuth* given every hour, and a strict diet enforced.

The *bismuth*, he asserts, does not produce intoxication, and a recently recorded case need not be taken as a criterion, for in it the "comparatively enormous doses" were given, in a very short period of time, to a child "for the purpose of applying Röntgen-rays to the digestive organs." (Great Heavens!) The small doses of *calomel*, however, he admits, do not infrequently cause a stomatitis, which is occasionally troublesome. After discussing the attempts "to effectuate disinfection of the intestine" by injections by the anus of *boracic acid*, *salicine*, *quinine*, or *nitrate of silver*, he has the grace to say that the injections must be regarded as distinctly dangerous, as peritonitis by perforation is one of the most frequent causes of death, and on that account he has now abandoned the rinsing, and does not regret having done so.

As habitual atony of the intestines follows the mode of treatment he advocates, and frequently lasts for a long time, Karlsbad salt is called into request, so that the patient has altogether rather "a good time of it."

Touching Serum.—The "Specific Serum Cure" can only

be considered in cases of dysentery from bacilli, since protozoans (amœbæ) do not form an antitoxin of the usual kind, and Shiga's Serum, which in Japan is said to have reduced a death rate of 40 per cent. to *nil*, in the Philippines utterly failed (probably because an alien bacillus was at work, and "was not having any"). He very naïvely says: "In short, concerning this subject, problems, interesting as well as proved by practice, have still to be solved." So to sum up the most recent treatment here advocated, there is nothing for it but to disinfect the gut from end to end. *Calomel* may produce poisonous effects when given in large doses, to prevent this, purge; smaller doses are more effectual when continued for three days (the bowel being previously thoroughly emptied by an ounce of *castor oil*); true, troublesome stomatitis frequently follows, but that is a mere detail. Then habitual atony of the intestines also results, but that can be got over, in time, by the continued use of Karlsbad salts. So the simple mode of procedure is this: First flush your main drain, thoroughly disinfect, then apply a thick coating to the interior that will last some time, and meanwhile keep on flushing: Result—

By way of contrast, the following cases from my notes may be interesting, first as illustrating an example of an ulcerated condition of the large intestine (Lösch) resulting, probably, from amœbæ infection.

CASE 1.—November 1st, 1895.—R. N., aged 49, a steady man, of small, spare build, but wiry, works as joiner in a ship-yard on the riverside, states that during the last twenty years he has had dysentery eighteen or nineteen times, *i.e.*, at the changes of the season it begins, and lasts, as a rule, five or six weeks or more; he is never without diarrhœa, stools average nine a day and are very urgent from 3 to 4 a.m. He is always thirsty, water, when drunk, "runs through him." He is not always pained, but when he is so it is before motions, across the bowels, occasionally cramped, feet and hands generally cold, urine plentiful and pale, appetite good, sleeps well. Had eczema up till 17 years of age. *Rumex crispus*, 5x, two hours.

November 4th.—Much improved, bowels now only act once a day, motions formed, has not been disturbed the last two nights. Calls himself "quite well."

N.B.—I attended him twice during the next eighteen months for dysentery, when there was much tenesmus and bloody stools, and on each occasion *mercurius corr.* 3 put a stop to it, and he was again at work within the week (being a Lodge patient, this speaks for itself). He has now been without an attack, to my knowledge, for the last ten years, and seldom gets diarrhœa either.

The following cases are of the other type and were evidently catarrhal.

CASE 2.—September 28th, 1895.—J. M., aged 11, had been playing football after school, the day being intensely hot, and had not changed his clothes. After going to bed had several rigors, and awoke in the early morning "doubled up with pain in the bowels," soon after which he vomited, and was purged. The pain continuing, his father every half-hour administered *aconite*, but the lad was soon delirious, passing motions involuntarily, and when I was summoned, in the early morning, I found him racked in pain, tossing about in bed, very thirsty, pulse 130, temperature 105°, headache, with white fur on tongue, which was dry in centre, and fœtid breath. He had just vomited a little watery fluid, and had also passed a motion in bed, chiefly slime. His abdomen was distended, hot and tender. He had been taking soda water and milk, but had rejected it. To have *baptisia* 1x every hour, alternated with *aconite* 3. On my evening visit his temperature was 99°, vomiting had ceased, but not the pain and thirst; the bowels had acted about hourly, chiefly blood and slime passing.

September 29th.—Has had fairly good night, bowels disturbed him about every two hours. Pulse 100, temperature normal, not so thirsty, abdomen still sore, tongue furred.

September 30th.—Feels much better, bowels acted four times in night, froth, slime, and blood, but each time there was tenesmus. *Podoph.* 6, two hours.

October 1st.—Improved, pain less, pulse 100, bowels acted twice in night.

October 2nd.—Still improving.

October 3rd.—Motions only three or four a day, like boiled sago, but little blood and slight tenesmus only, pain gone from abdomen. Has taken more nourishment, chiefly milk.

October 6th.—Still improving, motions are in shreds,

chocolate coloured, with very offensive smell, carrion-like in odour, but there is no bright blood. Tenesmus less, also thirst, tongue clean, pulse 100.

October 7th.—Motions more fæcal—two—complains of much pain lower back.

October 8th.—Sat up a while last evening, much better.

October 10th.—Improved all round, appetite good. Has had a natural motion without pain. *Podoph.* 6, three hours. Ate some chicken and rice pudding.

October 12th.—Down stairs, feels "quite well," still very weak and thin.

CASE 3.—October 2nd, 1895.—M. M., aged 9, attacked with diarrhœa, for which I ordered *arsen. alb.* 3x, two hours.

October 3rd.—Still diarrhœa, but with tenesmus now and blood, but no fever. *Pod.* 6, one hour.

October 6th.—No blood nor purging since 4th. *Nux vom.* 1, three hours.

CASE 4.—October 2nd, 1895.—A. M. M., aged 5, shivering, fever, white tongue, headache. *Gelsem.* 1, two hours. Improved till 5th, when she passed several greenish, offensive motions, with much tenesmus, nausea and colic. *Ipecac.* 3x, two hours.

October 6th.—Bowels still loose, chiefly slime and blood.

October 7th.—Less loose and no blood.

October 8th.—Improving. *China* 1, two or three hours.

Neither of these cases lasted a week before she was convalescent; the last was curious, in that the purging, &c., did not commence till three days after the rigor. All made very speedy recoveries after acute stage had passed.

These cases are not cited as being anything out of the common, but I think will bear favourable comparison with those treated by "up-to-date methods," such as are advocated by the learned Professor, who probably sneers at Homœopathy, like most of his kind.

METALLIC FERMENTS.

By T. G. STONHAM, M.D.Lond.

THERE appears in the April number of *L'Art Medical*, over the signature of Dr. Paul Tessier, a *résumé* of a very interesting paper communicated to the Therapeutical Society of France by M. Bardet, on the subject of metal ferments, which was first introduced to the Academy of Medicine by M. Albert Robin. The subject deals with the infinitesimal, and though not strictly relating to homœopathy, may yet be of interest to our readers. We therefore give a brief account of what seem to us to be the most important points.

Firstly, it is necessary to distinguish the solutions of metal ferments used by M. Albert Robin from colloidal metals, as their physiological effects are essentially different, and they are not in the same physical state. For instance, colloidal metals dissolve in water at a considerable concentration, whereas it is impossible for solutions of metal ferments to contain more than mere traces of the metal, for any increase of concentration causes them to precipitate, and they lose their properties; colloidal metals can be used as medicines, and retain their specific properties, but do not act as diastases, while metal ferments lose their distinctive qualities as metals, but act as diastases, that is to say, they can effect an intense chemical action by catalysis by their mere presence, and without taking any appreciable part in the reaction.

