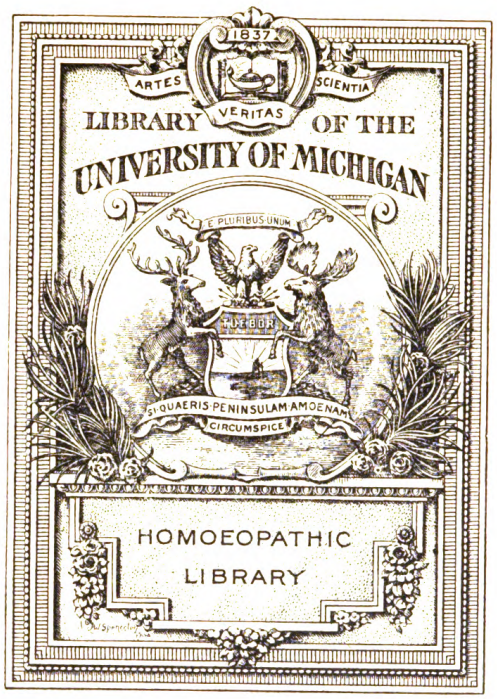

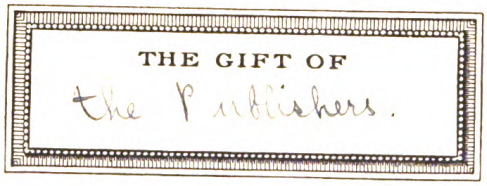

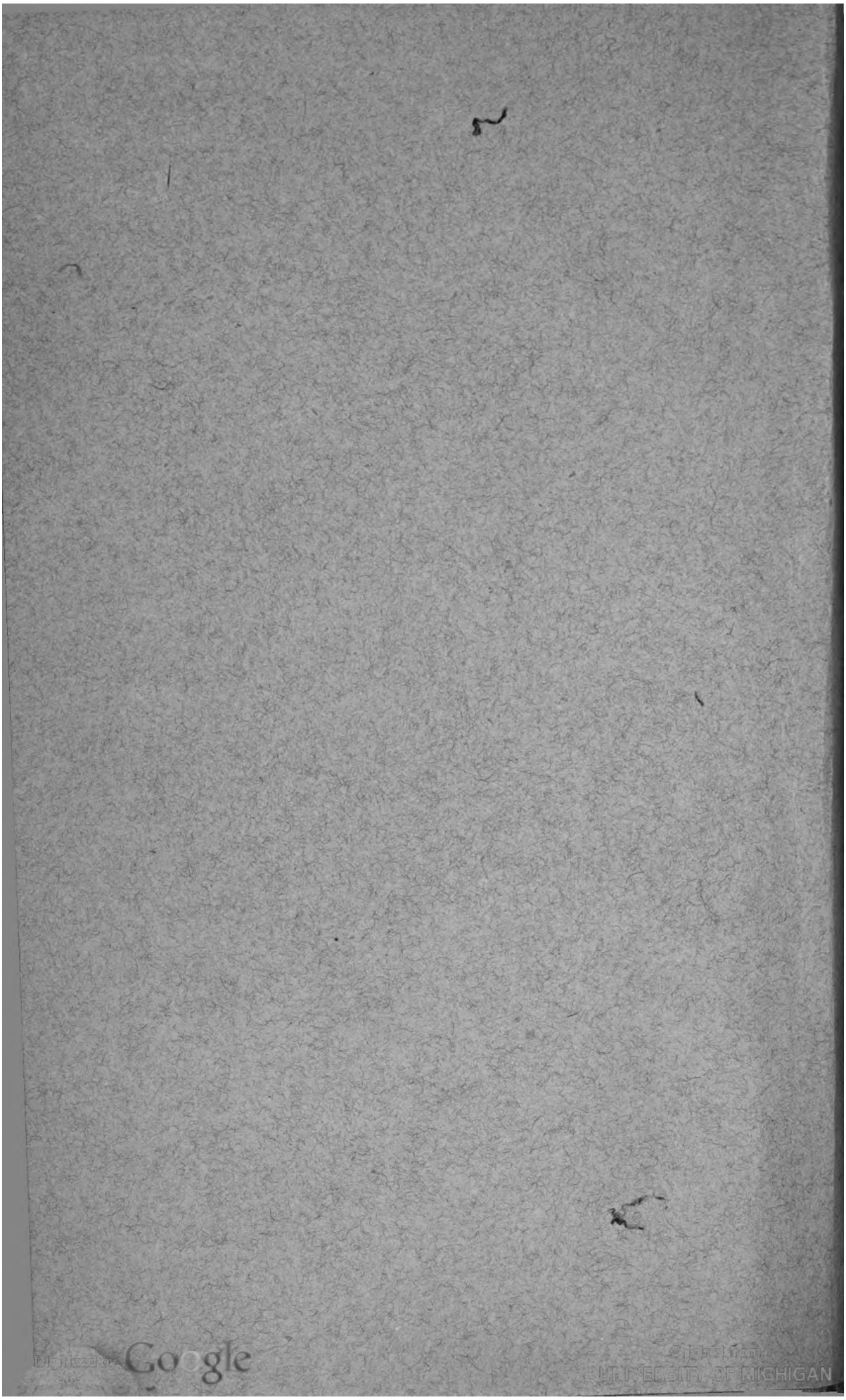

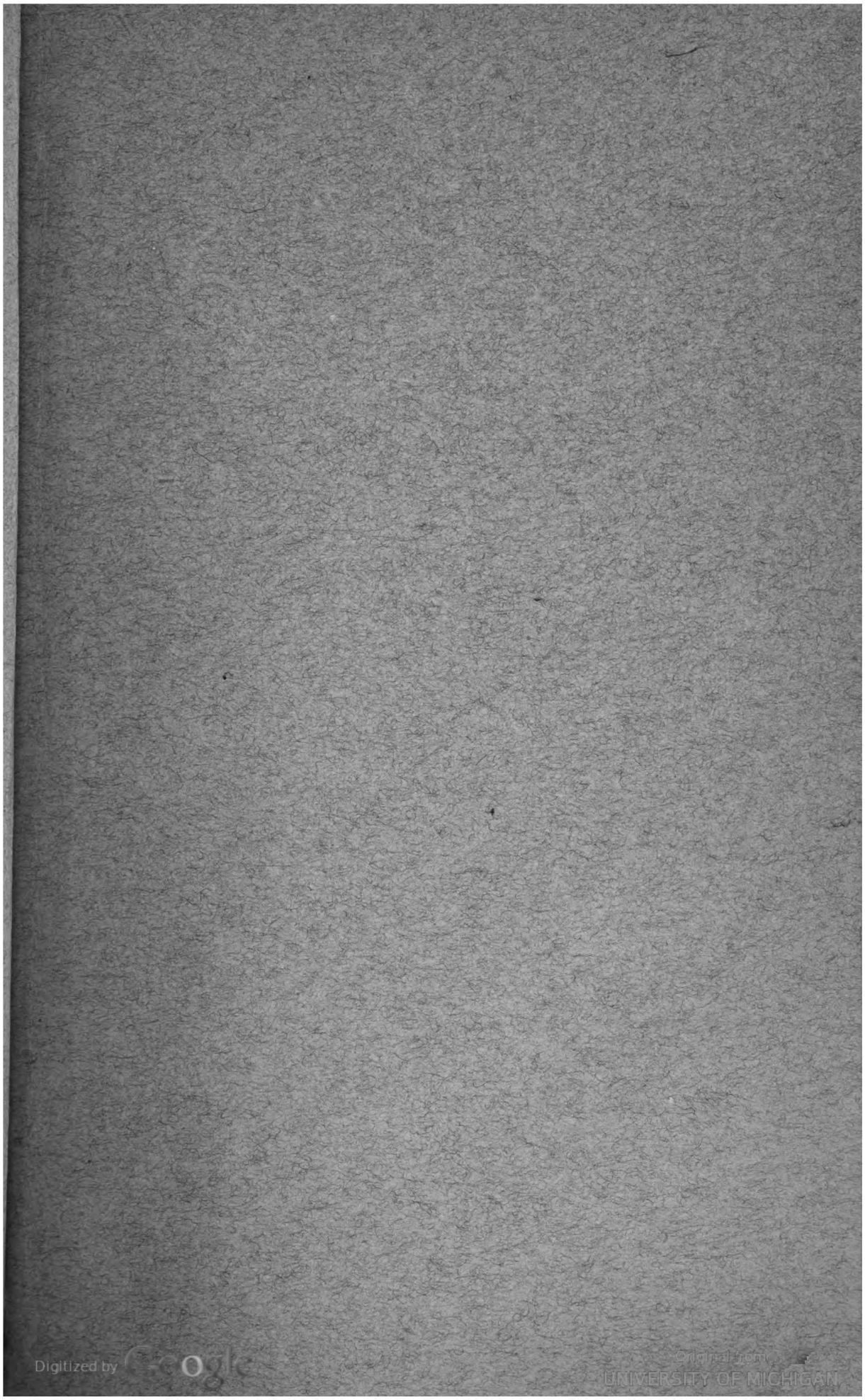

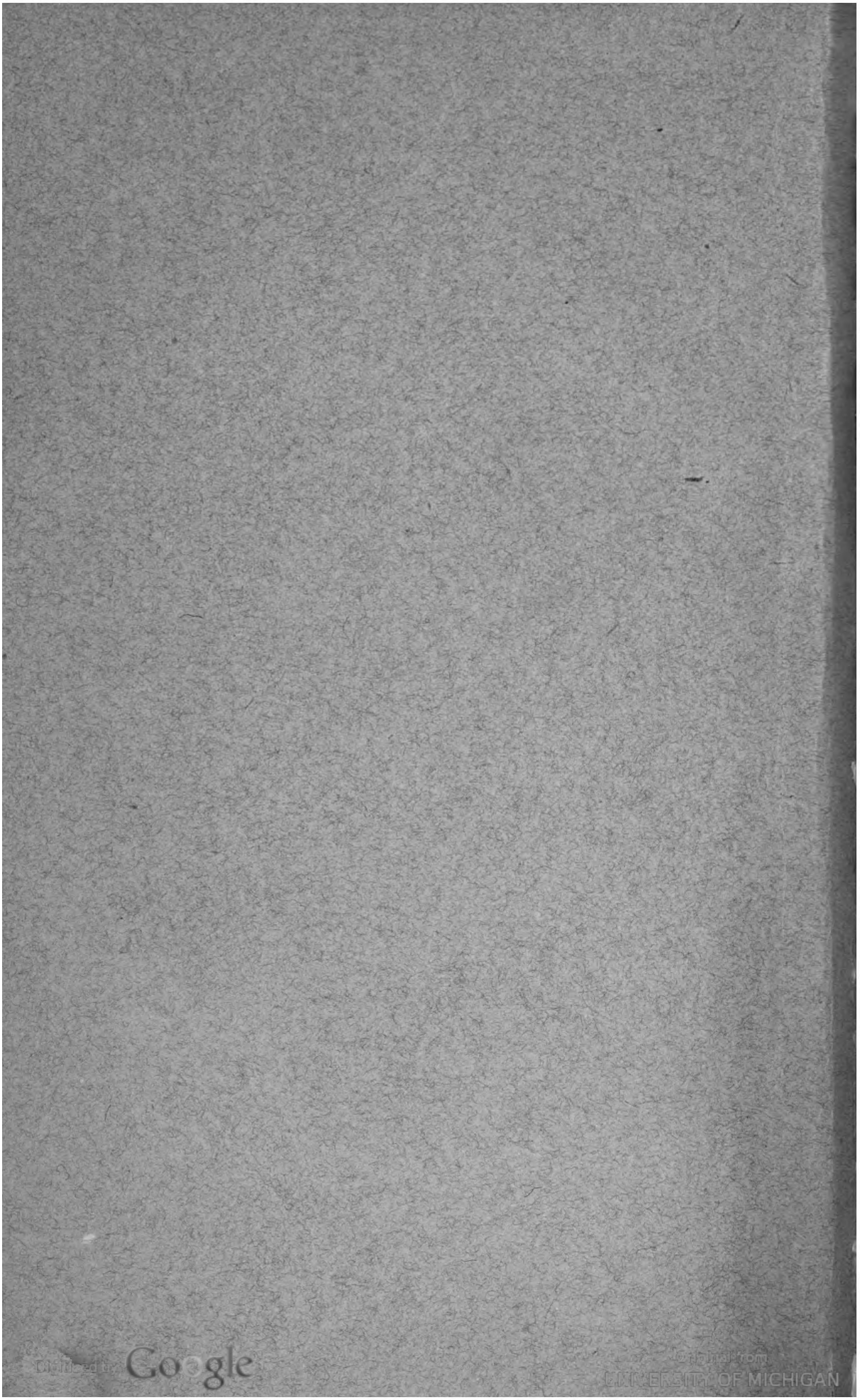

THE BRITISH
HOMŒOPATHIC REVIEW.

JANUARY, 1910.

Editorial Notes and News.

***** The Editor would be very glad if those who kindly promised contributions to our pages would send them on at the earliest possible date.**

Diaphragmatic Pleurisy.

UNLESS great care is exercised in examination of these cases they are apt to be mistaken for cases of *acute peritonitis*. An attempt should always be made to identify the exact nature of the complaint, even though this may have but little bearing on the medicinal treatment. The homœopathic physician should always be guided in the selection of the curative remedy by the symptoms manifested at the time by the sick person rather than by theories (which may or may not be correct) regarding the pathological substratum. The symptoms of diaphragmatic pleurisy commence as a rule with severe abdominal pain, and often with a rigor. The temperature rises to 103° or 104° F., the pulse is rapid, the abdomen rigid and tender to pressure, and the knees are drawn up. Hiccough is frequent and nausea and vomiting are common. It will be observed how closely these symptoms resemble those of acute peritonitis.

* * * *

Diseases due to Cereals.

FIRST of all we have *beri-beri*, believed, on very good evidence, to be due to rice. Dr. Braddon tries to show that it is only certain kinds of rice that are responsible

for the production of the disease. Similar instances with other cereals are not unknown; for example, *pellagra* is due to eating diseased maize; *ergotism* to eating diseased rye; and *lathyrism* is a disease brought on by eating various kinds of lathyrus (chick pea).

* * * *

Miner's Nystagmus.

All the conclusions of the late Mr. Simeon Snell are not accepted by those who see many of these cases. Dr. T. H. Butler points out that miner's nystagmus differs from ordinary nystagmus in that it gives rise to the subjective sensation of surrounding objects being in rapid movement, and to vertigo. It is essentially a colliery disease, and is not found among ore-miners, boiler-makers, nor employees in photographic plate factories, all of whom work in semi-darkness, and some of them in positions as cramped as those of the coal-miner. In the early stages of the disease nystagmus is elicited only when the eyes are turned up, and this does not cease when the head is thrown back, as some have maintained. True nystagmus must not be confounded with cases of asthenopia with nystagmoid movements.

* * * *

Talalgia.

This is a painful affection of the heel which exists without *apparent* lesion. According to Schwartz it is of two varieties. The *first*, which is the more common, is accompanied by an old-standing subcalcanean exostosis, the result of long-continued injury, and is consequently more common in waiters, shop assistants, and others whose occupation necessitates much walking and standing. The subjacent soft parts are irritated, and an artificial bursa is formed, and in some cases the fibro-fatty tissue is chronically inflamed, with a consequent neuritis of the neighbouring nerve filaments. The *second* variety exists without an exostosis. Irritation and dropsy of the subcalcanean bursa is the usual cause of the pain in these cases. This may result from trauma, but is more commonly of gonorrhœal origin.

We find pain in the heel associated with other conditions, such as "lithæmia," neurasthenia, ovarian disease, prostatic troubles, and stone in the bladder. Pain at the back of the

heel, at the insertion of the tendo Achillis, is regarded as a form of arthritis, and is usually due to gonorrhœa, and sometimes to gout.

Many medicines have a special relation to the heel, *e.g.*, *allium cepa* (ulcer on the back of the heel), *antim. crud.*, *caust.*, *graph.*, *ledum*, *manganum*, *sabina* (especially useful in strong, plethoric women suffering from rheumatic inflammation). Pain in the heel may also be associated with tenderness of the soles of the feet, with or without callositis, as in *antim. crud.*, *lycopodium*, and *silicea.*

* * * *

Nitric Acid Intoxication and Cholera.

EMMERICH (*Münch. med. Woch.*) propounds a curious theory—viz., that the intoxication of cholera is due to the nitric acid set free in the system by the action of the cholera vibrio in changing the nitrates of the food into nitrites. The starting point of this theory is the fact, pointed out by Petri, that the cholera vibrio has this power, and the author believes that foods such as cucumbers, radishes, cabbages, turnips, &c., which are rich in nitrates, are acted upon in the body in this way by the bacillus of cholera. Moreover, these conclusions are equally applicable to cases of cholera nostras, and of infantile cholera, for the bacteria of both diseases have this acid-forming power. The *Bacillus coli* has the same action, but it normally only inhabits the large intestine, and to this region nitrates rarely penetrate. Occasionally, for purposes of radiography, massive doses of *subnitrate of bismuth* are given, at times with fatal results. Such fatal results are believed to be due to the fact that the drug has reached the large intestine unchanged, where contact with the *B. coli* has set up a fatal acid intoxication.

* * * *

The Thyroid and Parathyroid Glands.

THE thyroid gland is an outgrowth of the pharyngeal hypoblast, and in some of the lower animals this communication with the pharynx is still maintained. In the amphioxus it is a hypo-branchial organ which pours its secretion into the pharynx, and in the fishes the duct communicating with the pharynx still remains patent. The colloid material contains extractives, such as xanthin, hypoxanthin,

creatin, &c., but its active principle is a compound containing *iodine* in organic combination, and it is this iodine-containing substance which possesses the physiological characteristics of the gland. It is called *thyro-iodin*. In goitrous glands this thyro-globulin compound contains no *iodine* and is physiologically inert. Its activity, therefore, appears to depend on its containing *iodine* in the molecule. In "marasmus" its internal secretion probably contains no *iodine* and no blood-pressure reducing substance. It often enlarges during pregnancy and in suppression of menstruation, and menstrual blood contains comparatively large amounts of both *iodine* and *arsenic* (Gautier). Marasmus is due to bad feeding. Cows' milk contains 6 parts of casein to 1 part of albumen; in woman's milk the proportions are equal, and in addition it contains thyro-globulin. It is interesting to observe the decided action of *iodine* and iodine-containing compounds, such as *spongia* and *merc. bin.*, on the disorders of the thyroid gland, and of *arsenic* in exophthalmic goitre.

In regard to the *parathyroid* gland, it appears that the pathological substratum of true *tetany* is due to disease of this gland, while its complete degeneration or total excision is followed by fatal results.

* * * *

Monsonia Biflora in Enteric Fever.

A TINCTURE of this plant has been employed by Mr. John Maberly, of Woodstock, Cape Colony, for the treatment of dysentery, and has proved very efficacious in arresting hæmorrhage and curing the disease. Its remarkable power in arresting hæmorrhage from the bowel suggested to him its use in enteric fever, He tried it and it proved so valuable that it became his practice to administer it in all cases in the third week of the disease, the period at which intestinal hæmorrhage is most likely to occur. This success led him to try it in the earlier stage of the fever with the hope of its aborting the attack or lessening its severity, but he found the constipating effect to be so marked as to prove objectionable. He has, however, since isolated from the drug a principle free from this objection, but which, nevertheless, appears to have a favourable influence in shortening the duration of the illness. This principle he has called entericin, and narrates four cases

in which it was given and the temperature became permanently normal on the sixteenth, seventeenth, fifteenth, and fifteenth day of the disease. The doses given were from one-half to two fluid drachms every six hours.

* * * *

Typical and Aberrant Forms of Disease.

SIR CLIFFORD ALLBUTT contributes a very interesting article to the *Lancet* of November 13 on "Typical and Fractional Pneumonia." It is interesting to us, because he so clearly recognizes that all classification of disease is arbitrary, and that though we construct a type—an abstract conception drawn from a multitude of cases—no individual case completely conforms to it, and may, on the contrary, depart from it widely. As an illustration he records two cases of pneumonia, one in which hardly any physical signs could be detected, only a small patch in the right axilla, but in which considerable anxiety was caused by extremely rapid pulse and respiration, the pulse running continually at 128 to 130, and the respirations at 55 to 60. The attack had commenced with violent vomiting. The disease processes seem to have singled out the medulla and to have left the areas more usually affected untouched. In the other case there was also only slight pulmonary affection, and the pulse and respiration symptoms were inconsiderable, but there was violent delirium. Though these cases are both classified under the heading of pneumonia, and both would no doubt show the presence of the pneumococcus, they are very far removed from the ordinary type.

* * * *

No Typical Treatment.

SINCE cases vary so much from the type, it follows that there can be no typical curative treatment. Sir Clifford Allbutt says nothing about the treatment of his cases besides mentioning that, in the first case, moderate doses of *phenacetin* were given, which remarkably controlled the temperature. We thought the utility of lowering the temperature in disease by antipyretics had been shown to be *nil*. It would have added greatly to the interest of Dr. Allbutt's cases if he had been able to show that these aberrant cases which he has so clearly individualized could be controlled by

medicines chosen to fit them. Evidently the treatment for the two cases ought not to be the same, and should also differ from cases more nearly conforming to the ordinary type of pneumonia. We are afraid the orthodox school is not yet in a position to make these fine discriminations in the choice of drugs. It is, however, the every-day practice of homœopaths, who, from their knowledge of drug symptoms, and by applying that knowledge according to the rule *similia similibus curantur*, are prepared to meet any unusual case with its appropriate treatment. In the above two cases we should expect that the bulbar case, the first one, would have been benefited by *belladonna* or *veratrum viride*, and the cerebral one by *hyoscyamus* or *lachesis*, unless a more detailed consideration of the symptoms than was given in the article referred to showed some other medicine to be indicated.

* * * *

The Solution of Calcium Oxalate Calculi.

DR. ROBERT MAGUIRE contributes to the *Lancet* of November 6 an account of a case where an oxalate of lime calculus lodged in the right ureter and resisted all efforts to dislodge it, till he devised a method for its solution *in situ* which proved successful. Starting from the fact that there is normally a very slight amount of calcium oxalate present in the urine, but that this, instead of appearing as a sediment, is held up in solution by the acid sodium phosphate of the urine, he decided to try whether by giving large doses of acid phosphate by the mouth he could so influence the urine that sufficient of the calculus should be dissolved to enable the remainder to pass into the bladder. He gave at first ½ oz., then 1 oz., and very soon 2 oz. of acid phosphate of soda dissolved in 100 oz. of distilled water, and ordered the solution to be drunk at frequent intervals during the twenty-four hours, and at times as far as possible removed from meals. The result was very successful, the pain gradually lessened, and in six weeks there were no signs or symptoms of stone. From experiments *in vitro* he found the proportions required to ensure the best result to be 5·35 grm. of *anhydrous* NaH_2PO_4, 3·25 grm. of *anhydrous* Na_2HPO in 1,420 c.c. of distilled water. As pure NaH_2PO_4 is difficult to obtain from the chemists, he advises that it should be prepared fresh, by neutralizing phos-

phoric acid by sodium hydroxide, and recommends the following procedure: Weigh out 6·6 grm. of H_3PO_4 conc. B.P.; add 45 c.c. of $\frac{N}{N}$ NaHO; make up to 100 c.c. with distilled water; dissolve in the liquid 8·2 grm. of NaH_2HPO_4, $12H_2O$, and make up to 142 c.c. Each volume of this solution diluted with sufficient distilled water to produce 10 volumes, will give a solution of the same respective strength of phosphates as were found in the urine after the administration of the acid sodium phosphate. This solution dissolved an oxalate of lime calculus weighing 0·442 grm. to an amount reducing it to 0·08 grm. in the course of six weeks. The calculus was placed in a piece of rubber tubing connected with a reservoir, from which the solution was allowed to trickle past the stone at the same rate as the urine would descend the ureter, so that the conditions met with in impacted calculus were imitated as nearly as possible.

* * * *

The Toxin and the Soil.

FOR many years now we have been witnessing the reign of the microbe. To its ubiquitous presence nearly all diseases have been attributed, and the efforts to destroy it have been the chief business of therapeutics. But lately there have been signs that the microbe will have to admit a partner to its throne, for it is beginning to be seen that the soil on which the microbe flourishes is of equal, or even more, importance than the microbe itself, and that the condition of the soil varies with the individual. Hahnemann long ago insisted upon this individuality of reaction to disease forces in different persons, and based his therapeutic measures on this fact. This same idea is fast gaining ground amongst the leaders of orthodox medicine, as the following extract from Professor J. A. Lindsay's lecture before the Royal College of Physicians on November 2, on "Darwinism and Medicine," will show. Professor Lindsay said: "The present generation of medical workers and observers is somewhat impatient of those conceptions of 'diathesis,' and 'temperament' which meant so much to our predecessors. We are disposed to think that these ideas lack definiteness and concreteness, that they are too vague to be of any real utility. Yet a study of evolution in its bearing upon disease may suggest to us that

these terms, vague though they are, adumbrate a great truth, viz., that in proclivity to infection and response to disease nothing is so potent as what we vaguely call 'constitution,' 'temperament,' 'hereditary tendency,' and the like. We have been intent upon the search for the microbe, a search which has already yielded brilliant results, and, it is needless to say, must be continued. But the response of the organism is an element at least as important as the presence of the toxin. In the future it may turn out that we shall be compelled to devote less attention to the seed, more attention to the soil."

* * * *

London Homœopathic Hospital.

1909 has been a most eventful year for this Hospital, inasmuch as it has witnessed the inauguration of the long-looked-for extension which has become necessary if the institution is to continue to adequately perform the work that falls upon it. The new Sir Henry Tyler Wing, as the extension is named, will add largely to the in- and out-patient accommodation, and it is estimated that when in operation the in-patients will increase from 1,200 to 2,000 per annum, and the out-patients will grow to 20,000. The cost of the new wing is to be £21,000, and the extension of the site £11,000, totalling some £32,000, which has been subscribed, and £2,500 out of the £3,500 that will be needed to furnish the new ward has been contributed. What the Board now have to do is to endeavour to raise some £6,000 required for extensive alterations to be made in the interior of the old Hospital building (built sixteen years ago) to bring it up to present-day requirements. The operating theatre is to be enlarged and new anæsthetizing and sterilizing rooms are to be formed. The fourth and fifth floors in the centre are replanned and enlarged. The kitchen department is to be re-arranged and much increased, and many minor changes are to be made elsewhere. That homœopaths will gladly help in this task we have no doubt, but we also invite all interested in the relief of the sick poor to lend a hand to this end, for as we have pointed out before, the London Homœopathic may fairly rank as one of London's general hospitals, seeing that its doors are open day and night for the reception of

cases of accident and emergency. Donations or annual subscriptions will be welcomed by Mr. Edward A. Attwood, Secretary, at the London Homœopathic Hospital, Great Ormond Street, W.C.

Original Articles.

ALBUMIN IN THE URINE.

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

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

No examination of a patient can be considered complete unless the urine has been tested for *albumin*. In the hurry of a large out-patient practice this is not always feasible, but in private practice it should never be omitted.

Albumin is so frequently present and under such divers conditions that its presence *per se* need cause no alarm. In high fever in children it is commonly found and disappears with the falling temperature.

In an interesting article in the *Wien. med. Woch.*, October 12, 1907, Professor Von Noorden illustrates many kinds of harmless albuminuria. Even casts may be present and yet the case is not serious. On the other hand, casts may be so few that they escape detection in a serious form of albuminuria, and hence the examination of the blood-pressure is a safer method of estimating the condition of the kidneys than by trusting to the examination of the urine alone. Heightened arterial tension is the precursor of renal disease.

Children and young adults in health frequently pass albumin. The urine of a number of young recruits in the army was examined and found to contain albumin after heavy marching; by the time they had got accustomed to their new life the albumin disappeared. It is sometimes a misfortune for the patient when his albuminuria is discovered, for at once a treatment of rest and restriction in diet is prescribed, which may be not only useless, but tend to induce valetudinarianism.

Case 1.—Nellie P., aged 13, has been under my observa-

tion for the last seven years. She suffers from orthostatic albuminuria. My first note was made January 23, 1902; she never had scarlatina.