To illustrate what is meant by catalytic action, some experiments by M. Lebon are very *à propos:* Take a layer or a roll of aluminium and freshen the surface. That done, plunge it into a phial containing *mercury*, taking care to maintain this light metal in the mass of *mercury*, and leave it there several hours; or, more simply, for the shortest possible time plunge the bar of aluminium into a weak solution of a *salt of mercury*, for example, in a 1 per cent. solution of the sublimate. On taking it out of the solution wash the bar by moving it quickly in distilled water, then dry rapidly with a clean serviette. Place it upon a support in a vertical position, and watch attentively. At the end of some minutes the metal is covered with a white frost, each filament of which rapidly lengthens, and in ten or

fifteen minutes the bar is completely covered with a white coating of alumina, the filaments of which reach two centimetres in length, if the apparatus has been kept from movement or from currents of air. The oxydation is so intense that the bar is raised to a burning temperature. This has been provoked by the slightest trace of amalgamation, so slight that the bar of aluminium, if weighed before the bath and after wiping, will not show sufficient difference in weight to be detected by the most delicate scales, and chemical analysis can detect no *mercury* in the alumina. Yet this infinitely small quantity of *mercury* has sufficed to cause the intense chemical action; it is a catalytic action; the *mercury* has been infinitely divided, and has acquired thereby diastatic properties.

Metal ferments can be prepared in two ways: by a chemical process, according to the method of M. Trillat, or by an electric method furnished by M. Bredig, who was the first to make these curious products known.

Trillat's method is to precipitate feeble solutions of metallic salts by an alkali in the presence of organic matter, especially *albumin*. In some hours the precipitate redissolves and furnishes solutions endowed with remarkable oxygen-reducing properties; in short, true artificial oxydases are produced which rapidly reduce oxygenated water, and effect the oxidation of quinones or of pyrogallol. Solutions of metal ferments made in this way have been given to subjects attacked with tubercular meningitis. The results observed have been striking, but transient. Patients who were comatose for a short time regained consciousness, a considerable defervescence took place, and urinary analysis showed an intense leucolysis and a great evacuation of toxic materials. The disease, however, resumed its course, and the patients died. The treatment, carried on by subcutaneous injections, in many cases led to necrosis on account of the alkalinity of the solutions, and had on that account to be discontinued. Recourse was then had to solutions obtained by means of electricity after Bredig's method, which is, shortly, as follows: in a porcelain capsule in a small quantity of pure, cold water, an electric spark is passed between two electrodes of the metal which one wishes to make soluble. The quantity of electricity and the voltage must not be too great. At each spark one sees a little cloud

form, like dust, of metallic vapour, which rapidly disappears in the liquid, and this, little by little, becomes more and more pronouncedly coloured. Gold gives a violet solution, silver a brown one, platinum and palladium a black. When the operation is finished the solution is filtered through a rather thick filter paper. It is impossible to fix much metal in the water, as concentration is soon obtained, and then the whole of the metal precipitates.

Metallic solutions of this kind contain about 30 milligrammes of metal per litre. When examined by the ultrascope, and a powerful ray of light is passed through them, one can see on a dark ground a number of small luminous points, which represent the light diffused by the metallic particles in suspension in the liquid, the particles themselves being of the size of the one-hundredth of a micron, or less. Each particle is animated by a vibratory movement, the Brownian movement, which is the more lively the smaller the particle. If a solution be watched day by day, one notices the particles increase in size, and their movements become slower; then their number diminishes, and at the same time a deposit is produced which becomes more and more apparent. It would seem that the particles aggregate, become larger, and fall when they attain a certain size. When the Brownian movement has disappeared the diastatic action also disappears. It is to be remarked that the properties of solutions of metal ferments seem to be identical whatever the nature of the metal dissolved, whether gold, or silver, or palladium, &c. It is doubtful for what length of time these solutions preserve their activity, for metal ferments require special physical and chemical conditions. They die like ordinary organic ferments, like yeast and enzymes, when they are submitted to certain toxic agents: *morphia, chloroform, arsenic.* Any electrolyte will at once kill the metal ferment and stop short its catalytic action, without the solution having apparently undergone any alteration. Ordinary glass may not be without some influence on the ferments, so that their preservation for a long time is a matter of difficulty. But there remains much to be discovered with regard to them, and the subject needs patient labour for its elucidation.

RHEUMATISM AS A FACTOR IN PELVIC PAIN.

By Dr. CASH REED, Liverpool.

SINCE the publication of my paper on "Pelvic Pain in Women" in your last issue, the relation of rheumatism as a contributory factor thereto has come unusually prominently before me. I will not trouble you with a recapitulation of the instances referred to in above paper, but supplement them with two or three others. The failure to improve a given case of dysmenorrhœa, *e.g.*, has resulted in the temporary interment of many a budding reputation. If, however, the fact that rheumatism is a most important contributory agent to pelvic pain be more widely grasped by what I submit in this short paper, then my task is a pleasant one, for patients will be benefited, and my friends' reputations maintained. I purposely spoke of *temporary* sepulture, for reputations in such cases are like sutures similarly situated, which have a happy knack of becoming negligible quantities.

CASE I.—Mrs. X., about the menopause, with a grown-up family, consulted me, a month or two ago, for pelvic pain, referred to the hypogastrium, relieved by movement, in fact, she could sometimes walk a couple of miles, when it would recur. It was worse in bed, frequently waking her up in the small hours, and worse also on turning in bed from one side to the other. She thus frequently had to rise at night to apply a mustard leaf in order to get relief.

Some seven years ago she had a child born, in a remote country place, with the complication of placenta prævia. The exigencies of the situation resulted in a very prolonged illness, the pelvic factors of which were cellulitis and endometritis. For the latter curetting was done. When I saw patient she complained also of pain in the right arm, with, after use, the usual paretic condition associated with a neuritis. She told me she had had expert advice, and was assured that there was nothing wrong internally, in fact, that the condition was conspicuously normal. On examination I found a great number of cicatrices with their falciform edges in relief, in the right and left vaults of vagina and in Douglas' pouch. The uterus was in normal position, but painful on movement.

Here was the key to the situation. Before examination sundry remedies had been employed without conspicuous benefit. Now *salicylate of soda* (natural) in 5-gr. doses, three times a day, was given. The result was dramatic. The patient has now gone to the extreme North of Scotland, in the confident assurance that all will be well, and in this I believe she is correct.

Remarks.—I referred to Dr. Ord, of St. Thomas's, in this connection in my paper, but his contention had reference to repairs of cervix in cases of laceration of that structure, and I showed an instance of this. I remember, many years ago, the late Dr. Bishop, of Edinburgh, the intimate friend of many of this generation of medical men, who was then private assistant to Professor (now Lord) Lister, advancing the view that a very obscure case of painful liver was due to rheumatism of its fibrous structure. He advanced the theory with some qualification, and it was received with that freezing urbanity, which is the prerogative of a lofty, if limited, intelligence in high places. Had *salicylate of soda* been known in those days, my impression is there would have been a scenic undoing of the opposition.

CASE 2.—Mrs. B., aged 30, complained of intermenstrual discharge and pain (mittelschmerz), green leucorrhœa, dyspareunia and hæmorrhage after coitus. She had had three dead-born children. On examination I found a tear on left side of cervix, with nodular edges, and metritis also. The introitus was healthy, so the dyspareunia could not be due to a lesion of that part of canal. In view of the likelihood of syphilis in this case I gave *merc. cor.* with distinctly satisfactory result, but the case only partially cleared up. At an interview now she volunteered the information that pain in the womb was much worse in damp weather, and that coitus was specially bad then. She added that she had been subject to rheumatic pains. She was therefore ordered *sod. sal.*, gr. v., t.d. At her next visit my notes say: "Patient is wonderfully better in every way, and she says 'the discharge after coitus and all the other symptoms are gone.'"

I should like to have cured these cases with distinctly homœopathic remedies, but I did not. Sometimes one employs antagonistic remedies with the object of clearing up some

ambiguity about a case, that is for diagnostic purposes, and it sometimes happens in such a circumstance that the patient is cured! If the patients referred to require further treatment, I shall probably give a course of *bryonia*, or *actea* and baths, and waters rich in *sulphur*. This last, by the way, combined with *guaiacum*, was a great remedy of the late Matthews Duncan. The combination is significant. I see in the latest publication I have come across on "Dysmenorrhœa," viz., that by Herman in the *Clinical Journal*, the writer lays stress on *guaiacum*, which seems to be his sheet-anchor in cases of this trouble. One may just mention also Dr. Luff's experience with *guaiacol* in rheumatic conditions. In the light of the evidence adduced I think it is quite obvious that cases of pelvic pain should be investigated in the light of a possible rheumatism underlying all. There is with us but little time to do this sometimes, with the enormous number of out-patients at our dispensaries. Ninety-three thousand was the number of attendances last year in all the branches added together. Recognising, however, in future, the point I have dwelt upon more clearly, I shall look to a better record of results in some of these obscure cases of pelvic pain in women.