November 4, 1903.—Albumin was abundant.

March 9, 1904.—Albumin present.

March 1, 1905.—Developed chorea.

January 24, 1906.—Albumin present.

October 24, 1906.—Albumin, a trace.

January 9, 1907.—Albumin present, with nitric acid test.

February 20, 1907.—Choreic movements.

October 30, 1907.—No chorea. Albumin present.

November 20, 1907.—Albumin abundant.

May 13, 1908.—Albumin abundant and chorea.

October 24, 1908.—Vomiting, headache.

November 25, 1908.—Excitable, clever at school, takes prizes.

December 16, 1908.—Copious albumin.

January 28, 1909.—Albumin present.

She has had at various times *plumbum* 6, *merc. cor.*, *adrenalin* 6, *phosph.*, *acid phos.*, *calc. carb.*, but none of these medicines had the slightest effect on the albuminuria. During this period I have admitted her into the London Homœopathic Hospital on various occasions, and as soon as the recumbent position was assumed the albumin disappeared, to reappear as soon as she was allowed up in the ward. This girl is constantly ailing, complaining of headaches and lassitude, and is nervous and liable to attacks of chorea, but she has no organic disease, and never has œdema. There have never been any casts found, although search has been made at various times.

In a paper read by Stejskal[1] on orthostatic albuminuria, he stated that 77 per cent. of the cases occurred among the young. The condition is associated with weariness, headache, vertigo, fainting, noises in the ears, palpitations, and pain in the back. Dyspnœa and constipation are frequent; the skin is pale and muscles flaccid. The condition usually persists from two to seventeen years, and is more frequent amongst young people than is commonly believed.

Incontinence of urine may be associated with albuminuria.

[1] *British Journal of Children's Diseases*, February, 1909, p. 83.

CASE 2.—Edgar C., aged 13. Admitted October 8, 1906. For some months past he had been troubled with incontinence of urine, which was worse at night and involuntary. Four days previously he had passed blood in considerable quantity, and this alarmed his mother and caused her to bring him for advice.

On admission the urine contained blood, and under the microscope blood cells and renal casts were seen. There was a large deposit of albumin on boiling. He was kept in bed with milk diet, and *terebinth.* 3 given every four hours.

On October 9 cellular casts were found, and blood cells were abundant, with much albumin. The quantity of blood had been so great that the urine appeared almost black on standing.

On October 22 there was no blood, but a little albumin, and incontinence of urine continues at times at night.

On October 26 *canth.* 6 was substituted for the *terebinth.*

On November 6 there were found granular, fatty, and blood casts, together with red and white blood cells.

On November 20, red and white cells, hyaline and granular casts, and clumps of bacteria.

On November 23 *plumb.* 30 was substituted for *cantharis.*

Leucocytes and hyaline casts were still present on December 4, 1906, and on December 7 he left the hospital, and on December 17 returned as an out-patient suffering from vomiting, and once during the previous week had had nocturnal enuresis. He had abdominal pain, headache, and "had been light-headed." I prescribed *plumb. carb.* 30, and a milk diet.

December 31.—Urine showed only a trace of albumin by nitric acid test only. He was decidedly better.

February 1, 1907.—Has been free from enuresis for five weeks. Then he discontinued his medicine, and twice during the last ten days has had enuresis and a return of headache. Urine shows a trace of albumin on boiling and with nitric acid. Ordered *carb. plumb.* 30.

During March and April he continued under treatment, and although the urine continued to show a trace of albumin, the enuresis ceased.

In June he got wet and enuresis returned, and on June 24 I gave him *cantharis* 12, ♏ii., four hours.

He continued under occasional observation during the summer, and when he came October 28 had suffered from enuresis only twice in four weeks.

I saw him next on January 16, 1908. He was better in every way, had only once had enuresis since the previous October, and the specimen of urine examined contained *no* albumin. *Cantharis* 12 repeated.

February 14.—Urine showed a trace of albumin and I returned to *plumb. carb.* 30. This medicine he continued to take more or less regularly.

I saw him on October 30, 1908. Feeling very well. No enuresis. Urine normal, no albumin. Ordered *plumb. carb.* 30 *bis die*, and to continue chiefly a milk and fish diet.

On May 14, 1909, I again tested the urine and found its sp. gr. 1015, *no* albumin.

This case is instructive for several reasons, incontinence of urine coming on for the first time in a boy of 13, should have been an occasion for seeking medical advice, when probably the long subsequent illness would have been avoided.

The sudden and severe hæmaturia which frightened the patient and caused him to seek advice was evidently an attack of acute nephritis, which yielded to treatment, and the subsequent albuminuria finally disappeared under *plumb. carb.*, and has been a permanent cure.

Albumin may be found in the urine, associated with œdema, but no apparent change in the urine to the naked eye. No blood or alteration of colour.

CASE 3.—Reginald C., aged 2 years 5 months. Came to me on June 13, 1907, with a puffy face, especially in the mornings, about his eyes. He had not had scarlet fever or any illness.

He came walking and apparently well, and was sleeping well, but his face was distinctly puffy. There was a tendency to diarrhœa. The urine showed abundance of albumin. I ordered *plumb. carb.* 12, pil. ii. ter, a milk diet and rest in bed.

He continued the *plumb. carb.* 12 through June, and on July 11 I again tested the urine, and found no albumin. His mother observed he had got much thinner, *i.e.*, the œdema had gone. He continued under observation, and the urine was frequently tested, but albumin did not reappear, and on October 17 I saw him for the last time with *no* albumin.

CASE 4.—Percy H., aged 10 years 9 months, came to me on July 23, 1908, from Bedfordshire. His father was a Norwegian. He had scarlet fever when 2½, and diphtheria when 5.

He had recently recovered from a second attack of scarlet fever, and had been convalescent for two months. His eyes were always puffy, and his mother said "his kidneys were bad." His tonsils were enlarged, and removal had been suggested. I found him very thin, and the urine showed a distinct ring of albumin with nitric acid. I ordered *plumb. carb.* 12.

On September 28 I saw him again. The urine was alkaline, and gave a ring of albumin with nitric acid. The tonsils were still enlarged, and I now prescribed *merc. cor.* 3x, and a paint of *glycerine of hydrastis* for the tonsils.

On October 19 the urine had a sp. gr. of 1010, was alkaline in reaction, and showed *no* albumin either with nitric acid or on boiling.

CASE 5.—Elsie H., a twin, aged 2 years 8 months, was brought to me on October 24, 1907, without appetite, and for the last two weeks had been constantly passing urine. I found her very anæmic. Albumin was present in the urine, but there were no other definite physical signs. I ordered *cantharis* 12, pil. ii. every three hours.

November 1.—No albumin. Repeat.

November 15.—Much improved generally and appetite better. Enuresis at night continues. Repeat.

December 6.—No albumin, and I now gave *china* 3x. ter. I did not see her again for a year, but on December 18, 1908, she came with pain in the hypogastrium and passing urine turbid with urates, but *no* albumin. For this I gave *lycopod.* 12.

CASE 6, I exhibited before the British Homœopathic Society, February 4, 1909. It was a case of unusual interest—paroxysmal hæmoglobinuria. R. L., aged 4, the third child in the family, one other living and one dead; breast-fed nine months; came as out-patient November 12, 1908.

The history of the illness was as follows: Four weeks ago he had pains round the loins, was feverish, and passed urine like "porter"; it then got clear again. Four days previous to coming to the hospital he again passed porter-coloured urine.

and the mother brought a specimen of this urine, which, on boiling, precipitated albumin copiously; but the urine passed at the time of the visit was normal; no albumin. He showed all the signs of anæmia, but there were no other definite physical signs.

November 28.—Four days ago he again passed similar urine, a specimen of which was brought with the child and tested by Dr. Watkins, whose report was: "Faintly alkaline; brown-red colour, with deposit. Hæmoglobin present with guaiacum test. Many crystals of oxalate of lime, and much granular matter, but no red cells or casts. Heavy cloud of albumin present. It is possible that the red cells have dissolved owing to period since emission (four days)."

The urine passed at the time of his visit was again clear and normal. I admitted him as an in-patient, and he was detained some time, but as he appeared quite well and passed normal urine, he was discharged, but re-admitted January 5, 1909, as he had again passed dark-coloured urine, and also at the time of admission passed urine of slightly red colour, with large quantity of albumin.

January 13.—When up and walking about the ward he suddenly began to cry and could not walk upright. The urine passed a short time after was red and contained albumin.

Since January 17 has had pain and swelling in his knees, with pyrexia, and is very anæmic.

January 29.—Developed keratitis, right eye. Knee-joints more swollen and painful.

February 2.—Cries each night with pain in his knees. No more red-coloured urine passed. *Kali chlor.* 3x was administered, as *chlorate of potash* has been known to produce hæmoglobinuria.

A blood examination was made by Mr. J. G. Hare, the pathologist, who reported as follows: Blood count: Red, 5,000,000; white, 10,000; hæmoglobin, 62 per cent.; date, February 2, 1909. Urine, first specimen: Sp. gr., 1023; albumin, +; sugar, —; urea, 1·9 per cent.; crystals, calcium oxalate; reaction, slightly acid; blood corpuscles, —; hæmoglobin, +. There was no deposit on centrifugalization, and no micro-organisms could be seen microscopically or on culture.

February 4, 1909.—A second specimen of urine tested the same day: Sp. gr., 1019; sugar —; albumin, +; urea, 2·1 per cent.; crystals, calcium oxalate; reaction, slightly acid; blood corpuscles, —; hæmoglobin, —. No deposit on centrifugalization.

CASE 7.—M. McI., aged 9, had recently recovered from a mild attack of measles. On May 16, 1909, she was attacked, with temperature 103·4 F. and almost suppression of urine. *Acon.* 3x and *bell.* 3x were at first prescribed, and later on *terebinth.* 6. Hot fomentations were continually applied to the loins at this time, and the greatest care observed to keep the child warm and free from chills. The urine was very dark, loaded with albumin, and under the microscope there were abundant renal casts of all kinds, together with blood discs, red and white. *Cantharis* 6, and subsequently 1x, was given. The urine gradually became more abundant, less dark in colour, then only slightly smoky, and lastly normal to the naked eye. The blood cells and casts correspondingly disappeared, and the quantity of albumin steadily lessened. Daily estimations of the albumin were made at first as follows :—

May 27. 2 per cent. albumin
„ 28. 2 „ „
June 4. 1 „ „
„ 5. 1½ „ „
„ 7. ·25 „ „
„ 13. ⅛ „ „
„ 16. The faintest trace.
„ 19. No albumin for the first time; that is to say, in five weeks this child had recovered from a very severe attack of acute nephritis.

CASE 8 was a lad who had come over from South Africa. He was continually passing blood-stained urine, which precipitated albumin on boiling. Under the microscope numerous blood cells could be seen, and amongst them the eggs of the *Bilharzia hæmatobia*. A variety of remedies were tried to arrest the hæmorrhage, but without much success, and I eventually lost sight of him.

Albumin is always tested for in examining candidates for life insurance, but the mere fact of its presence, apart from other symptoms and findings, should be no reason for rejec-

tion or loading the premium. Repeated examinations should always be made in these cases before making a prognosis, and the cautious physician will do well to bear this in mind.

I have not quoted any adult cases, but in them the presence of albumin is of equal interest, and may never be suspected till a sudden chill ushers in uræmic coma, or eclampsia occurs during the puerperium, or again, albuminuric retinitis may be discovered prior to the appearance of albumin in the urine.

ON SOME RECENT CHANGES IN THE MANAGEMENT OF CASES OF ABDOMINAL OPERATION.

By EDWIN A. NEATBY, M.D.

It is a far cry from the pre-antiseptic days to the present reign of asepsis in operative surgery. My earliest impressions were received in the years immediately succeeding 1876, when the operator's coat was a multi-coloured garment bearing the marks of many campaigns, thin enough in places with long wear, but thick with stiffened gore; worn perhaps with the sleeve wrists folded back, but even there in the interests of the venerable garment rather than of the patient! What wonder that, after a clean amputation, a copious flow of "laudable pus" soon followed, in spite of a manual dexterity seldom witnessed nowadays. But this was not destined to last long, for in the late seventies of last century (how long ago it seems!) Listerism was creeping into London surgery, mainly due to one of my teachers, John Couper, a dapper little Scotchman, a cousin of the great Lister, better known as an ophthalmologist, and, as far as I know, still in the land of the living. Much honour is due to him, for he persevered in spite of opposition and ridicule.

It would not be profitable or interesting to trace all the stages from then until now, but let me recall to mind the state of matters some fifteen or sixteen years ago, when I began abdominal surgery myself. These may be called the antiseptic days. Listerism had triumphed and *gone*—at least as regards the spray and the special carbolic dressings, but much chemicals were in use for the surgeon's hands, the

patient's skin, and even his wounds. Yet during these days there flourished the greatest of abdominal surgeons, the man who first knowingly operated on an extra-uterine gestation, building up an unequalled reputation on "simple cleanliness," and not too much of that, making a plea for his "favourite germs," which would be killed by too much chemicals. The main difference in *our dressings* then and now was that we used a mass of what we called shredded gauze. And for what purpose? To absorb the fluid from the abdominal wound, for every case was then drained with a Keith's glass tube, and every patient was dressed twice a day, or oftener, for the first three or four days. What a business those dressings were—for patient and surgeon. Then followed gauze drains which did not drain, and how pleasant those were to remove! But soon routine drainage disappeared. I said just now that we used to dress our cases twice daily for three or four days. That was if they were fortunate enough to be ovariotomy cases and not hysterectomy. In the latter case the cervix and broad ligament were encircled with stout rubber tubing fastened with pressure forceps, never meant for so base a usage. The cervix formed a pedicle, which was transfixed with pedicle pins and tied with thick silk. How slighted those pedicle pins feel as they lie neglected on the glass shelf of my instrument cabinet. They are kept there polished in honour of their past service, but they have not been used since 1897 or 1898. With the pedicle fixed in the wound our troubles and sorrows *began* about the seventh or eighth day, and lasted more or less till the seventh or eighth week. It is with a little self-satisfaction (may I hope pardonable?) that I recall these days, for I was the first to introduce the intra- or retroperitoneal treatment of the stump into the London Homœopathic Hospital. I have not forgotten the pleasurable sensation I experienced when I visited a patient who had left me to be operated upon by a distinguished surgeon (not at our hospital). She was just getting up after seven or eight weeks in bed, and she enquired after a patient she had seen in our hospital before her own operation. They were operated upon on the same day—she by the old method, my case by the new; and it was perhaps a little unkind of me to tell the lady that my case left hospital well in four weeks.

Since the introduction of the intraperitoneal method no great improvement has been possible in abdominal hysterectomy. Save that I now leave the stump severely alone, as a rule, without trimming or stitching, and also save time and facilitate manipulation by cutting out the tumour as rapidly as possible, and tying the vessels afterwards, no changes have been recently made.

A word as to the preparation of the patient prior to operation may not be out of place. At one time I adopted the plan, first introduced, I believe, by Dr. Burford, of giving either *arnica* or *belladonna* and *merc. corrosivus*, with the object of raising the resisting power, as we should say nowadays. At present I think the best way of doing that is by any remedy or general measures which seem to be called for by the patient's condition.

I still give an aperient before operation, but I am not sure that this is a good routine plan. One point I am careful about is, where possible, to give the dose the night but one before the operation, and to give no more than enough to produce one good action. The object of this is to leave the patient undisturbed the night immediately before the operation, and to obviate the lowering of the blood-pressure which follows considerable purging.

After operation I give no medicine by routine. For extreme sensitiveness to pain I find *chamomilla* 12 of very great service. For the headache, with flushed face, which sometimes follows ether anæsthesia, I give *belladonna* 1x. The vomiting due to the anæsthetic is best met by posture and the free use of water to wash out the stomach. I find *apomorphine* useful if there is much empty retching.

There are a few points in the externals of abdominal surgery which claim a passing reference on the ground of practical usefulness. As regards hand-washing, I was educated to much chemistry; the method was simple and good. It happened that at times I was obliged to operate without the aid of chemicals, and I was doubly scrupulous in the use of soap, brush, and much water; no ill-results followed; so I gradually adopted my present method—water and soap with a little ammonia in the early part of the washing, and if in a private house, six relays of water. In hospital I find the

ammonia, followed by ten minutes of running water, and then by a good soak in spirit or biniod. lotion to be adequate. I have not habitually tested my hands, because I find that so few of those who do so find them sterile, that I begin to have pity on "my favourite germs," as Lawson Tait put it, and also on my hands.

During the chemical and early aseptic days I used to find we got a good many stitch abscesses, which were annoying and disappointing, though not serious. I repeatedly changed my sewing materials, with no very satisfactory results, and I frequently got our pathologist to incubate the catgut or silk, but found it to be sterile. Some of them were, I doubt not, due to tying the stitches too tightly, but I cannot help thinking some were due to the silk or gut becoming contaminated by handling.

Sir Almroth Wright has proved by investigation that germs rapidly multiply in skin softened by much warm water and stimulated by brushing. Hands practically sterile at the beginning of an operation swarm with pathogenic micro-organisms after an hour's operating. You must remember, too, that at an operation in a well-equipped hospital success depends, not on the operator's hands only, but on those of his assistant (sometimes two of them), and three or four nurses—five or six pairs of hands. The most important of these (as regards stitch abscesses) are the surgeon, the assistant, and the instrument nurse. It is during the closure of the wound when the silk is handled by the nurse who threads the needles, and by the assistant or operator, that harm ensues. These reflections led me to adopt rubber gloves for myself and all taking part. The results have amply justified the procedure. Experience shows that hands differ very much, and also the consciences of those who scrub them! For one spell one of our surgeons used to find his cases very liable to go wrong. He enquired if my cases were doing the same. He found they were not, and was informed by the sister that the house-surgeon, when assisting me, wore gloves. He then made him do the same for his (the surgeon's) cases, and they no longer became septic. This was a clear proof of the value of gloves. I must here observe that it would be totally unjustifiable to relax one's care in cleaning the hands because gloves were to be worn.

In the *Journal of Gynæcology of the British Empire*, December, 1905, Grimsdale, of Liverpool, gives three series of forty cases, each where the operation was conducted (1) with the aid of chemical antiseptics, (2) with asepsis, and (3) with asepsis *plus* the use of rubber gloves. The second series was better than the first, and the third than the second.

My little fad of wearing caps during abdominal operations may be classed amongst recent external changes. Most Americans who visit our operations at the London Homœopathic Hospital express surprise that none of my colleagues take this precaution. When I see them freely "rubbing fringes" over an open abdomen, I confess to a similar feeling myself; it is safer to "rub caps." I have been told by some that their "results are good enough"; mine are not.

With regard to a mask, I prefer an "aseptic silence," or a near approach. As to the advanced toilets of some of the Continental and Transatlantic surgeons, I think the climate and the habits of surgeons in this country do not call for them.

Speaking of the personal toilet of the operator reminds me of changes in the matter of the peritoneal toilet of the patient. I think it was Sir Frederick Treves who pointed out the harm that may result from an excessive sponging and manipulation of the peritoneum. We can all remember when every crevice, cranny, and pocket of the peritoneal folds were either wiped out thoroughly or as thoroughly flushed; sometimes, indeed, first one and then the other. If the peritoneum is "cleansed" it should only be from obvious gross impurities. We cannot *cleanse* it by washing, but we can very readily disseminate infective matter; we cannot remove all traces of bacteria by sponging, but we can very readily break down protective barriers if they exist. Our procedure should vary according to the nature of our case. In clean operations for simple uterine myoma or ovarian cystoma, little or no cleansing is needed; blood-clot may, of course, be gently removed from the empty pelvis; it probably does more harm than good to search for blood which may have wandered into the flanks or among the coils of intestine. The peritoneum can effectually deal with a small effusion of aseptic blood. In infected cases, where septic peritonitis has already taken place, much attempt

to cleanse is useless or harmful. The removal of escaped contents from visceral perforation, when obvious and accessible, is, of course, desirable, but for the rest, Nature must be encouraged to do her best by posture, drainage, and reversed lymphatic current. To these I will refer again in a moment.

Leaving subjects of minor importance, there are two or three points on which I ask your indulgence, while I refer to them quite briefly. Before a sister society, our *confrère*, Dr. Johnstone, gave an able summary of the then newest views regarding shock. He showed it to be a condition due to over-stimulation and subsequent exhaustion of the vaso-motor centres, resulting in lowered general systolic pressure. This reduced blood-pressure can be readily demonstrated experimentally on animals by the use of the mercurial manometer, and clinically, even during operation, by the sphygmometer. It is accompanied by an increase of pressure in the splanchnic area, where blood accumulates unduly. Now, in the paper referred to, Drs. Burford and Johnstone showed the value of intravenous saline infusion in combating the shock of operation, and incidentally, its uselessness in septic cases. Of the importance of these authors' views there can be no question, nor doubt of the fact that they have saved many lives by this means from an untimely end. When the shock is associated with collapse, due to the loss of blood occurring suddenly, the intravenous method is, without contradiction, the method of choice.

Time and experience show that it is not without dangers; first, it is easily overdone; second, it is easily done too rapidly. The result of error in these directions is, first, danger of œdema of the lung; and next, danger of secondary hæmorrhage. The latter may occur (and prove fatal) from raw surfaces left by the separation of adhesions. It is a safe conclusion that were the blood-pressure raised more gradually by other means, such hæmorrhage would not occur. Of the alternative method more immediately.

Now there is one deduction which was not drawn, if my memory serves me rightly, in the paper on "Shock" to which I have referred; it was its bearing on the administration of stimulants, during and after operation. I have always opposed by my practice the routine administration of brandy and

strychnine. I have believed that in slight cases of shock they were unnecessary, and in severe cases useless. Some recent experiments have shown that these agents are not only useless, but harmful; indeed, the deduction of their harmfulness might have been made from their known action and the above-quoted definition of shock. The nerve centres in the medulla are becoming exhausted by multiple and excessive peripheral stimuli; the brandy or *strychnine* further stimulates these centres. If able, they respond momentarily and are left more exhausted; if unable, the resulting exhaustion is still greater without a temporary rally. I am glad to believe that the brandy craze in the profession is nearly over—for such circumstances, and that if a patient must die from shock, as is sometimes inevitable, he is left to "die natural." The *strychnine* and *digitalin* bogey is not yet "laid." I hope the charts I exhibit, taken from a paper by Walton, of the London Hospital, will do something towards giving it a quietus, as far as we here met are concerned.

Now, gentlemen, what are the alternatives? First, during operation, posture is of importance; the Trendelenburg position well carried out is of use, not only in facilitating the operation and so saving time, not so much by getting blood into the cranium, but by getting it out of the abdomen. If drugs are to be given they should act on the peripheral circulation directly and not on the nerve centres directly. For this purpose let me commend to you *ergot*, *adrenalin* or *pituitary extract*. *Morphia*, again, is infinitely preferable to stimulants, for sedatives like opium prevent the conveyance of peripheral stimuli to the nerve centres. I do not use *morphia* by routine myself, but in a few cases I have found it extremely helpful. The main advantage of cocaine spinal anæsthesia is that shock is practically absent, no impulses being transmitted upwards. I have no manner of doubt that moderate saline infusion is the greatest agent we have in combating shock. If the peritoneum is quite clean, 10 to 20 oz. can be poured into the cavity and left. By this means the blood-pressure is raised and leucocytosis produced.

After the abdomen is closed, if there is moderate shock, a pint, by the long rectal tube, every hour or two at first, with the foot of the bed raised for a few hours, is a prompt

restorative. While pulse and respiration are still working absorption will go on. Ordinarily, even if hæmorrhage is added, this is enough.

Two or three months ago I had a tedious case of retro-peritoneal myoma, with Mr. Frank Shaw, of St. Leonards. The operation was long, the denuded surfaces extensive, and the bleeding almost alarming. For a short time it seemed doubtful if the patient would leave the table alive. A rectal saline was given at once, and after a few minutes the pulse became perceptible; it was repeated at frequent intervals, and the next day she was sitting up in bed bright and smiling.

I do not intend here to go into the merits of continuous proctoclysis, as introduced by Murphy, of Chicago, and Moynihan, of Leeds, in cases of septic peritonitis. In such conditions the results, where the injection is combined with the Fowler position, are simply marvellous. We have thus in our hands measures which far surpass in efficacy *strychnine* and brandy.

The mention of posture after operation leads me to refer to some innovations in the after-treatment, to which I attach some importance. For nearly two years I have been feeling my way to somewhat radical changes in the post-operative management of abdominal cases. They may be summarized as follows:—

(1) Abandonment of the prolonged supine position.

(2) The free allowance of bland liquid at an early stage, and the early return to semi-solid or solid diet.

(3) Allowance of free movement of limbs and change of position in bed, to secure comfort and sleep.

(4) The very early getting of the patient on to the couch and on to her feet.

(5) The abandonment of early aperients.

These practices are, as you know, in opposition to the routine treatment we have all been accustomed to for so long. It is difficult to get out of a groove and to throw overboard time-honoured traditions, even though on reflection we know them to be based only on theoretical conceptions. Contrast the old practice of rigid stillness for a fortnight or more on the back, an extra pillow for a treat after a week, and an occasional turning by a nurse on to the side; semi-starvation diet for

several days; *merc. dulcis* or early enemata; cautious getting up after three weeks, &c. Contrast this, I say, with lots of fluids to drink, free voluntary movement in bed, sitting up with pillows or bedrest as soon as shock is passing off, out of bed and on the feet on the third or fourth day, semi-solid or solid food in thirty-six or forty-eight hours, indeed as soon as the vomiting of the anæsthetic is over. The bowels usually act naturally.

What are the counter-balancing disadvantages? I do not know any. There are, however, certain qualifications to be mentioned. First, I take, if possible, more care than ever with the abdominal wound—*e.g.*, by removing pressure forceps early, by using different sponges for wound and surrounding skin, and by putting in extra through-and-through supporting sutures. Second, no routine must be established. Each case must be taken on its own merits. If the patient was unfit to be up and about before she is obviously not better able three or four days after a considerable abdominal operation.

The advantages I claim for this plan are, that vomiting is less, flatulent distension is diminished, appetite and digestion are improved, the natural action of the bowels is encouraged, sleep is better, muscular tone is not impaired, the heart's action improves, and there is less tendency to venous thrombosis.

A few years ago I had quite a number of cases of blocking of the saphena vein, and after searching about for a cause, I came to the conclusion that it was due to the prolonged rest with the knees flexed. I have had no such cases recently, but I do not attribute the exemption solely to the freer movement after operation. At that time I was not aware that during an abdominal operation, not only is the blood-pressure lowered, but the specific gravity of the blood becomes notably increased. One great advantage of the free use of normal saline solution is that it tends to restore the specific gravity to normal.

One point more and I have done. We saw earlier that exhaustion of the vaso-motor centres is produced by the transmission of multiple impulses from the periphery. In the same way multiple impulses from the intestines to the centres controlling their muscular apparatus bring about their exhaustion. These stimuli may be toxic or mechanical. Reduced peristalsis and abdominal distension result. This

follows chloroform more than ether, and manipulation more than exposure. (Moral, do not change your sponges too often.)

The condition of ileus or hyperdistension, due to paresis of muscular walls, should be met by a stimulus acting locally, not centrally. It is in order to recommend to your notice the use of *eserine salicylate* in such cases that I have alluded to the subject. Repeated doses of gr. $\frac{1}{100}$ to gr. $\frac{1}{50}$ have a very prompt and comforting action. Of course, if sepsis is the cause, the chances are against us, but even here, with other measures to raise the resistance and facilitate elimination, the old hopeless attitude is no longer necessary, and *eserine* may contribute material aid.

The first thing that opened my eyes to the possibility of another routine than the one I had been adopting for so long was the occurrence of a case in one of the surgical wards, where, after an intestinal anastomosis, a man became delirious and insisted on sitting out of bed the day after operation. He moved about freely and could only be kept quiet by allowing him to smoke. The patient made a satisfactory recovery. About that time I read an article by Boldt, of New York, advocating the early getting up of abdominal cases—so early as to upset all one's preconceived notions. He had arrived at getting his cases up in from twenty-four to thirty-six hours after operation, and reported over a thousand cases (his own and other operators) in which early getting up had been practised without any bad results. His cases include almost all forms of abdominal operation, in many instances complicated by collections of pus, bad adhesions, &c.