A NOTE ON COLLINSONIA CANADENSIS.

By W. THEOPHILUS ORD, M.R.C.S.Eng., L.R.C.P.Lond.
Fellow of the British Homœopathic Society.

Collinsonia is one of the drugs introduced to homœopathy by the late Dr. Hale in his *New Remedies*. It is chiefly used by us in piles and constipation, also in inflammatory conditions of the rectum. But its sphere of usefulness is actually far wider than this, and, indeed, almost rivals the polychrests in extent and value. My attention having lately been drawn to this fact by an article by Dr. Ellingwood, in the *Medical Brief*, it seemed that a short sketch of the drug incorporating these recent experiences might be of interest to readers of the British Homœopathic Review.

The action of *collinsonia* on healthy human subjects is to produce portal congestion, followed next by catarrh of mucous

membranes, and, finally, cardiac distress, ending, presumably, in dropsy. It seems probable that the heart symptoms are produced by back pressure through the right side of the heart, secondarily to the venous congestion and engorgement which is the primary effect of the drug. Necessarily the lungs also are engorged, pains and cough are experienced, and in *Clarke's Dictionary of Materia Medica* "hæmorrage from lungs" is recorded as a symptom, whether cured or produced is unfortunately not stated. The catarrhal condition of mucous membranes affects them all, from nose to anus, and is produced by the venous engorgement of the capillaries and blood supply. In accounts of the provers, and of cured cases, it is not easy to detect if *collinsonia* has any specific action on the nervous symptom, but Farrington compares its action to that of Stannum in neurasthenia; and in Dr. Burt's provings "irritation of cardiac nerves" was thought to have occurred. These facts are sufficient to indicate that the sphere of action of *collinsonia* is more extensive than we generally suppose, and that it should be thought of in many conditions in which we tend to ignore it. These conditions may be briefly considered under the head of its three spheres of action—(1) portal and gastric, (2) mucous membrane, (3) cardiac.

(1) *Portal.*—The two common uses of the drug come under this head, *i.e.*, for piles, usually with bleeding, and with a sensation as of sticks in the rectum, with pressure; and for constipation, especially if associated with piles and bleeding. But it is obvious in tracing the action of the drug in the system that this begins in the liver, and that a passive congestion of that organ is the first step in the chain of symptoms that follow. Hence we have gastric disturbance with diarrhœa; this results—by exhaustion—in an atonic condition of the stomach, and also of the bowels, thus causing a condition of extreme constipation. Colic, flatulence and nausea, with cutting pains in the stomach at rest, and weight in the epigastrium, are symptoms which sufficiently indicate the cases of gastric disturbance which *collinsonia* will relieve. Dysentery with hæmorrhoids and tenesmus is also amenable to this remedy, and its use in sub-acute *proctitis* and *prolapse* both of rectum and vagina must not be overlooked.

But whilst the effects of portal congestion on the circula-

tion in mucous membranes has been made use of, the fact that venous congestion in the superficial and other veins occurs has been ignored. In the paper referred to above, attention is called to the fact that *collinsonia* is of great value in *varicosis in any locality*. Dr. Ellingwood has for twenty years past used it in persistent varicosity in the limbs, in varicocele in young men, and lately in a case of acute varicose veins in the vagina in a woman five months pregnant. In all these conditions the results have been marked and satisfactory, and many reasonably early cases of varicose veins and of varicocele have been cured by *collinsonia*, when indicated by the total symptoms.

(2) *Catarrh of Mucous Membranes.*—Whilst the primary effect of *collinsonia* in mucous membranes is due to venous congestion of the capillaries, the secondary effect is to cause chronic catarrhs with mucous discharges. Hence, in the nose we have nasal catarrh, with heat of face, frontal headache, and also bleeding piles and constipation. Such a combination will certainly yield to this remedy. Similarly catarrh of the pharynx, larynx, and bronchial tubes, when accompanied by symptoms of portal congestion, especially if relieved by bleeding from anus, returning when bleeding ceases, are especially amenable to treatment by *collinsonia*. It has been used also with success in sub-acute cystitis from pelvic congestion, and should not be forgotten in this condition. Mucous discharges from the bowels, both with constipation and diarrhœa, indicate the secondary stage of its action on the venous capillaries lining the membrane. Hence in muco-enteritis, and in some forms of dysentery, *collinsonia* will effect a cure, and has been so used by Dr. Ellingwood.

It has also a special value when given before operations for fistula, piles, or other rectal conditions. Much as *arnica* is known to be of value previous to operations on other parts, so *collinsonia* finds its sphere in strengthening the rectal circulation and removing congestions preparatory to operations in that region.

(3) *Circulatory.*—The action of *collinsonia* on the heart has been referred to. It is said to produce good results in functional heart disorders with palpitation, when pelvic congestion is present, and especially when the symptoms are relieved by hæmorrhage from rectum, only to return after cessation of

that discharge. Sensitiveness about the heart, fulness, oppressed breathing and faintness are indicating symptoms, according to Dr. Clarke. *Collinsonia* is said to also be of use in cardiac dropsy, and when the general congestive symptoms are present; it might certainly be tried then with a prospect of success.

Sufficient has, perhaps, been said to confirm the statement that *collinsonia* has a wider field of action than some of us may have supposed, and probably we might all study the drug carefully and use it more frequently with success. Finally, Dr. Clarke tells us that pains in the limbs and joints were experienced by some of the provers, and that neuralgia and rheumatism in suitable cases have been also cured by it. There need be no difficulty in selecting these cases, if the fundamental principles of the drug-action be kept in mind, *i.e.*, portal and rectal congestions, with tendency to venous hæmorrhages and mucous discharges, usually with piles and constipation.

Clinical Cases.

By E. W. BERRIDGE, M.D.

(*Continued from p.* 360.)

Case 13.—*Kali carbonicum.*—March 16th, 1872, Mr. F. R., aged about 25, sent for me in the evening. About a week previously he had caught cold from changing his dress. For the last five days frequent desire to swallow the saliva, but was often unable to do so; and when thus unable, it caused a choking in throat, the heart beat quicker, and he felt weak, with difficulty of breathing. He could swallow food or drink. At first the symptoms came on by night only, but he has had them all this day also. When lying on right side the heart felt suspended to left ribs, and seemed dragging them to right side. This morning he had pain as if lower lobe of right lung were adherent to ribs. For last three nights has only been able to sleep sitting up, because otherwise the saliva would not run down throat. Heart's action irregular and tumultuous, with systolic murmur, loudest at apex.

Diagnosis of Remedy.—Sensation as if heart were suspended : *Kali carb.* (1073).

Sensation as if lungs adhered to chest : *Cadm. s.* (86), *euphorb.* (183), *gadus* (39), *kali n.*, *mezer* (906), *ran.-bulb.*, *senega*, *thuja* (2040).

The remaining symptoms being either vague, or not found in the *Materia Medica*, the choice rested between these two. The first was the most characteristic, as it belonged to only one remedy ; though the second was more characteristic as being a later symptom.

I gave one dose of *kali carb.* 4 m. (Jenichen) at 10 p.m.

March 17th.—Saw patient at 5 p.m. Had slept well, and could lie down last night. Throat symptoms nearly gone to-day. Heart quiet all night, and ever since. No pain in chest. Feels stronger. Auscultation showed heart to be regular and quiet, and systolic murmur less. Soon recovered completely and permanently.

Comments.—(1) This case shows the value of keynotes. A keynote is a symptom, or group of symptoms, so characteristic of a remedy, that whenever we meet with it we always, or nearly always, find the remainder of the symptoms also under that remedy. Hence in prescribing according to a keynote, we do not ignore the totality of the symptoms, but merely use that keynote as a guide thereto. Cases occur in which, through the imperfections of our *Materia Medica*, we cannot cover the totality of the symptoms. Here keynotes are especially invaluable ; because, if we can cover these, we may safely neglect the remaining vague and general symptoms which may be found under many medicines, though not, perhaps, in the existing semeiology of the one in question. In other cases we may find two or more conflicting keynotes; often here the true *simillimum* is a remedy yet unknown, but which comprises all, as subsequent provings have more than once demonstrated. In such cases we must decide which is the most important keynote, and select the medicine to which it belongs as the best indicated remedy; and when its curative action is completely exhausted, make a fresh selection for the remaining symptoms. In a third class of cases there may be no keynote discernible, all the symptoms being of nearly equal value, and all belonging to many medicines. Here the only plan is to eliminate, one by

one, the medicines which have not all or the majority of the symptoms, and to select that which corresponds to the greatest number. A writer has said that to call keynotes "a quintessence of symptoms," and "always characteristic symptoms," is too flattering a description of many of them; also that "the idea of a keynote, which is a single symptom or condition of occurrence of a symptom which, if present, shall infallibly guide us to a certain remedy, is antagonistic to Hahnemann's insistence on the necessity of the correspondence of 'the totality of the symptoms,' or of 'the more striking, singular, uncommon, and peculiar (characteristic) signs and symptoms.'" But this latter expression of Hahnemann is exactly what is meant by a keynote; and his advice here is not only a necessary rule for the selection of the remedy when we cannot cover the "totality of the symptoms," but also a valuable guide to a more rapid prescription even when we can. And when the same writer continues that "when such a keynote is found not among the pathogenetic effects of the medicine, but is got from clinical experience, or some other source [what 'other source' is possible?], the divergence from Hahnemann's treating is still more obvious"; it suffices to reply that Hahnemann himself incorporated clinical symptoms in his *Materia Medica;* and that Bœnninghausen's *Repertory*, which Hahnemann said he preferred to all others, contains many of them. A good knowledge of keynotes saves much time and labour; it is, however, a method liable to abuse by the careless and incompetent, and should only be employed as Opie mixed his paints: "With brains, Sir!"

(2) This case is a practical argument against the unscientific and unhomœopathic method of alternation which Hahnemann emphatically denounced. Several symptoms of the patient had not been recorded under *kali carb.;* but by prescribing only one medicine at a time, and not alternating it with some other on the pretext of covering the totality of the symptoms, not only was a good cure effected, but some additional clinical symptoms were obtained, which, if verified, will prove of great value. A writer has given his opinion of alternation, that "in many cases it is a most valuable method; and considering the often composite character of the cases we meet with in practice, it is frequently an indispensable and

strictly scientific mode of practice, and it was recommended and practised by Hahnemann himself in many of his published works and in his letters." That some physicians may find it "indispensable" is not denied; others do not; and it all depends upon our knowledge of how to use the *Materia Medica* and *Repertory*. But how it can be "strictly scientific" to prescribe alternated medicines before they have been proved in alternation is less easy to understand. The assertion that Hahnemann recommended and practised alternation is a "terminological inexactitude," based upon a misconception of what he taught, and upon an ignoring of the essential difference between *à posteriori* "alternation" (the change of remedy according to a corresponding change of symptoms), and *à priori* "alternation" (the change of remedy without such corresponding change of symptoms). Hahnemann's clear statement (*Organon*, 272 and note) demonstrates what his teaching and practice really were.

(3) This case shows that homœopathy can cure even organic cardiac disease. The patient had incipient rheumatic endocarditis from catching cold, and the systolic murmur denoted that fibrin was already deposited on the valve. In chronic cases, where the fibrinous deposit is of many years' duration, and the valve thickened and distorted thereby, a complete cure cannot be expected; but even here homœopathy will best palliate the symptoms, and so enable the patient to pass the remainder of his days in comparative comfort.

(4) The following comparison of similar symptoms may be useful. In 1888 Mr. A., aged 45, told me that about six years previously he took *causticum* 6, thrice daily, for deafness. It caused a feeling about apex of heart as if there were strings there breaking. Twice afterwards he took the same twice daily, and each time it produced the same symptom, though to a less extent. In 1868 I cured with one dose of *cinnabar* 200, "Sometimes when lying on right side she feels as if the contents of body, from axilla to hip, were being dragged over to right side, causing a feeling as if she had no room to breathe."

RECURRING ATTACKS OF ACUTE LOCALISED ŒDEMA.

By Dr. W. F. H. NEWBERY.

(*Continued from p.* 366.)

SINCE writing my last report of the above I have received a very kind note from the senior Editor, suggesting that this is probably a case of "Angio-Neurotic Œdema." I think I may be excused for not "spotting" it, as I have not found any colleague, "Allopathic" or "Homœopathic," who has ever seen a case. The literature, too, is very meagre on the subject. Next month I hope to give some further account of the progress of the case. In the meantime I shall be rather disappointed if what I have already reported does not call forth any comments on this very rare complaint.

SHORT CLINICAL NOTES.

By Dr. COMPSTON, Crawshawbooth (Lancs.).

Lachesis.—This medicine is of great value in the debility some patients feel in spring. I have several patients who are troubled with *debility, usually associated with want of appetite and emaciation*—such symptoms as would suggest tuberculosis or other wasting disease—in the spring time. I have found *Lachesis* 30, t.d.s., of great value in this condition. I might add that the most marked cases have been females, and have belonged to families in which there was a history of tuberculosis.

Sulphur.—I will give two cases showing the use of this invaluable medicine. *Girl*, aged 17, thin, bilious temperament. Suffered from nocturnal enuresis when about 8 years old. Family and personal history good. For several months has had almost nightly enuresis during sleep. During the day there was a *sense of tenesmus in bladder region at end of micturition.* Mouth very parched on waking in morning. One dose *sulph.* 30 given, and for three weeks after this she only wet the bed three times. Another dose completed the cure. *Gentleman*, aged 39. Lympho-sanguine. Rheu-

matic and gouty family history. Healthy life and good habits. Eighteen months ago he developed an itching eczema of lobes and ear passages, with steadily increasing deafness. These symptoms were aggravated by bathing in salt water or if run down. His voice sounded a long way off to himself. Politzerising did not improve him. He had been to one or two ear specialists without benefit. A single dose *sulph.* 30 improved him so much that it was three months before he wrote to tell me he was quite better, the condition having gradually improved.

Æsculus. — Married lady, aged 35. Three children. Lympho-bilious. Very bad family history of rheumatism and phthisis. For years has had trouble in lower part of back; this has been much worse since child-bearing period, she having had pelvic abscess, &c. She has been to several doctors for her back. It was in *left sacro-sciatic region, aggravated on first rising in morning, having a stiff, bruised feeling; also much aggravated by prolonged exertion, especially the day after* the exertion. It was also aggravated three days before and during menstruation, which is regular, but excessive, lasting seven days. No complaint of piles. Dose, *æsc.*, cm. For a few days was decidedly worse, since then her back has not been so well for years, and she does not feel it in the morning. The patient is still under treatment for some uterine condition, which did not yield to a second dose of *æsc.*, cm., but has greatly improved since dose of *sep.*, cm., followed by *æsc.*, cm. I may say there were several weeks between each dose of medicine.

Cases from Hospital Practice.

This section is reserved for reports of interesting cases occurring in Hospital or Dispensary practice, new methods of treatment, and all purely professional matters. These should be carefully, or, if needful, elaborately recorded and described. Each contributor will, if necessary, be allowed two pages of the REVIEW every month for this purpose.
Reports should be sent on as early in the month as possible.

DEVON AND CORNWALL HOMŒOPATHIC HOSPITAL.

SODIUM SALICYLATE IN ATTENUATION IN A CASE OF SUB-ACUTE RHEUMATISM.

E. N., aged 25, when first seen was in bed, and stated that he had been unable to move for about seven weeks. On February 14th he was admitted. Pain was chiefly in shoulders, knees, ankles, and hands, and inclined to shift from one part to another. Free pespiration, with distinctly acid reaction. Heart *nil.*

In addition to usual auxiliary treatment, patient was put on a course of *bry.* About ten days after admission patient developed an acute attack of tonsilitis, which ran an ordinary course under the administration of *mercurius, hepar sulph.*, &c. On March 2nd patient was put on *colchicine* (Merk) $\frac{1}{180}$, ♏ iv., 4 h. I have nearly always found *colchicine* give relief, but this time I was disappointed, and very little progress was made, though various remedies were tried up to March 19th. On this date *sodium salicyl.* 3 x., gr. ij. (in tablets), 3 h. was given, with *ars. iod.* 3 x., gr. iij. (in tablets), t.d. p.c. Improvement was marked and continuous, so that on April 4th patient was discharged practically well. He was told to come up as an out-patient, but as he did not do so, the conclusion is that he did not find it necessary.