I was not bold enough to plunge straightway into such advanced methods, but I soon began to feel my way towards it. The following are some of the early cases given as examples :—

1907. S. F.—Large double ovarian tumours, one of which had ruptured, filling the abdominal cavity with sticky, gelatinous, semi-fluid substance. Up on the tenth day. Did exceedingly well. Scar, seen several months after, was quite sound.

F. L.—Salpingo-oöphorectomy ; for tuberculous inflammation. Ill in bed long time before operation. Up about tenth or eleventh day. Seen recently, scar quite sound ; health much improved. Came into hospital subsequently for tuberculous knee.

E. K.—Hysterectomy for myoma causing hæmorrhage. Up on eighth day. Uninterrupted recovery. Watched for eighteen months, scar remained sound.

K. C.—Hysterectomy for myoma; adhesions to rectum and adnexa. Up on the eighth day. Seen recently, scar remained sound.

J. D.—Hysterectomy. Up on third day. Seen recently, scar sound. Is at work in a public institution with much standing.

Miss R., sent to me by Dr. Stonham; removal of an ovarian cyst, size of tennis ball, for pain. Patient aged 67. Up on the couch on the fourth day, and made an uninterrupted recovery. She has continued well up to the present date, and the scar remains sound.

Mrs. W., aged 51, sent to me by Dr. Hardy, for continuous hæmorrhage and offensive discharge at intervals. Early in 1908 uterus and intraligamentous myoma removed abdominally. Up on the third day, and made an excellent recovery.

On the other hand, Mrs. F., sent to me by Dr. Tindall, and Miss B., sent by Dr. Frank Shaw, both of whom had been suffering severely from hæmorrhage and were very anæmic, were kept in bed a fortnight or more, though they were allowed to sit up in the bed and to move about more freely than in the old days. These last cases are mentioned to show that no hard-and-fast routine is followed, but that every case is treated on its own merits.

This year we have advanced a little further; favourable cases are moved on to the couch the day after operation. I have in my mind as I write one of hysterectomy and one of appendicectomy, done early in November, 1909, who both appeared to have nothing the matter with them on the day after operation, and were got out of bed.

It is with pleasure that I acknowledge the wise and careful assistance given to me in these cases by the various house surgeons, and perhaps still more, as being even closer in touch with the patients, the Sisters of the wards—Sister May and Sister Cousins. Without the encouragements and cautions given by these latter, the progress would have been neither so safe nor so good.

Clinical Cases.

CLINICAL NOTES.

By A. E. HAWKES, M.D.
Hon. Medical Officer, Hahnemann Hospital, Liverpool.

SEPTIC THROAT.—A few weeks ago Nurse——, while attending on a case of colotomy, contracted a severe sore throat. The pulse ran up, the temperature was 101·5° F., and the tonsils were both affected with follicular inflammation. She had had no prior experience of homœopathy, but willingly took the *ailanthus* IX I mixed for her, about one-third of a drop for a dose, and in thirty-six hours she was quite well. She had already seen the good effect of *veratrum* 3x during attacks of colic, to which, together with some diarrhœa, her patient was subject.

She, however, came to use the *veratrum* under circumstances somewhat differing from those originally calling for its exhibition, and it had to be pointed out to her that the discomforts of an attack of icterus were more likely to be relieved by *merc. dulc.*, which was accordingly given with advantage. She had early to learn that empiricism and homœopathy are not quite the same thing. This nurse's first contact with homœopathy has favourably impressed her, and she is very anxious to watch its effect in cases of actual disease.

APEX PNEUMONIA.—Some few weeks ago I attended a young man, aged 23. His right apex was dull, and his temperature 103° F.; moreover, there was a fair quantity of blood in the expectoration. *Phosph.* 2 was the chief remedy, and it acted admirably, but the hæmoptysis required a few doses of *millefolium* IX, and the remaining dulness gradually cleared up under *iodium* 3x. The clear, green expectoration was carefully examined for the tubercle bacillus with negative results.

I have recently seen a lady whom I treated some years ago with the same remedies for similar dulness and general symptoms. She has gained flesh and is quite well, although she seemed long ago to be threatened with phthisis.

URETHRAL FEVER.—A gentleman, aged 74, who has long

needed to use a catheter habitually, had a rigor; his pulse was rapid—110—and his temperature 102° F. He was very thirsty and his skin was dry. A few doses of *aconite* 1x, about one-third of a drop every hour, removed these symptoms in twenty-four hours.

ADVANCE OF HOMŒOPATHY IN THE WEST.

DEVON AND CORNWALL HOMŒOPATHIC HOSPITAL, PLYMOUTH.

Extension Opened by the Earl of Morley.

THE Earl of Morley opened the extension of the Devon and Cornwall Homœopathic Hospital on December 1, when there was a good attendance, including Lady Mary Parker, the Mayor and Mayoress of Plymouth (Mr. and Mrs. John Yeo), Sir H. Mortimer and Lady Durand, Vice-Admiral Wilson and the Misses Wilson; Revs. W. K. Burford (President), Prebendary W. E. Burroughs, N. N. Lewarne, R.D., Rhys Harries; Dr. W. F. H. Newbery, Dr. P. Wilmot; Messrs. R. W. Winnicott (Deputy-Mayor), H. Hurrell, T. Greek Wills (Deputy-Chairman), F. Underhill (Governor of Plymouth Court of Guardians), Roseveare, Vickery, W. Lewis (Hon. Treasurer), A. Geach (Hon. Secretary), C. G. Brien, F. A. Wiblin (Architect), and others.

The Rev. W. K. Burford, President, and members of the Committee received the visitors at the main entrance. Bouquets were presented to Lady Mary Parker by Miss Greening (Sister-in-Charge), and to the Mayoress by Mrs. W. K. Burford. Mr. F. A. Wiblin (Architect) presented a key to the Earl of Morley; after which the visitors inspected the Hospital.

The inaugural meeting was held in the men's ward, the Rev. W. K. Burford presiding. After the singing of the hymn "Thou to Whom the Sick and Dying," devotions were led by Prebendary Burroughs and Rev. Rhys Harries, Chaplains to the Hospital.

The Chairman spoke of the difficulties of reconstruction, and of how they had been surmounted. They called it a homœopathic hospital, and such it was, with all the advan-

tages of the "One scientific medical system under the sun." As an agent of general philanthropy it commended itself as comparing favourably with any hospital in the West, both on the score of economy and curative results. The presence of the Mayor and Mayoress was pleasing proof that the Hospital had civic sanction. The services of the various helpers, together with that of the doctors and nurses, were gratefully acknowledged. A special tribute of praise was paid to Mr. Lewis (Hon. Treasurer), to whose enthusiasm the completion of the extension in this the jubilee year of the Hospital was largely due.

Mr. W. Lewis explained that the cost of the new property amounted to £1,963. The estimated cost of the alterations for the operating theatres, &c., was £4,110, which, added to the sum already expended, gave a total of £6,073. A list of donors showed a sum of £2,728, and there was a balance against the Hospital of £3,341. Notwithstanding the deficit, they could afford to be optimistic. They had now, in addition to the many facilities for work at the back of the premises, three large wards nameless and unendowed. If any persons who had the funds at their disposal would feel disposed to hand their names down to posterity, now was the time to have their names given to the wards by paying off the debt.

The Earl of Morley, in declaring the extension open, expressed the pleasure it gave him to be connected with an institution which had done such excellent work. The Hospital originally started as a dispensary, just sixty years ago. After it had been working twenty years, he believed, it was removed to 6, Princes Street. There again it was found that the premises were not big enough for the work to be done, and a more commodious place had to be found. The work had increased steadily, and the Committee decided to build the new wing to the premises in Lockyer Street, which he had pleasure in opening that day. In building that wing they decided to have a thoroughly up-to-date hospital, and they secured it. They had an X-ray room, provision for open-air treatment, and many other treatments which he was sure several gentlemen present would be able to tell them about better than he could. There was still a considerable amount of money to be raised. People had come forward very well

up till now, but after they had been through the Hospital and had seen the excellent work done, he felt certain more people would come forward generously. During the past year, 1,246 accidents were attended to, against 984 in the preceding year; 9,214 surgical dressings, against 8,399. The Hospital had a capacity for forty beds. He felt certain that the excellent work done by the Hospital would continue, and that it would attain even better results than in the past.

The Mayor of Plymouth, proposing a vote of thanks to the Earl of Morley, said he was a homœopathist from conviction. That the Hospital, first known as a dispensary, had emerged from the obscurity of Flora Street and Princes Street—back streets of the town—and was now known as the Devon and Cornwall Homœopathic Hospital, proved that the public had found out that homœopathy was effective. The Committee was to be commended for this bold stroke. They had done what was absolutely necessary, what had been highly commendable, and they had done that which if they had neglected they would have been highly blameworthy. He hoped by their subscriptions and by their hearty co-operation in that noble and splendid work they would be able to say of those who were outside waiting, " Let them come in."

Dr. George Burford (London), seconding, said they were a minority cause. Every cause worth its salt had been a minority cause at some time or other of its existence. They were told by critics that majorities were always wrong. Minority causes had the happy knack of being the majority causes of the future. Homœopathy was the medicine of the future; it had already begun to materialize as the medicine of the present. Dr. Burford said he looked forward to the extension of this Hospital just as had happened to all the other homœopathic hospitals in Great Britain.

Sir H. Mortimer Durand, supporting, said he heard on all sides of the untold good the Homœopathic Hospital had already done, and he was delighted to think that it now had an opportunity of doing more good. He had himself become a convert to homœopathy many years ago.

Dr. W. F. H. Newbery stated that they had been labouring a long time under disadvantages. If they could have seen the work done in the small out-patients' department during the

past four or five years, which had been increasing greatly, they would have wondered how the work could be done. Again and again when he had gone down to attend to the out-patients—perhaps there would be thirty or forty—the atmosphere was so bad that it must have been something like the "Black Hole" of Calcutta. Now all that was changed, and they had a building which gave them very much more space than they had had before in connection with the out-patients' department. The wards were airy, and there would be ample room for half as many again as they had been in the habit of packing away in half the space. There would be very great advantage in that respect.

Dr. Wilmot and Mr. Wood (Secretary of the British Homœopathic Association) also supported the proposition, which was carried with acclamation.

Afternoon tea was served after the meeting.

The four floors of the new wing are served by an electric passenger lift, the large car of which is to take operation cases. This is the first direct coupled lift installed in Plymouth on the alternating current main, and it is fitted with solenoid brake control. The contractor who successfully carried out this equipment was Mr. A. Marshall Hunt, of Bristol.

Notices, Reports, &c.

BRITISH HOMŒOPATHIC SOCIETY.

THE third meeting of the Session was held at the London Homœopathic Hospital on Thursday, December 2. Dr. Stonham, Vice-President, was in the chair.

After the minutes had been read and confirmed, Dr. Harold Fergie Woods, of Selby, was proposed as a member of the Society by Dr. Washington Epps, and seconded by Dr. E. A. Neatby. Dr. John Weir, of London, was balloted for and unanimously elected, and formally admitted a member of the Society. It was announced that Dr. Percy Cox, formerly of Manchester, had resigned his membership. There were present as visitors, Dr. Ridpath, Dr. Fergie Woods, Dr. F. Wheeler, and Dr. Hare.

A microscopic slide of diphtheria bacilli obtained in almost pure culture from a pustular rash on the palms of the hands and the soles of the feet was shown by Drs. BLACKLEY and HARE.

Dr. BLACKLEY said the case occurred in a female, aged 38, who came to the Hospital last May with a rash on both hands resembling psoriasis palmaris. She was in good health, and the family history was good; had worked hard, and used "Lifebuoy" soap—a strongly alkaline soap—for washing. The palms and palmar aspect of the fingers were bright red, denuded, and intensely painful. She was treated at first as an out-patient, but was admitted to the wards on July 1, when the palms and palmar surfaces of the fingers, as well as the soles of the feet, were covered with red, purulent blebs. The pus from the pustules was examined by Dr. Hare, and found to yield an almost pure culture of *Bacillus diphtheriæ*. The origin of the infection was thought to be from a cat which had had a discharge from one ear, and was accustomed to sleep in the sink at which the washing was done.

Dr. HARE said that Dr. Blackley's case was the thirteenth in which he had found the diphtheria bacillus associated with skin disease; the organism had been isolated in all the cases, and had usually been obtained from the serum or pus of closed bullæ. They had all yielded to antitoxin treatment. He mentioned a fourteenth case which had come under his observation since Dr. Blackley's, and occurred in a child who had an acute pustular and vesicular eruption of the skin of the face, with swelling of the eyelids and diphtheritic membrane covering the right eyeball. Pure diphtheria bacilli cultures were obtained, and diphtheria antitoxin was injected, with the result of cure in one week.

Dr. Blackley's case got well under *petroleum* 30, one dose, *diphtherinum* 200, one dose, and *petroleum* 200, one dose, at intervals of a week.

Mr. KNOX SHAW showed a prostate, enucleated suprapubically, in a man aged 77. He was admitted to hospital on October 7 with retention of urine. Catheterization was practised with difficulty till the 12th, when the prostate was enucleated suprapubically; no drainage tube was used. On the thirteenth day after the operation the wound was quite

dry, and a catheter was then passed and retained for a few days. He passed urine naturally on the sixteenth day. The middle lobe of the prostate was enlarged and had caused the retention.

Mr. KNOX SHAW then showed a specimen of ileum, cæcum, and ascending colon, which had been successfully removed for carcinoma. The case was that of a single woman, aged 51, who was admitted on October 3. Seven years ago she had had a tumour of the right breast, which, under treatment by Dr. Macnish and Dr. Margaret Tyler, had disappeared. For the last two years she had had abdominal pain and diarrhœa alternating with constipation; sour-smelling material had passed in the stools, but no blood. Three weeks before admission a freely movable mass was felt in the right ileo-cæcal region. On November 9 the mass, with a portion of the ileum, the cæcum, the appendix, and the ascending colon, with some glands, were removed. The divided ends of the colon and ileum were closed, and these two portions of bowel were then reunited by lateral anastomosis. An action of the bowels took place two days after the operation; in ten days she was out of bed, and is now going to a convalescent home.