Remarks.—The case is noted as being cured by a remedy in attenuation, which "our friends the enemy" would have given in doses of from gr. x. to gr. xx.

W. F. H. N.

BRISTOL AND CLIFTON.

A Case of Protracted Diarrhœa.

Florence F., aged 23, came to the Hahnemann Hospital on March 1st complaining of diarrhœa, from which she had suffered for eighteen months.

It occurred nearly every morning on rising, and was accompanied by much flatulence, but no pain. The stools were described as being fairly normal in appearance, containing neither mucus nor blood, and there was no prolapse. The motions were retained with difficulty, and in addition to the two or three actions of the bowels in the morning, the diarrhœa sometimes occurred later on in the day also. *Podoph.* 3.

A fortnight later the patient reported having been troubled only on one morning, and had left off the medicine on account of constipation. *Hydrastis* 3x was now ordered.

In another fortnight's time the report was not so favourable, the diarrhœa having returned on two or three mornings. *China* 1 was substituted, and sufficed to complete the cure, there being no return of diarrhœa, but the bowels acted naturally once a day.

Although *Podophyllum* was indicated by the sudden, painless character of the stools and morning aggravation, it was not alone sufficient to cure the patient, but required to be followed by *china*, probably on account of the poor state of the patient's general health.

C. O. B.

BIRMINGHAM.

An Old-Standing Case of Frequency of Micturition and Alternative Incontinence—Cured by Cantharis.

N. P., aged 19, single, came to the out-patient department on May 16, complaining of frequency of micturition and incontinence.

The patient, a well-developed, healthy looking girl, said that all her life she had been unable to retain her urine for more than two or three hours day or night. If she endeavoured to do so beyond this time involuntary dribbling

invariably ensued. An examination of the urine revealed no pathological condition. It was not even unduly acid. She was given *bell.* 3x t.d.s. and told to report in a week.

May 23rd. No improvement. *Cantharis* 3x t.d.s.

May 27th. Patient now reports a great improvement. She is disturbed once only in the night. Repeat *cantharis.*

May 30th. Apparently cured. She is sleeping right through the night and passes water three times a day only.

June 6th. Discharged.

She has reported since that there has been no further trouble.

Notes.—The curious feature of this case was the fact that the dysuria, cutting and scalding of *Cantharis* were entirely absent; the only discoverable symptoms being the frequency of micturition and the alternative incontinence, the tenesmus being absolutely painless, though the bladder was apparently intolerant of any quantity over two ounces.

Whatever the old-standing sensitiveness was due to—and she was emphatic that she had been troubled with it all her life—and in spite of the paucity of symptoms, *cantharis* was evidently the *simillimum,* for the relief it gave was striking and instantaneous.

Cases such as this, of cures of complaints of many years standing, completed in a few days by infrequent and infinitesimal doses of medicine, are remarkable testimony to the efficacy of the homœopathic principle. A. A.

LONDON HOMŒOPATHIC HOSPITAL.

(*Children's Department.*)

Two Cases for Diagnosis.

Violet W. F., aged 13 months, was brought to me from the country with a swelling on the left side of the neck. The child was fair and healthy, tissues somewhat flabby, with prominent forehead. The parents were healthy.

At 11 months old this swelling was first observed, and it had steadily enlarged.

The family doctor had diagnosed either "a hernia of the lung," or a "fatty tumour."

There was a swelling on the left side of the neck above the

clavicle, the size of a pigeon's egg. It was soft and painless, with distinct fluctuation, without redness; the skin moved freely over it. To transmitted light (examined with the electric lamp) it was as translucent as a hydrocele of the tunica vaginalis. It was in fact a simple cyst of the neck, or, as it is sometimes called, a hydrocele of the neck. The parents told me Mr. C., surgeon to one of the London Hospitals, had diagnosed it a nævus. I subsequently learnt that the child was taken to see Mr. L., of another Metropolitan Hospital, who confirmed my diagnosis of a cyst.

The following cases are from the London Homœopathic Hospital clinic:—

Charles D., aged 6 months, came with a swelling of the right side of the neck, below the ear and posterior to the ramus of the jaw. It was the size of half a tangerine orange, painless, with no inflammatory redness of the skin. It was soft and somewhat fluctuating to the touch, and when firmly squeezed could be much reduced in size. It was not translucent to transmitted light, over one part the skin was a small area of conspicuous dilated veins. It was a very vascular nævus.

Lachesis 12 in Diphtheria.

Annie W., aged 2, came on May 24th, 1907, with a temperature 101·4°. She was very fretful, but able to come with her mother to the hospital. On examining the throat, a suspicious patch of membrane was seen on the left tonsil. With a swab I wiped off some of this, and the operation was accompanied by slight bleeding, although no force was employed. The swab was submitted to the Pathologist of the hospital, who reported, in due course, "cultivations made from the swab show the presence of the diphtheria bacillus." *Lachesis* 12, three hours, was prescribed.

On May 27th the patch on the left tonsil had entirely disappeared, the child was very much better, with a temperature 98·6°.

On May 30th improvement was maintained, and *china* 3x *ter die*, was substituted for *lachesis* 12.

On June 7th she was feeling quite well.

ONOSMODIUM 3 IN CEPHALALGIA.

Walter R., aged 14, has been attending for some time with severe headaches, generally has two or three a week, ending with vomiting. He is a nervous boy, given to sleep-walking. *Bell* 3 and *iris* 3x were prescribed at various times with benefit.

I then found he was astigmatic with both eyes. This trouble was corrected, but still the headaches continued.

On May 17th, 1907, I prescribed *onosmodium* 3, and on June 7th he reported having had no headache for three weeks.

Dr. Clarke's *Materia Medica* says "*onosmodium* has probably cured more cases of headache associated with eye-strain than any other remedy since it was proved."

J. ROBERSON DAY.

BROMLEY.

ACUTE MASTITIS FROM PIN PRICK.

Miss M. P., aged 21, came to me on May 14th with history of pricking her right middle finger while fastening a collar ten days previously. The wound was festering and patient said there was some tenderness in the axilla. Boracic compress locally. *Lach.* 6 every three hours.

May 16th. Finger much better, tenderness in axilla almost gone. Repeat.

May 24th. Patient returned saying finger got well in two or three days, but the tenderness in axilla had never quite gone, and during the last twenty-four hours had become acute. On removing the scab from finger a bead of pus escaped, a small tender gland could be felt in the axilla. Ordered poultice to axilla. *Hepar. s.* 3 every three hours.

May 24th. Patient in bed. Had slept little owing to pain in right breast, which was now swollen and tender. Temperature 100·5° F. Pulse 98. A red streak extended from breast to axilla. *Rhus. T.* and *Lach.*

May 25th. Temperature last night 103·5° F.; this morning, 102° F. Pulse 108. The breast was now very swollen and red all over. *Rhus. T.* and *Sulph.*

In the evening temperature had risen to 104° F. though by 8 o'clock was 102·8°. Pulse 110. *Bell.* every two hours.

May 26th. Temperature 100° F. Pulse 100. Had been

delirious in night. Breast hard and bright red. No fluctuation could be made out, but several hard nodules throughout the gland. Under gas a free incision was made in outer part of mamma, a drainage tube inserted and packed with iodoform gauze. No pus found. Bleeding slight. Repeat.

Four hours later outer dressings removed, aseptic compress applied. Patient feeling very comfortable.

Three hours later I was sent for, the nurse saying that soon after my second visit hæmorrhage had set in and had continued ever since. On removing the dressings a small skin vessel was pumping, which was easily stopped with pressure, but the patient was very exhausted and faint. Pulse difficult to count. *China* every hour.

May 27th. Good night. Temperature 97° F. Pulse 75. Breast still hard and tender, redness almost gone, patient looks pale. *China.*

May 28th. Doing well. Temperature last night 99° F., this morning 97° F. All redness gone from breast, which is smaller.