Drs. NEATBY and ORD showed an adeno-carcinoma of the right uterine cornu; there had been some post-menopausic hæmorrhage and an offensive discharge. The tumour was of peculiar shape, protruding from the right cornu of the uterus, from which it was a distinct outgrowth, and was mainly carcinomatous tissue.

Dr. RIDPATH, of Sunderland, who was introduced by Dr. Le H. Cooper, then read his paper on "The Selection of the Remedy." The paper was an able exposition of Hahnemann's instructions for the selection of the remedy, as set forth in his *Organon of the Healing Art.* He emphasized the fact that pathological conditions, or "ultimates," are not disease, but the results of disease, and are not the principal factors to be taken into account in choosing a remedy. He advocated the following of Hahnemann in his method of taking the case, by carefully writing down all the symptoms of the sick person, as first furnished by himself, and afterwards those noticed by those about him, and then selecting the remedy by considering first the general symptoms and then the particulars.

He noticed as causes of failure in prescribing, bad case-taking, pathological prescribing, the wrong potency, too frequent repetition of the remedy and alteration of medicines. To illustrate the proper manner of selecting the remedy, he gave in full four cases, one of which we append.

Case of Renal Calculus—Lycopodium.

June 7, 1906.—F. C., aged 31, book-keeper in mercantile house, complained of having been unwell for a long time, during which he had been under much medical treatment, and he had been told that he was suffering from renal calculus, for which he would have to be surgically operated upon. During the attacks he was continually kept under the influence of *morphia* hypodermically, "which did no good, indeed, quite the reverse, there being no easing of the intense pain, and then the *morphia* making me sick."

His first outing was to visit me, as he did not like the idea of being operated upon. On this date I have entered in my case book as follows:—

Dull aching pain in left hypochondrium for months. Sharp sticking pain from left loin down to pubis. Last year had a fall down a trap and thinks he may have strained himself. Urine frequently bloody. Once had red sediment in his urine. Alternate diarrhœa and constipation. Desire to take deep breaths. Dull ache for months down outer left thigh and leg. Sensation of throbbing internally; conscious of heart beating. Borborygmi; heat of back; right hypochondrium sore to touch; appetite easily satisfied. Must wait a long time for urine to pass. Urine intermittent flow. Must wait a long time for urine to start. Retarded.

With these symptoms I at once turned to Kent's Repertory, with the following result. The numbers indicate the page in the Repertory, second edition:—

Pulsation internally, 1353.—Acon., aur., alum., bor., bry., cact., calc., calc.-p.

Desire to breathe deep, 760.—Caps., carb. v., caust., chin., crot. t., glon., ign., lyc., merc., mez., mosch., ntr. s., nux. m., par., phos., ran. b., sang., seneg., sep., stann., stram., sulph., verb.

Easy satiety, appetite, 478.—Bry., caust., chin., ign., lyc., merc., phos., sulph.

Pain right hypochon., 563.—Bry., chin., ign., lyc., merc., phos., sulph.

Urine frequently bloody, 679.—Chin., lyc., merc., phos., sulph.

Heat of back, 878.—Lyc., phos., sulph.

Urination interrupted, 656.—Lyc., phos., sulph.

Urination retarded, 651.—Lyc., sulph.

Here you see that the probable remedies were reduced to two, lyc. and sulph., and without going any further with the Repertory I made use of what little knowledge of materia medica I possessed to decide which of these two remedies I was to give. The first question I put decided the selection. I asked the patient if he observed any difference in the temperature of his feet. He at once replied, in astonishment, "Yes, the right is colder than the left. This," he continued, "I told the last three doctors I had, but as they only laughed at me for describing such a symptom I was afraid to mention it to you, and now, wonderful, you have just asked me that question." This confirmed the selection of *lyc.*, of which I gave him *lyc.*, M., four doses, to be taken in water night and morning.

July 2.—Much better in every respect, has no pain to speak of. But as this is not a report of treatment I briefly state that he continued well with occasional repetitions of the medicine till, on November 5, while at the lavatory, the flow of urine suddenly stopped, and after a short time something passed with great pain, followed by free flow and continued immunity from pain.

A very animated discussion followed the reading of Dr. Ridpath's paper, in which the Vice-President and Drs. Weir, Wheeler, Byres-Moir, E. A. Neatby, Roberson Day, Knox Shaw, Goldsbrough, Eadie, Dudley Wright, Hey, Miller Neatby, Woods, and Le H. Cooper took part.

Dr. Ridpath replied.

PUBLIC LECTURE ON "ARSENIC."

By Dr. Wheeler.

On Wednesday evening, December 8, Dr. Wheeler delivered, at Chalmers House, 43, Russell Square, one of the monthly popular lectures that are being given this winter under

the auspices of the British Homœpathic Association. Dr. Wheeler had an appreciative audience which filled one of the Association's rooms at '43, Russell Square. The subject, "Arsenic," was treated in a manner suitable for a lay assembly. He discoursed on the history of the drug and its employment as a secret poison by the Borgias, Pope Alexander VI., Catherine de Medici, and Lucrezia Borgia; how the poison was supposed to be conveyed in poisoned gloves, rings, keys, apples, flowers, torches, and the use that had been made of these facts in romantic literature. He mentioned also the Aqua Tofana, which was a mixture of arsenic and cantharides, and probably destroyed the victims to whom it was administered by disorganizing the kidneys.

Tracing the history of arsenic down through the centuries he came to the important date, 1786, when a book was published on arsenic by Samuel Hahnemann, recording all that was known of it, his facts being culled from 389 different authors, and containing recommendations for recording and regulating the sale of the poison which are similar to those in use at the present day. This book was written before Hahnemann had discovered the homœopathic law, as it was not till 1790 that his researches led him to formulate the idea in his mind, and not till 1810, twenty years later, that he felt justified in considering it sufficiently tested to set it forth authoritatively in the *Organon*. The discovery of the homœopathic law at once converted arsenic from being known only as a dangerous poison into one of the most valuable of remedies. A signal proof of this was afforded during the outbreak of cholera in this country in 1850, when the great similarity of the symptoms of cholera to those of poisoning by arsenic led homœopaths to employ that drug largely in the treatment of cholera patients. The report of the medical officers employed by the Government to tabulate the results of the treatment of cholera patients at the Metropolitan hospitals disclosed a mortality of 51 per cent. in the general hospitals, but only of 16 to 17 per cent. in the Homœopathic Hospital. This good result was a great help in obtaining security for the practice of our belief in the subsequent Medical Act; a clause was inserted disenabling the Medical Council to strike off the Register any qualified practitioner

merely on the grounds of his professing and practising in accordance with any particular medical theory or belief.

A crude kind of homœopathy has long been practised by the arsenic-eaters of Styria, who, beginning with minute doses, gradually increase the amount till they can bear with immunity considerable quantities. They take it to enable them to climb hills better without losing breath. Arsenic is known in poisonous doses to have the power of causing degeneration of the heart-fibres, so that the Styrian arsenic-eaters are using the drug in a homœopathic manner. So also are those who give arsenic to horses to improve their coats, as arsenic has a very great influence on the skin, and causes falling out of the hair. To show that a drug which has a depressing effect in large doses has a stimulant effect in a smaller one, Dr. Wheeler quoted the results of some experiments he had made on the action of arsenic on protoplasmic life in its simplest form. He had exposed yeast to the influence of various strengths of solution of arsenic and found that a solution of one in a thousand killed the yeast-cells, a solution of one in ten thousand allowed them to grow, but more feebly than natural, while a solution of one in one hundred thousand stimulated their growth.

Dr. Wheeler concluded an interesting lecture by an eloquent peroration expressing the hope that as Hahnemann's great discovery of the law of similars had changed our ideas about arsenic, from its being viewed only as a deadly poison to its being valued as one of our most potent agencies for the cure of disease and the restoration of the sick to health, that so also the two main hindrances to the acceptance of Hahnemann's doctrine — prejudice and pride — might be changed to steadfast adherance to established truths and a proud humility in learning new ones.

LAUNCESTON HOMŒOPATHIC HOSPITAL, TASMANIA.

THE Annual General Meeting of the Hospital was held on September 24, 1909, Mr. Henry Ritchie in the chair.

The Medical Officer (Dr. P. Douglas Smith, M.B., C.M.) reported: It gives me pleasure to be able to report that the past year has been the most successful since our Hospital was

opened. Whereas 75 patients represent the greatest number admitted during any previous year, this year 120 were received into the Hospital as in-patients. There were remaining at the end of June, 1908, 3 patients, and at the end of June, 1909, 10 patients were in Hospital. Those discharged and died totalled 113. Of these, 89, or 79 per cent., were cured; 10, or 9 per cent., were improved or relieved; 4 were unimproved; 1 was sent out owing to the infectious nature of the case; and 9, or 8 per cent., died. Of the deaths, 1 was due to pneumonia, 7 were due to causes necessarily fatal, such as advanced cancer and heart disease, and 1 patient died of a combination of enteric fever, advanced chronic Bright's disease, hydatids, and two or three other ailments. Thirty-seven cases of enteric fever were treated during the year, and the only one who died was the patient above mentioned. Altogether, since the opening of the Hospital, and up to June 30 last, 105 cases of enteric fever has passed through our hands, with a mortality of less than 1 per cent.

The financial statement showed that the receipts for the year totalled £719 6s. 5d., and the expenditure £697 2s. 4d., leaving a credit balance of £22 4s. 1d.

THE BRITISH HOMŒOPATHIC ASSOCIATION (INCORPORATED).

SUBSCRIPTIONS and Donations received from November 15 to December 15, 1909:—

GENERAL FUND.

	Subscriptions. £ s. d.	Donations. £ s. d
Alfred Powell, Esq.	1 1 0	—
H. M. John, Esq.	0 10 6	—
C. F. Pearson, Esq.	1 1 0	—
The Earl of Dysart (for Scholarships in connection with the Honyman-Gillespie Course).	—	50 0 0
Mrs. H. Fowler	2 0 0	—

LADIES' BRANCH.

Sale of Work...	—	14 9 4

LADIES' NORTHERN BRANCH.

	Subscriptions. £ s. d.	Donations. £ s. d.
Miss Amelia Moore	1 1 0	—
Mrs. John Calder	1 0 0	—

An adjourned meeting of the Executive Committee was held on Monday, November 15, at 4 p.m., and the Medical Committee met on Monday, November 22. A special meeting of the Council was held on Thursday, November 25, at 3 p.m., and the usual meeting of the Executive Committee on Wednesday, December 8, at 4.30 p.m. The Committee of the Ladies' Branch met on December 14.

An interesting lecture was given at Chalmers House on Wednesday, December 8, by Dr. C. E. Wheeler, M.D.Lond., B.Sc., on "Arsenic."

A public lecture will be delivered at Chalmers House on Wednesday, January 19, 1910, at 8.30 p.m., by Dr. Alfred Pullar, M.D.Edin., on "Popular Conceptions of Medicine and the Aims of Hahnemann."

Scholarships in connection with the Honyman-Gillespie Course have been awarded to Dr. H. Lovett Cumming and Dr. Jessie M. Murray respectively.

[LADIES' BRANCH.]
KENLEY STREET DISPENSARY.

There has been a great increase in our numbers in November — 316 as against 242 for October; those for December show a decrease—only 88 up to December 13. This we must attribute to the absence of our doctor, who was suddenly called up North on November 27. For nearly three weeks his place was ably filled by Drs. Ramsbotham and Murray, who attended, the first-named three times, the second twice weekly.

Patients for November, 107; attendances, 314.

Therapeutic Digest.

LACHESIS IN FACIAL NEURALGIA.—Dr. E. R. Miller reports the case of a man, aged 72, who had for eighteen months following the extraction of a molar tooth suffered intense pain in the left upper jaw. The pain was acute, lancinating, piercing, as if one forced in a knife into the affected region. It was worse from eating, from drinking cold water in the morning and afternoon, from taking acid things, and from movement. It was better from warm drinks, at night and after dinner. There was very great sensitiveness of the dental cavity in the morning, which was increased by suction, swallowing, talking, and laughing. It was always better in the evening. *Mag.-phos. aconite, arsen. alb.* and *merc. sol.* were tried without effect, although the treatment was continued for six weeks. Finally, on account of the last indications, *lachesis* was given in the 6th, then the 12th, and then the 30th dilution, with rapid relief, and complete cure at the end of a mouth.—*New Eng. Med. Gazette,* November, 1908.

POISONING BY INFUSION OF STAR ANISE (ILLICIUM ANISATUM).—MM. Balthezar and Ogier presented to the Society of Legal Medicine an account of a family poisoned by star anise. Badiana, or star anise, has not the reputation of being a dangerous drug, and one is accustomed to use it without taking any precaution. Yet a whole family presented symptoms of poisoning from having drunk, after dinner, a glass of a strong infusion of it. These are the symptoms reported: During the night which followed the repast there was first vomiting, then loss of consciousness and epileptiform convulsions, with biting of the tongue. Complete recovery at the end of eighteen hours. We remark that the infusion of star anise absorbed by the patients was fifty times stronger than the usual dose. This fact demonstrates the convulsive properties of star anise, and as this umbelliferous plant (does it not belong to the magnolias?—Ed. *B.H.R.*) enters into the composition of the liqueur absinthe, one must attribute to it a share in the convulsive influence that this liqueur possesses. The above cases of poisoning complete our patho-

genesis of the medicine, for hitherto neither convulsions nor loss of consciousness have been credited to it.—*L'Art Médical*, June, 1909.

THE ANTIMENINGOCOCCIC SERUM OF FLEXNER IN GONORRHŒAL ARTHRITIS.—MM. Pissayy and Chauvet, relying on the similarity which exists between the meningococcus and the gonococcus, have made use of the antimeningococcic serum of Flexner in the treatment of two cases of gonorrhœal arthritis. They made repeated injections of 20 to 40 c.c. of serum at frequent intervals. After each injection they noticed an elevation of temperature and a recrudescence of the pains for a short time, the pains being of a nocturnal character and disappearing in the morning. The various symptoms of gonorrhœal rheumatism reacted differently to the serum. (*a*) The pains were the first to go, after having changed their character. (*b*) The joints lightly affected in which there were only a little puffiness and functional impairment rapidly got better. (*c*) The pseudo-phlegmonous joint affections passed through several phases in their evolution to cure. (1) The spontaneous pains disappeared at once without there being any modification of the local condition; provoked pains continued. (2) Provoked pains disappeared. (3) The joint commenced to diminish in size, the extra-articular œdema to change its character and to progressively disappear; but there remained some puffiness of the joint, not painful, and compatible with slight movements. (4) A crisis supervened, comprising a thermic, a sweat, and a urinary crisis. From thenceforth the puffiness of the joint almost entirely disappeared, the patient began to walk, and the case progressed to cure.

Symptoms may be caused by the serum; in the first case pain came on in joints hitherto unaffected. These induced symptoms end in a crisis which coincides with definite improvement.—Dr. Marc Jousset in *L'Art Médical*, November, 1909.

THE SALTS OF CALCIUM IN NEPHRITIS.—In the *Semaine Médicale*, M. Tumminia recounts his experience with this remedy in a number of cases of nephritis, treated by him in the hospital at Palermo. He proceeded as follows: The diagnosis of nephritis having been made the patient was kept for ten days on an absolute milk diet, his urine collected

every twenty-four hours and chemically and microscopically examined. Then for the next ten days, while continuing the milk diet, a daily dose of ½ to 1 grm. *chloride of calcium* was given, his urine being examined as before. Then the medicine was discontinued and the urine analyzed for a dozen days more. The blood-pressure was also measured before, during and after the treatment. Of twenty cases, M. Tumminia obtained on three occasions results almost unhoped for; thanks to the *chloride of calcium* he saw the daily quantity of urine increase and almost reach the normal, the density was increased, and the albuminuria and casts diminished, and finally entirely disappeared; the blood-pressure was considerably raised. In thirteen other cases the treatment gave results which, through not so marked as the preceding, were yet very encouraging; under the influence of the *chloride of calcium* the quantity and specific gravity of the urine increased, the albumin and casts diminished, and the arterial tension was raised, but the disappearance of albumin and of the renal elements in the urine was not complete. In four patients treatment by *chloride of calcium* for the ten days effected no improvement.—Dr. Marc Jousset in *L'Art Médical*, November, 1909.

STARCH AND INFANT FEEDING.—Dr. Edmund Cautley, Physician to the Belgrave Hospital for Children, combats the prevalent idea that because there is no starch in human milk all starch-containing foods are contra-indicated in the feeding of infants during the first few months of life. From a variety of observations he draws the following general conclusions:—

(1) A diastatic ferment is secreted by the salivary glands and pancreas of new-born infants.

(2) Its amount and activity are slight in the first few weeks of life, and after that rapidly increase.

(3) The glands, notably the pancreas, can be trained by means of a starchy diet to the secretion of an increased amount of the amylolytic ferment.

(4) Practical experience has shown that the usual barley water contains about 2 per cent. of starch. If mixed with an equal quantity of milk there will only be 1 per cent. of starch in the mixture. Such an amount is non-injurious and almost

certainly is beneficial, for it encourages the growth of lactic acid bacilli and the formation of lactic acid, which are of advantage in preventing the growth of proteolytic bacteria.

(5) If a starchy food is used in the first few weeks of life it is advisable to begin with a milk mixture which will not contain more than 0·5 per cent. of starch, and to gradually increase the amount as the child grows older. If the stools become very acid, or if they give a distinct starch reaction, the percentage of starch in the diet must be reduced.

(6) The evil effects of starch in early life are due to (*a*) excess; (*b*) its administration in the form of a more or less insoluble emulsion instead of as soluble starch; (*c*) the substitution of starch for the necessary protein, fat, and salts. In other words, the mischief results from deficiency of necessary proximate principles of diet rather than from the presence of starch.—*Lancet*, November 6, 1909.

SOME CINA CASES.—Dr. Charles J. Lopez, of New Orleans, in an article on "Some Uncommon Indications for *Cina*," points out that *cina* is a medicine having a distinct influence on the nervous system, as well as its power in causing the expulsion of worms, and that the nervous symptoms cured by it need not necessarily have their origin in worm irritation. He brings forward three cases in support of this. The cases were suffering from a kind of convulsive tic. The patients were a lad aged 15, a boy aged 13, and a girl aged 10. They all had jerking movements of the limbs, so that they could not write or play the piano, the feet jerked spasmodically, especially the left foot, which was in constant spasmodic motion, sudden jerkings of the fingers, twitching of the limbs, pulsation of the superciliary muscle. *Cina* was administered steadily for two months in the case of the young man, and three months and a few days in the other two cases. The potencies used were 6, 12, 30, and 200 in rotation, and the frequency of the doses was also constantly changed from once a day to once a week, according to the patient's progress. Dr. Lopez has been able to keep in touch with the three patients for the last ten, seven, and six years, and they are free from any recurrence of nervous disturbance.—*North American Journal of Homœopathy*, August, 1909.

A CASE OF METRORRHAGIA.—April 21, 1899.—Mrs. W. H., aged 30, married, two children. Trouble has now existed for six years, during which time she has had much old school treatment, including curetting, without benefit. Is flowing almost all the time. Menses appear ten days before time, and last ten days, are bright red in colour, very profuse, accompanied by headache and bearing-down sensations. Aversion to much covering, wants to be cool, cannot stand a hot room. Sensation as though needles and pins were pricking her feet, < stepping. Numbness of feet. Flow < from any exertion. During flow is very weak. Dragging-down sensation from umbilicus. *Secale cornutum* 200, three powders, one every night on going to bed.

May 3.—Menses came on April 25 and lasted until to-day, were profuse the first two days, dark and clotted. Bearing down and backache.

May 12.—Leucorrhœa, of which she complained, is much less now. Numbness of feet much better.

May 22.—No flow yet. Feels well.

June 2.—Menses came on day following last visit (May 23), lasted six days, and were normal in appearance and quantity.

Some treatment for her constitutional condition followed, but the metrorrhagia did not return.—*North American Journal of Homœopathy*, August, 1909.

BARIUM AND "LOCO" DISEASE.—Some interesting work carried out by Dr. Crawford and reported to the Johns Hopkins Medical Society in May, 1908, serves to illustrate two points very forcibly—namely, first, the tremendous importance of a knowledge of the part played by inorganic substances in the metabolism of animals and plants, a *rôle* that is only just beginning to be understood; and secondly, the value of clinical laboratory work, not only in connection with human disease, but also in that of animals. Loco disease is an affection chiefly of cattle, occurring in America and in Australia, as a result of eating a leguminous plant called the "loco" plant. The term is of Spanish origin, from a word meaning crazy. Animals that have the complaint present two types of symptoms—gastro-intestinal and nervous, the latter

leading to craziness in the animals' behaviour. *Post-mortem* examinations reveal nothing characteristic, though occasionally there is ulceration of the stomach and dilatation of the vessels of the dura mater. That the plant is the cause of the disease was proved by feeding experiments. Dr. Crawford found that an aqueous extract of the plants, given orally to rabbits, caused death within a very short time. Repeated small doses of the plant caused emaciation and death in somewhere about ten days. The symptoms were those exhibited by cases of "loco" disease.

It seemed natural, at first sight, to expect that the poisonous principle would be some organic vegetable substance—an alkaloid or a glucoside, for example. Many attempts have been made to isolate some definite active principle of this sort from the plant, but all were unsuccessful. It was only when attention became directed to the *inorganic* constituents in the ash of the dried plants that light began to be thrown upon the matter. It was discovered that barium was present in very large amount—200 grm. of the dried plant containing from 76 mg. to 173 mg. of barium acetate. Crawford then fed rabbits with food to which small doses of barium had been purposely added, and he found that the animals developed symptoms of acute or chronic poisoning that were like loco disease. It was found that if the barium were first removed from the extract of loco plant, animals could eat it with impunity, whilst if the barium were now reintroduced the animal was soon killed. When analyses of "loco" plants from various parts of the country were made, it was discovered that in some places hardly any barium was present, whereas in others it was abundant. Animals could eat the specimens of loco plant that were wanting in barium without suffering harm. The results of the laboratory investigations, therefore, point to the fact that loco disease depends upon the prevalence of barium in the soil of the ranches over which the cattle graze, that the metal is taken up by the plants, which when eaten produce the poisonous symptoms.

If barium salts can kill animals in this way, how important they must be in the human economy. It is likely that inorganic constituents of foods will receive increasingly close attention as time goes on, and one of the elements to which too little

attention has been directed in the past would seem to be barium.—*The Journal of Clinical Research*, October, 1909.

BROMIUM, 1x-2x.—WHOOPING COUGH.—It appears that few, if any, physicians recognize the extraordinary value of this remedy in the treatment of this intractable affection. This fact appears the more singular as its pathogenesy manifestly indicates its use in spasmodic affections of the bronchial portion of the respiratory tract. This is probably due, in a large measure, to the worthlessness of the remedy in stock because of its instability and tendency to rapid deterioration. The reliability of the drug must be insisted upon absolutely if its use is not to prove disappointing. Have it fresh and properly prepared and in the lower dilution, the 1x and 2x being found most affective by me.

In some cases the beneficent effect is promptly apparent. More often there can be observed no appreciable effect of the remedy until it has been taken persistently for ten days or two weeks, then there results so complete and sudden an amelioration of the disease as to be, in some cases, almost startling—so much so that you will at times doubt your diagnosis of the condition. It is then that the paroxysms of coughing completely disappear or become infrequent and less spasmodic, with a tendency to disappear within a very short period of time. With the continued administration of the remedy at less frequent intervals, the few tardy symptoms clear away and the little sufferer remains well.

The indiscriminate use of the remedy necessarily means some failures, but the dearth of characteristic indications or symptoms in the early stages of the disease has led me to an almost routine use of the remedy as soon as I am fairly sure of my diagnosis.

The only special indication that can be given you are, the aggravation late in the day and early part of the night, and also from the warm air of a poorly ventilated room.

In association with *bromine*, *belladonna* and *ipecac.* are valuable intercurrents; *belladonna* for dry cough with the appearance of fever, and *ipecac.* where there are excessive quantities of mucus with a tendency to vomit—both condi-

tions are from bronchial inflammation resulting from taking cold.

An effective way to administer the remedy is to add 2 to 3 drachms of the 1x and 2x dilutions to 6 oz. of simple syrup —giving a teaspoonful from one to two hours.—*The Clinique.*

LEAD POISONING FROM A SODA-WATER FOUNTAIN.—In the *Boston Medical and Surgical Journal* of November 4, Drs. Patch and Taylor have reported a case of lead poisoning from an unusual source. A Russian Jew, aged 55, was admitted into hospital on August 22, 1908. His wife and one daughter were ill from lead poisoning, and another daughter had recovered from it. For the past two years the patient's health had been failing. Two months before admission he had severe colic with hæmaturia and constipation. The pain continued. For a few days he was forgetful and could not complete his sentences. On admission he was semi-conscious and difficult to rouse. Lead line on the gums. Knee-jerks normal and no evident paralysis. The skin was pasty and the mucous membrane pale. Pulse of low tension. Fine moist râles at the basis of the lungs. Ankles slightly œdematous. Urine contained a trace of albumin and a few hyaline and granular casts. It was found that eighteen months previously the patient bought a second-hand soda-water fountain, in which lead piping was afterwards substituted for the block-tin piping which had become leaky. His only drinking water was obtained from this fountain. He began to feel week and to lose power in lifting. In the following month he had crampy pains in the abdomen and limbs. Later, wrist-drop and atrophy of the supraspinati and muscles of the arms developed, and some of the muscles gave the reaction of degeneration. Under *potassium iodide* and *galvanism* he recovered. — *The Lancet,* December 11, 1909.

NOTICE TO CORRESPONDENTS.

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All MSS. should be in the hands of the Editor by the 15th of the month at the latest.

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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 Médico-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 Médical, Revue Homœopathique Française, Revue Homœopathique Belge, The London Graduate.

THE BRITISH
HOMŒOPATHIC REVIEW.

FEBRUARY, 1910.

Editorial Notes and News.

***** The Editor would be very glad if those who kindly promised contributions to our pages would send them on at the earliest possible date.**

School Clinics. THERE is a movement on foot to establish what are called school clinics in the elementary schools. Their object is to treat those children whom the school inspection medical officers report to be in need of it. A beginning has been made at Bradford, where a doctor and nurse were appointed last July, and the first school clinic opened ready to treat all children sent from the schools by the visiting school medical officers. From July to December 4,050 attendances were made at the clinic; 590 children came for examination and 841 for treatment. On Monday mornings and afternoons and Tuesdays, only eye cases are seen; on Wednesdays and Saturdays, skin diseases; on Thursdays, ear diseases; and on Fridays, anæmic children and those of poor nutrition. The influence of the clinic is already showing good results. Of the 841 treated, 546 are reported cured; and with regard to neglect and dirt, whereas in 1906 only 3 per cent. were clean, in 1908 nearly 20 per cent. of all the children were beyond reproach. In 1906, 70 per cent. were decidedly dirty; in 1908 not more than 40 per cent. were really dirty. A school clinic has been opened in London at Devon's Road School, Bow. Probably in time these school clinics will become general. If this should

be the case, homœopaths should endeavour to ensure the appointment of as many of their number as possible to the post of school clinic doctor. This is advisable in the interests both of the spread of homœopathy in this country, and of the welfare of the children, for whose complaints homœopathic treatment is so much the most pleasant and efficacious.

* * * *

Intermittent Claudication.

THIS affection is at times met with in the horse. A horse after being driven for fifteen or twenty minutes stops, the hind legs get stiff, and soon it is unable to stir. It may fall down and show signs of great suffering. In from half an hour to an hour it will recover and go on comfortably for another fifteen minutes, and then the attack recurs. In *post-mortem* examination of such cases the main *artery* of the affected limb has been found blocked with a clot, or when both legs have been involved the abdominal aorta has contained a thrombus.

A similar train of symptoms has been described in man accompanying obstruction to the main *arterial* supply to a limb; numbness, tingling, paresis, or transient paralysis are the usual symptoms, and arterio-sclerosis is generally present. In both these cases the phenomena observed owe their existence to arterial obstruction, by which a relative ischæmia is produced: a condition in which the demand for arterial blood is in excess of the possibilities of supply. The main artery being blocked, the deficiency in blood supply is a deficiency in quantity. A persistent use of the salts of *barium* would probably help the patient.

* * * *

Angina Pectoris.