May 29th. Drainage tube removed, and from this date temperature never rose above normal. The mammary gland gradually resumed its normal size, though for some days the lobules were distinctly indurated. It was a fortnight later before she was sufficiently recovered from the blood depletion to go down to the seaside.

H. W. T.

Correspondence.

ANGIO-NEUROTIC ŒDEMA.

To the Editors of THE BRITISH HOMŒOPATHIC REVIEW.

DEAR SIRS,—My friend, Dr. Newbery, has written to ask if I had seen cases, and could supply any information as to the etiology of Angio-neurotic Œdema. If so, would I do so in July number of "REVIEW"? In reply let me say that sundry cases are scattered through my hospital and other notes, but they require unifying, a task which I must defer to some future occasion.

Liverpool,
June, 1907.

WM. CASH REED.

Foreign Reports.

FRANCE.

NEURASTHENIA is a common disease at the present day. Dr. P. Jousset has just described, in the *L'Art Médical*, a case, with the treatment he proposes.

A lady patient of his was, in the month of January, 1906, attacked with influenza. This was the occasion of an attack of neurasthenia, which began on January 31st, with anguish of mind, disordered sleep, and loss of strength. A prominent symptom that persisted for more than six months was a state of mental anxiety, characterised by fear; fear of events caused by socialism, so that she would have no money in the house. She was the same in regard to her own affairs; she dreaded the most necessary resolutions; she found scruples in what she had or had not done; she was a prey to a constant indecision. Fear, scruples, restlessness and anxiety characterised her condition. Night brought her no relief, though the form of the disturbance was altered; she was sleepless, and so hot that she was forced to uncover herself. She continually changed her position in bed; she was restless and desired to get up, and with it all there was almost the fear of death.

Her appetite, which was usually moderate, was now almost gone; she hardly ate anything, and as this went on for months she got very weak. During this time she was prone to attacks of *lipothymia*,[1] which frightened her very much. There was excessive anguish and fear of death, indefinite pains were felt all over the body with the exception of the head. During these attacks she was obliged to lie down, as she felt too weak to sit up.

Nux vom., *ign.*, *tarentula*, and several other drugs were tried without any benefit. From a more attentive study of the symptoms, it was thought that *aurum* and *arsenicum* were indicated. *Aurum* 30, three globules thrice a day, and *arsenicum* 12, three globules in the evening, rapidly improved the case, so that by September she was practically cured. The attacks of lipothymia had been cured by *moschus* 1.

[1] A group of symptoms indicating profound failure of the vital functions, for which Gee has revived this old term *lipothymia*.—(SEN. ED.)

An examination of the pathogenesis of *aur.* and *arsen.* will show the perfect homœopathicity of our treatment.

Arsenicum.—This drug was given on account of the disordered sleep. On comparing Hahnemann's *Materia Medica Para*, we find she cannot fall asleep before midnight on account of anxious heat, for many days (1010). About 1 a.m. excessive anxiety; sometimes she is hot, sometimes as though she would vomit (1009). The nocturnal pains only become tolerable when she walks about (773). She can find rest in no place, continually changes her position, will get out of one bed into another, and lie now here, now there (1008). Hahnemann says that this nightly restlessness "scarcely occurs so markedly in any other medicine." After midnight, feeling of anxious heat with desire to throw off the clothes (883). The whole night much heat and restlessness, on account of which she cannot fall asleep, at the same time pulsation in the head (874). We would further notice that the mental symptoms of *arsen.* and those of our patient were quite in accord, for Hahnemann expressly remarks anxiety and anguish with restlessness.

Aurum.—This drug has for long been regarded as an important one in cases of melancholy. Hahnemann asserts that he has cured cases of melancholy with a tendency to suicide by the first trituration of *aurum.* He further states that he has obtained more complete and rapid cures with *aurum* 30. In his *Materia Medica* we find the following: Very much given to feel offended; the slightest thing which he thought offensive affected him deeply, and caused him to resent it (337). He sits apart all by himself in a corner, wrapt up in himself as if in the deepest melancholy, if left undisturbed; but the slightest contradiction excites the greatest heat and anger (340). Constant sulky seriousness and reservedness (341). Peevish dejection; he thinks nothing will succeed with him (342). He thinks that everything happens awkwardly, or that he does everything awkwardly (343). Always restless and undecided . . . this condition deprived him of all perseverance, all energy (347). Great anxiety, that has its origin in the præcordial region . . . and that drives him from one place to another (350). Melancholy; he imagines he is

unfitted for the world; he is filled with intense delight when he thinks of death, so that he longs to die (356).[1]

The above extracts are sufficient to show how closely the symptoms of the patient corresponded to those of *arsen.* and *aurum*, as found in our *Materia Medica.*

DR. PAUL TESSIER.

GERMANY.

AT the two first meetings of the Berlin Homœopathic Society, held during the present year, two interesting and valuable papers were read, the one by Dr. Bastanier, Berlin, on "Artificial Nutrition of Infants," the second by Dr. Dammholz, Berlin, on "Homœopathic Treatment of Gastro-intestinal Diseases of Infants." This latter paper will be noticed in a subsequent issue.

At the beginning of his statements Dr. Bastanier pointed out that in numerous cases (80 per cent. at the Charité of Berlin), *gastro-enteritis infantilis* is due solely to overfeeding. Rachitis, convulsions, cutaneous eruptions and anæmia are often due to, or aggravated by, the same cause.

The caloric value of cow's milk and woman's milk is nearly equal. But still, only healthy children digest undiluted cow's milk, and that not on account of the larger proportion of albumen or the coarser coagulability of cows' milk, but only on account of its heterogeneous composition. This heterogeneous composition is connected with the whey, and not with the albumen, as Finkelstein showed by his original experiments. He mixed cow's whey with albumen and fat of woman's milk, and *vice versâ.* The latter mixture agreed very well with the children whilst the former disagreed with them.

Bastanier thinks the doctrine that farinaceous food is indigestible for infants within the first three months a great error. This opinion has been refuted long ago, and it has been proved conclusively that saliva and pancreatic juice of the smallest children are able to digest amylaceous food stuff. When cow's milk is diluted it makes better gruel than water, and Bastanier recommends :—

[1] The numbering of the symptoms of *aurum* is apparently quite different in Dr. Tessier's edition of the *Materia Medica Para* and ours.—(SEN. ED.)

During the first month, 5 to 10 grammes of barley for 1 litre of gruel.

During the second month, 10 to 20 grammes of barley for 1 litre of gruel.

During the third to sixth month, 30 to 40 grammes of barley for 1 litre of gruel.

The gruel should be boiled for three-quarters of an hour. As the diluted milk shows a lower calorific value than pure milk, *carbohydrates* are added. Here Bastanier advises malt sugar (Maltose) which is contained in Mellin's Food, Soxhlet's "nourishing sugar" (Nährzucker), and Keller's soups.

Healthy children with increased foodstuff increase in weight, and show a great tolerance towards quantitative and qualitative alterations of this food.

Sick children are very sensitive to both. Only one certain specific nourishment agrees with them, and any alteration of composition or *increase* of quantity produces no increase but sometimes a decrease of weight (*Paradoxical Reaction.*)

There are *four different stages of disturbed nutrition* :—

I.—Disturbance of Balance.

Symptoms. — Paradoxical reaction. Normal stools. No fever. Intolerance (*a*) against fat (too much milk); (*b*) against any amylaceous food.

Diagnosis only possible by daily weighing.

Treatment.—Reduction of fat or flour in the food. *Thin milk,* buttermilk or gruel.

II.—Dyspepsia.

Symptoms.—Loss in weight. Increased and altered stools (slimy, green, yellow with white particles), fever to 40° C. (104° F.).

Treatment.—Milk diluted with much water.

Decomposition.

Symptoms.—Loss in weight, frequent loose stools, very little urine. Children look grey and are very quiet.

Treatment.—Wet nurse, or, if impossible, withdraw the total of fat and give "Magermilch," buttermilk without sugar. In convalescence add malt sugar, Soxhlet sugar, &c.

IV.—Intoxication (Non-Infectious.)

Symptoms. — Cholera infantum with albuminura and glycosuria.

Treatment.—For one to two days no food at all, but much water. Afterwards smallest doses of woman's milk ten times a day, 5 to 10 grammes.

The fever disappears mostly within forty-eight hours, the other symptoms more slowly. The child is not well until it is able to digest milk.

In infectious cases of gastro-enteritis, the fever is independent of the diet.

In the *discussion* following the paper, most of the members of the Society declined to adopt a scheme for the nutrition of children suffering from gastro-enteritis. They emphasised the good results obtained by them without a schedule like Dr. Bastanier's. The President, Dr. Windelband, said that the homœopathic medical treatment is the main point. Dietetic treatment stands in second rank. Only Dr. Gisevius, senior, and Dr. Gisevius, junior, agreed with Dr. Bastanier's views, and think it advisable for every up-to-date medical man to be master of the different methods of artificial nutrition. In the acute stage of gastro-enteritis Dr. Gisevius, junior, recommends to withhold all food for twenty-four to thirty-six hours, allowing only boiled water to drink. As soon as the symptoms are better, Gisevius gives one of the following preparations.

"*Combey's Vegetable Bouillon.*"—Ground maize, dry peas, dry white beans, barley, wheat, lentils. Boil 30 grammes of each with 20 grammes cooking salt for three hours in 3 litres of water until 1 litre only remains. Then filter. Stir one teaspoonful of wheatmeal, ricemeal, barleymeal or oatmeal with 100 grammes of this broth.

"*Acorn Cocoa.*"—Stir 40 to 50 grammes of acorn cocoa with 10 grammes of meal in some cold water, then pour over it 1½ litres boiling water and boil till only 1 litre remains. Then add 30 grammes malt sugar.

"*Keller's Malt Soup.*"—Into 350 c.cm. of milk 50 grammes meal are gradually stirred with gentle heating. Then 100 grammes Löflund's "Malzsuppen Extract" are dissolved in 650 c.cm. of lukewarm water. The two solutions are mixed, and boiled for two or three minutes with constant stirring.

"*Buttermilk Soup.*"—15 grammes of best meal are stirred up with 1 litre of buttermilk, then 60 grammes of cane sugar and a teaspoonful of fresh butter are added; the mixture is then heated to boiling and allowed to bubble up repeatedly.

This preparation Gisevius prescribes in cases of dyspeptic and emaciated infants, and in cases of chronic gastro-enteritis with insufficiency of digestion, fats, hydrates and albumen.

Dr. KRANZ (Weimar).

OPENING OF THE HOMŒOPATHIC HOSPITAL IN UTRECHT.

ON May 1st last took place, under the most favourable auspices, the formal opening of the new Homœopathic Hospital in Utrecht, before a gathering which was, in every sense of the word, a representative one. As our readers have already been informed, this Hospital consists of a wing of the Deaconesses' House in Utrecht, which has been leased for a period of five years by the "Society for the Furtherance of Homœopathy in the Netherlands." Here it will exist side by side with wards devoted to allopathic treatment, and will, as elsewhere under similar circumstances, doubtless be able to give a very good account of itself. As we have already said, the assembly was quite a representative one, for besides many State officials, there were present delegates from the "Society for the Furtherance of Homœopathy in the Netherlands," a very large number of our Dutch colleagues and their wives, as well as many influential lay supporters of homœopathy, with the Baron van Boetselaer in the chair. After reading a large number of congratulatory telegrams, the Chairman called upon Dr. Voorhoeve, President of the Committee, to open the new wing, which he did in a speech full of militant enthusiasm and "go." After him came Dr. Wouters, of Arnheim, with a brief address on "Hahnemann as a Man and as a Physician," which was listened to with rapt attention. After this the wards, two in number, and containing together twenty-five beds, were thrown open for inspection, and much praised by all present. Provided with central heating, well ventilated and well lighted, the work done in these wards promises, in the hands of Dr. A. I. B. van Royen,

the physician in charge, to be of the best. In connection with the wards is a well-appointed laboratory and spacious out-patients' rooms for the polyclinic in connection with the Hospital. We heartily wish our Dutch *confrères* "God-speed" in the work to which they have just put their hand.

Therapeutic Digest.

NATRUM MURIATICUM.—IN a paper entitled "Introduction to the Study of Natrum Muriaticum," by Dr. Edwardo Fornias in the *Hahnemannian Monthly*, a summary is given, culled from various sources, of the knowledge of the poisonous and other qualities of common salt acquired by various old-school authorities. This is of interest in connection with the two cases narrated by Dr. Stonham in the March Review. The use of water from chloride of sodium springs in the treatment of cold abscesses, adenitis, tubercular arthritis, &c., has given good results after evacuation of pus, baths or irrigations being employed with rapid success. In children with lowered vital functions, hypothermia, and in two cases green diarrhœa, sea-water, sterilised and diluted, was injected under the skin. General amelioration with increase of weight resulted.

On the other hand, the use of salt in albuminuria is dangerous, excess may lead to ascites, it being asserted by Strauss that the reason of the good effect of milk diet in Bright's disease is due to the small quantity of salt thus introduced into the system. In epileptics the suppression of salt in the diet is reported in thirty cases to have reduced the frequency and severity of the seizures. Also that half the usual doses of *bromide of potassium* sufficed to control the attacks in those who took no salt. In a paper on "Nephritis" our colleague, Dr. Sauer, of Breslau, recently stated that he had verified that: (1) The absolute abstinence from salt, in the healthy individual, produces albuminuria; (2) Excess of salt in the food brings about the same result; (3) The total suppression of salt in a nephritic patient lowers notably the quantity of albumen in the urine; (4) Excess of salt in food in nephritis increases the proportion of albumen and the dropsical effusions.

DEATHS UNDER ANÆSTHETICS.—IN the *New England Medical Gazette* for February is a valuable paper by Dr. Winfield Smith, of Boston, on *anæsthesia*, in which two cases of death are narrated. One occurred in a woman aged 64, who was etherised for reduction of a fractured neck of femur. Some hours after she had been put back in bed, she was found to be still unconscious and breathing deeply, and died next morning without recovering consciousness. A diagnosis of cerebral hæmorrhage was made, which was confirmed afterwards by *post-mortem* examination. The other case given is that of a man aged 40, who died immediately after the conclusion of an abdominal operation, before being moved. Breathing suddenly ceased, the case being one of sudden and complete paralysis of the respiratory centres. Every known method of stimulation was employed ineffectually. The author regrets that he did not re-open the wound and massage the heart, and gives an extract from the *Therapeutic Gazette* for April, 1904, where notes of twenty-eight cases are given in which this was done, with accounts of the three methods that may be employed. Reference is made to the so-called danger-signal under chloroform—that if the patient keeps his eyes open during narcosis, or opens them again whenever the surgeon closes them, some difficulty may be expected. This sign was noted in 21 out of 329 cases, and in each case there was either excessive vomiting, cessation of respiration, asphyxia, syncope, or prolonged excitement. The paper gives a summary of modern conclusions as to the safety of various anæsthetics, and is followed by a brief but interesting discussion.

Obituary.

MR. JAMES EPPS.

WE regret to record that the death took place, on April 22nd, of one who for more than half a century has been intimately associated in the public mind with homœopathy. We refer to Mr. James Epps, the well-known homœopathic chemist. The words "Epps" and "homœopathy" can hardly be dissevered in this country, so constantly does the one recall to mind the

other. Mr. James Epps was the third of four brothers, all of whom, but himself, were medical men, and also enthusiastic homœopaths. Of these Dr. John Epps was the most celebrated, and by his unflagging zeal in lecturing and his large practice did much to firmly establish what was at the time a new system of medicine. But the work done for the cause by Mr. James Epps was no less important. A homœopathic pharmacy which had been started by his brother, Mr. George Epps, in Southampton Row, was taken over by him when the former vacated it on becoming qualified as a medical man, and the business was soon removed to 112, Great Russell Street. A branch in the city was also established in Old Broad Street. The West-End business was afterwards removed to 170, Piccadilly, underneath the entrance to the Egyptian Hall, and that in the City to 48, Threadneedle Street. The premises in Piccadilly were retained for over fifty years, till 1904, when the Egyptian Hall was pulled down, and another location had to be found at 60, Jermyn Street, where the firm now carries on the business in more commodious if less prominent quarters.

Mr. Epps's careful and conscientious preparation of homœopathic medicines according to Hahnemann's directions quickly won the confidence of homœopaths, both lay and professional, and success was soon assured. This became phenomenal when to the ordinary business of a pharmacy was added that of a cocoa manufactory. Epps's Homœopathic Cocoa soon attained a world-wide reputation. It was the invention of his brother, Dr. John Epps, who patented a mixture of cocoa, arrowroot, and sugar, and recommended it to his patients instead of tea and coffee, which so frequently interfere with the action of homœopathic medicines. The heavy duty on cocoa had recently been lowered, the public was ready for a new beverage, and the business capacity and advertising ability of Mr. James Epps soon procured for the cocoa an enormous sale at a time when there were few competitors in the market.

In another way the firm of Epps has done good service to homœopathy, viz., in taking upon themselves the duties of publishers of homœopathic literature. Many medical works, notably those of the late Dr. Compton Burnett, have been published by them, as well as domestic handbooks and medical brochures of a popular kind.

Mr. Epps gave generously to homœopathic institutions, especially to the London Homœopathic Hospital, in which he endowed two beds, and he was always ready to do what he could to advance the cause of homœopathy, his enthusiasm for which never flagged. His attention to his business was unremitting till within a few weeks of his death. For many years he was accustomed to drive himself in a carriage drawn by a pair of black horses daily to his warehouses in the city, arriving there between 10 and 11 o'clock. He was born on April 29th, 1821, so that he had almost completed his eighty-sixth year. His only son, Mr. James Epps, junr., an active member of the firm, predeceased him, having unfortunately died suddenly while on a visit to the West Indies in February, 1905. Mr. Hahnemann Epps, his nephew, and the brother of Dr. Washington Epps, Physician to the London Homœopathic Hospital, is now the senior member of the directorate of the private limited liability company into which the business was turned in 1893.

Reviews of Books.

Medical Priestcraft: A National Peril. By John Shaw, M.D. Lond. London: F. S. Turney and Co., 22, Paternoster Row, E.C.

THIS is destined to be an epoch-making book; and, as a present function, it is one of the clearest "signs of the times" as regards that redistribution of the relations between the profession and the public which is fast being precipitated by the inelastic and unprogressive action of certain official bodies. Others than the author are protesting against the tyranny of the medical juntas. Pamphleteering has already set in; the public journals are scenting the break-up of the anomalies which have become positive abuses; that dumb and patient organism, the rank and file of the profession, is beginning to be critical and *im*patient; and all the signs are present which usually precede the collapse of intolerable strain. How intolerable this has become is shown in the autobiography of the present volume.

We have already alluded to the events which have culminated in Dr. John Shaw's withdrawal from the Royal College of Physicians, and his request for removal from the roll of the Medical Register. They have been sufficiently described and sympathetically commented on in an earlier number of the Review.

The book is divided into two parts: Part I. deals with the personal experiences of the writer, which have compelled him to take up his present position. In Part II. he surveys the present political constitution of the profession of medicine, and brings out the grave anomalies in our ruling powers in a manner that arrests the attention.

The Royal College of Physicians is first dealt with, and the fact that elections to membership are held in a comitia *pledged to secrecy* is placed in juxtaposition with the injunction of the Medical Act of 1858, that no qualifying body shall reject a candidate for examination on account of any theory of medicine he holds. Yet, asks the author, "who ever heard of a homœopath, an anti-vivisectionist, or an anti-vaccinationist, being elected a member of the Royal College of Physicians?" And he continues, "It follows that the college comitia—this twentieth-century Fehm-gericht sitting in secret conclave, has power to blast at its very outset the career of one who might have become a benefactor of the race."

Next the General Medical Council is dealt with, and its workings in secret still more trenchantly exposed. It appears that any one can make a secret accusation against a brother practitioner, undeterred by the consideration that the documents might hereafter see the light in a court of law, because the Council hold these communications as inviolate, and will not produce them even at the bidding of the High Court of Justice! A case actually arose recently, and the *British Medical Journal* remarked that "the incident shows that the General Medical Council will strenuously resist any attempt to violate the confidential character of documents submitted to it in disciplinary cases." The comments of *Truth* on this are pointed. "I believe I am right that even the man who is on his trial before the Council is kept in the dark as to much of the evidence against him. The Council, in short, seems to follow a procedure for which the only parallel is that connected with the Lion's Mouth at Venice!"

Dr. Shaw next takes up the professional attitude towards homœopathy, and criticises it severely. "It is difficult to believe that the spirit of religious intolerance can have exceeded that of official medicine towards homœopathy." He declares that it would be puerile and fatuous to deny that *similia similibus* contains truth, and that it is the duty of the official representatives of a humane and scientific profession to ascertain that truth. And he adds: "It has been a puzzle to me throughout my professional career to understand the antipathy that orthodox medicine has ever displayed towards homœopathy." Yes, and a puzzle to others also.

The British Medical Associaton and its trade-union ways come in for severe handling, and the author pointedly warns the profession against the dangers to liberty that are enshrined in the "Medical Acts Amendment Bill" and in the "Charter" for the British Medical Association.

The volume is well worthy the careful perusal of every general practitioner in the British Islands. The shoe, long worn by homœopathy alone, is now pinching others also; and we may well see in the remonstrances of these the dawn of professional right and freedom for ourselves.

Notices, Reports, &c.

BRITISH HOMŒOPATHIC ASSOCIATION.

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B.H.S. GOLF.

In the first round of the Golf Tournament, Byres Moir beat E. M. Madden; J. Powell beat E. F. Cronin; all the other players drew byes. H. W. T.

BRITISH HOMŒOPATHIC ASSOCIATION.

THE Council of the British Homœopathic Association has an advertisement in this issue offering a prize of twenty guineas for the best pamphlet in explanation of the principles and practice of Homœopathy. As it is for circulation amongst the laity, it should be short, clear and to the point, written in an attractive style, and, while accurate, free from technical expressions. In order to secure the prize, it must not only be the best, but, in the opinion of the Pamphlet Committee, must be suitable for its purpose. The Committee, we may state, have authority to acquire, on suitable terms, any other besides the prize paper which may particularly commend itself to them. Competitors should send their MS. type-written, and distinguished at the end by a motto in place of the writer's name. The MS. should be addressed to the honorary secretary of the Association, Mr. Charles Stewart, 2, Marchmont Road, Richmond, Surrey, and should be in his hands by August 1st.

The advertisement in the last issue gave the last day for receiving MSS. as June 30th. This time has been represented as too short, and for this reason it is now extended one month.

NOTICE TO CORRESPONDENTS.

*** *We cannot undertake to return rejected manuscripts.*

All MSS. should be in the hands of the Senior Editor by the 15th of the month at the latest.

AUTHORS and CONTRIBUTORS receiving proofs are requested to correct and return the same **as early as possible** to Dr. MCLACHLAN, 3, Keble Road, Oxford.

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Contributors of papers who wish to have reprints are requested to communicate with the Publishers, Messrs. BALE, SONS AND DANIELSSON, LTD., who will make the necessary arrangements. Should the Publishers receive no such request by the date of the publication of the REVIEW, the type will be broken up.

All books for Review should be sent to the Publishers.

Papers and Dispensary Reports should be sent to Dr. MCLACHLAN, 3, Keble Road, Oxford.

Advertisement and Business Communications to be sent direct to the Publishers.

Communications have been received from Dr. AVENT, (Birmingham), Dr. GALLEY BLACKLEY (London), Dr. C. O. BODMAN (Bristol), Dr. BURFORD (London), Dr. COMPSTON (Crawshawbooth), Dr. ROBERSON DAY (London), Dr. NEWBERY (Plymouth), Dr. CASH REED (Liverpool), Dr. WYNNE THOMAS (Bromley).

BOOKS AND PERIODICALS RECEIVED.

St. Louis Medical Review, The American Physician, The Calcutta Journal of Medicine, Medical Century, The Medical Times, The Vaccination Inquirer, Le Mois Medico-Chirurgical, The Hahnemannian Monthly, The Chironian, The Homœopathic Envoy, The New England Medical Gazette, Pacific Coast Journal of Homœopathy, The Medical Brief, The Homœopathic Recorder, The North American Journal of Homœopathy, The Homœopathic World, The Indian Homœopathic Review, Universal Homœopathic Observer, L'Art Medicale, Revue Homœopathique Française, Revue Homœopathique Belge.