A SIMILAR explanation has been offered to account for the pains of angina pectoris—in any case of the true coronary angina. It would seem, therefore, that we may have "intermittent claudication of the heart" and "angina pectoris" of the thigh. In angina pectoris a block exists in the main blood supply to the ventricular walls, commonly the left, of such a nature that the demand for a greater quantity of blood cannot be met. In the most severe cases of angina there is sclerosis at the root of the aorta, that is, the block is

at the orifice of the coronary artery. The lesion must be one that reduces the lumen of the vessel; mere rigidity and atheroma of the wall is not enough; though, in a very real sense, anything that destroys the elasticity of the vessel wall is equivalent to a reduction in size of its lumen. This explanation seems a very reasonable one of many cases of sudden death in angina. There is some sudden reason for an increased supply of blood to the ventricle: but this demand cannot be met and a relative ischæmia is produced in which the quantity of blood flowing to the ventricle falls below the minimum demanded by the organ for this particular crisis; hence cramp or paralysis and sudden death. In the case of a leg one can stand still, till equilibrium is once more established, but in the case of the heart the conditions are different. Sometimes even the first attack is fatal, as in the case of Thomas Arnold, of Rugby; but in his case there was but one coronary artery, and that, considering the size of the heart, was of small dimensions. Thomas Arnold's name will always be associated with Rugby, though at the time of his death he had recently been appointed to the Professorship of Modern History at Oxford.

Is it possible that the phenomena of angina pectoris may be explained in some cases by vaso-motor constriction of the coronary arteries, such as is found in other arteries to account for "dead fingers," the phenomena of Raynaud's disease, and in muscular cramps? Further, there can be little doubt that acute over-distension of the ventricle also plays a part in the phenomena of angina pectoris, when remedies like nitrite of amyl and glonoine act so promptly by reducing arterial tension.

* * * *

Explanation of some other Symptoms in Angina.

DR. JAMES MACKENZIE thinks that the feeling of *constriction* in the chest is associated with, and due to, spasmodic contraction of the intercostal muscles. Whether this is so or not, in many cases the sensation is *as if* the heart itself was spasmodically constricted; and in either case we at once think of *cactus* with its "belt of pain," as well as its sensation "as if the heart were grasped by an iron hand."

To explain the radiation of the pains, it has been suggested

that the stimuli arising in the heart are conducted to that segment of the cord which gives origin to the ulnar nerve, to the distribution of which the pain is referred. In the great majority of cases the pain radiates down the left arm (*acon., cactus, crotal., kalmia, rhus, spig., tabac.*). In some cases it radiates down both arms (*spig.*). In rare cases it is referred to the right arm only (*phyto.*). In cases where it radiates down both arms, or to the right arm only, Bramwell thinks that the irritation which causes the pain has its point of origin *outside* the heart, *e.g.*, a lesion of the root or the arch of the aorta, or of the outer coat of the aorta. In this connection it should not be forgotten that aortic disease is often due to syphilis.

But may not the right ventricle suffer from "angina" as well as the left, and the right affect the right arm, just as the left ventricle affects the left arm?

Bramwell would explain the pains of angina as the result of excessive stimulation or irritation of any part of the sensory (afferent) nerve apparatus connected with the heart itself, or the great vessels at its base. He believes that on this hypothesis the pains in the various forms of angina can be best explained. His views, however, are by no means universally accepted.

* * * *

Mitral Regurgitation in Elderly People.

On this subject Sir R. Douglas Powell, in a lecture delivered about a year ago, makes some pertinent remarks: "The development of a mitral murmur in elderly people is very common, and is not necessarily of much importance. If the first sound be not wholly replaced, and if the cardiac rhythm be fairly steady, and the pulse volume fairly good, you need not trouble about the existence of a murmur. Indeed, I have often expressed the view that many old people are the better for the existence of a certain degree of mitral reflux, since it neutralizes the mechanism of acute over-distension of the ventricle, which is part of the phenomena of angina pectoris." A curious fact about mitral murmurs (regurgitant) is that while they may be very evident in the recumbent posture, yet when the patient sits up they may quite disappear. Why this is the case is difficult to explain. Is it merely a physical change due to falling back of the heart, and affecting the mitral orifice so as to produce a murmur?

"Safty-valve" Action.

It has been long taught that in some circumstances the closure of the *tricuspid* valve is not complete, and a certain quantity of blood is forced back into the auricle. This has been called its "safety-valve action." The circumstances in which it usually happens are those in which the vessels of the lung are already full enough, when the right ventricle contracts, *e.g.*, in certain pulmonary diseases, in very active exertion, and in great efforts. Such is the old explanation. Another possible advantage of the incompetence is that the regurgitant jet, in all probability, directly stimulates the "bundle of His."

We have long held that there is a similar safety-valve action of the mitral valve, and this is usually associated with deep sighing inspirations. One can often detect mitral regurgitation when a healthy man takes a very deep inspiration while standing erect. It is important to remember this when examining cases for life insurance. Those who have done much cycling uphill or against a strong head wind will often have experienced the necessity of jumping off because of a curious tight sensation about the heart and difficulty of breathing, evidently cardiac in origin. This, we believe, is due to over-distension of the left ventricle, and the natural tendency is to stand still and take a few deep inspirations. It is at this point, we believe, that the safety-valve action of the mitral is so important in preventing paralysis, from acute over-distension, as well as actively stimulating the "bundle of His," and so reducing the chances of heart failure to a minimum. In elderly people mitral regurgitation is evidently of the nature of a "safety-valve action."

* * * *

Sciatica.

Billroth, many years ago, pointed out that there were certain cases of sciatica in stout, obese *women* that differed in some respects from ordinary sciatica.

Goldthwait, of Boston, in 1905, accurately described the condition which is now well recognized by orthopædists as *sciatica due to weakness of the pelvic ligaments.* The main lesion is usually a subluxation of the sacro-iliac synchondrosis, more rarely weakness of the ilio-lumbar or pubic ligaments.

In every case there appears to be a definite laxity of the articular ligaments leading to want of exact apposition of the joint surfaces and a consequent inequality between the two sides of the pelvis. One would expect this form of sciatica in sacro-iliac disease in either sex. But the chief cause is undoubtedly repeated pregnancies, and to a less degree the changes in the pelvic ligaments associated with each menstrual period.

Inflammatory conditions and trauma acting upon these ligaments may also induce a like result; in this connection gonorrhœa, syphilis, and rheumatism must be remembered. We would suggest such medicines as *ruta*, *cup. ac.*, and *silicea* as worth a trial in this form of sciatica.

* * * *

Alcohol and Immunity.

THE Wellcome Physiological Research Laboratories have issued a report of some experiments on animals by Dr. P. R. Parkinson, which had for their object to ascertain the influence of alcohol on the reaction of the body to infections. He studied the action of alcohol on the phagocytes and its effect on the opsonic index to *Staphylococcus aureus*. Rabbits were the animals chosen for the experiments. He concluded that alcohol has no effect upon phagocytic activity until it is of such concentration as seriously to injure the vitality of the white corpuscles, a concentration of one in eight, a quantity which could not possibly enter the blood under ordinary circumstances. On the other hand, small quantities of alcohol injected into rabbits may stimulate the production of antibodies temporarily. While a large dose lowers the opsonic index for twenty-four hours, continuous moderate doses cause a permanent lowering of the opsonic index.

* * * *

Treatment of Nævi with Solid Carbolic Acid.

AN important paper was read before the Electro-Therapeutical Section of the Royal Society of Medicine on November 19, by Dr. E. R. Morton, on the treatment of nævi. He brought forward an entirely new method of treating nævi which had been introduced to his notice by Dr. Geysor, of New York, and which he had found so successful that he now

treats more cases with it than by all other methods put together. The process is one of refrigeration carried out by means of the local application of solid carbon dioxide. The solid carbonic acid is formed into the shape of a large, firm crayon and this is firmly pressed upon the nævus for from thirty to sixty seconds. The temperature of solid carbon dioxide is – 79° C., and the effect of a crayon made of this substance being pressed firmly on the nævus is to rapidly freeze it. The frozen surface becomes pure white and hard, like a piece of china. Thawing takes place as soon as the crayon is removed and the depressed tissue gradually returns to its normal place and colour. Reaction sets in at once, and within a few seconds the treated area is firmer and soon becomes brawny and swollen. A wheal develops with acute hyperæmia within half an hour, and a vesicle within an hour. In a few days a crust forms, which is left to detach itself spontaneously. In a fortnight the treated area has completely recovered, leaving a surface of a smooth pink colour which gets paler as time goes on. Ultimately there remains a pale, soft, pliable, elastic scar which is as good as that left by radium. Like radium, the application of solid carbonic acid does not immediately destroy the tissues, but sets up a reaction in them which destroys the nævus and replaces it by natural scar tissue. The application is practically painless, though there may be some discomfort during the thawing out; usually one application, if the carbonic acid crayon has covered the whole of the affected area, suffices for a cure. Dr. Morton gives details of the method by which he forms the solid crayons from the snow produced by the evaporation of liquid carbonic acid when let out from a cylinder, in which it is stored at high pressure (20 atmospheres or more).

* * * *

Phosphorus and Chloroform Poisoning.

A GOOD deal has been written during the last year or two with regard to delayed chloroform poisoning, several cases of which have been reported in the medical journals. In these cases vomiting sets in several hours after the administration of the anæsthetic; there are often slight jaundice, muscular tremors, general prostration, acetonuria, convulsions, and finally coma and death may follow. The symptoms

resemble those of poisoning by phosphorus, and so do the pathological changes. There are central hyaline necrosis of the hepatic lobules, fatty degeneration of the liver cells and fatty degeneration of the kidneys and heart; also submucous hæmorrhages, and shallow ulcers, from which there is sometimes much hæmorrhage, may occur in the stomach and duodenum. All these conditions are commonly found *post mortem* in both phosphorus poisoning and in delayed chloroform poisoning. When recovery occurs repair of the hepatic necrosis ensues rapidly; the necrotic cells are absorbed and their place taken by multiplication of the remaining healthy cells in two or three weeks.

Phosphorus, too, has been found by experience to be a good preventive of the vomiting which usually takes place after the inhalation of chloroform, and we think it would be a good routine practice to give it in every case. It is probable that chloroform may always affect the hepatic cells to some extent, though the more serious symptoms of delayed chloroform poisoning occur but rarely. Phosphorus not only counteracts the ordinary slight disturbance, but would probably by its exquisitely homœopathic action prevent the necrosis and fatty degeneration which are the pathological basis of the more severe affection.

* * * *

Specificity of the Conditions for Tumour Growth.

AT the Pathological Section of the Royal Society of Medicine, Dr. M. Haaland, on November 16, adduced evidence as to the conditions necessary for the successful transplantation of tumours. Tumours transplanted into the bodies of the animals from which they had been excised almost invariably developed, while if transplanted into other animals, whether the subjects of tumours or not, they in nearly all cases gave a negative result. This plainly shows that the tissues of each animal are biologically distinct from those of others of the same species, and that the tumour which will flourish in one animal will be unable to gain a footing in another. The practical bearing of these facts is that the greatest care should be taken, when removing a malignant growth, that the wound should not be inoculated with any of the cells of that growth, as they would readily become fresh

foci of disease. They also show the improbability that cancer is spread by infection, the specificity of the conditions necessary for the growth of the cancer cell making it unlikely to grow when introduced into another body, where it would encounter a *milieu* to which it was unaccustomed. Other experiments led to the same result, and showed that the conditions for tumour growth are specific, and that the conditions for which two histologically indistinguishable tumours are adapted are so different that they cannot be exchanged without the malignant mode of growth ceasing altogether.

* * * *

Malaria and Quinine.

THERE are two facts with regard to malaria and quinine which, taken together, are very puzzling. The one fact is the demonstrated power that quinine possesses of destroying the malaria plasmodium in the blood. The other fact is that frequently, although the patient may have taken quinine in large doses and for long periods, the malarial parasite persists, and that this is not necessarily due to fresh infection is proved by those cases which, having contracted malaria in India or elsewhere, return to this country, and yet for a long time—it may be years—are subject to occasional attacks of malarial fever, and this although they are treated each time with large doses of quinine. An explanation may possibly be found in the faculty that all living organisms have of gradually adapting themselves to their environment, so that it is possible that a race of malarial parasites immune to quinine may be developed. Lieutenant-Colonel Leslie[1] points out, in discussing this subject, that fresh-water amœbæ may be gradually habituated to salt water; that the infusorian *stentor* kept in a weak solution of corrosive sublimate becomes tolerant of a solution containing four times the quantity of this poison that is fatal to stentors taken from pure water; that trypanosomes frequently develop in an animal being dosed with atoxyl a race of trypanosomes that is immune to that drug, and these produce descendants in a new animal host which retain this immunity; and that races

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[1] Address delivered at the opening of the Malarial Conference, Simla, October, 1909.

of colpidia have been obtained that could live in fairly strong solutions of quinine. However large a dose of quinine be taken, it cannot form a very strong solution of this drug in the blood, and it is quite possible that though the majority of the malarial parasites may succumb to it, yet in some cases a few of the hardier ones may survive and gradually develop an immunity to quinine. Treatment by quinine would then be useless.

Original Articles.

A RARE NASAL CASE.

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

Consulting Physician and late Physician for Diseases of the Eye, Ear, Nose, and Throat to the Devon and Cornwall Homœopathic Hospital; Assistant Ophthalmic Surgeon to the London Homœopathic Hospital.

In a monograph on nasal polypus, published in 1887, Dr. E. Woakes referred to a pathological condition which he described as *cleavage of the middle turbinate.* His view of this condition was that polypoidal development took place in the trabeculæ of the spongy bone, the new growth gradually distending the surrounding bony tissue, till at length a breach was formed in the anterior surface, its slow increase giving rise eventually to a large vertical cleft. The bone was thus divided into two lateral portions, and exit given to the contained polypoidal tissue. His views were somewhat adversely criticised in certain quarters, but the present writer has repeatedly met with the condition described, and has satisfied himself as to the accuracy of the observations recorded.

The case now to be described recalls this process, but, as will afterwards appear, while resembling it in the initial stage, it also presents a contrast to it in further development, and at the same time affords a means of differential diagnosis, should any doubt arise as to the character of the growth observed.

In September, 1908, a lady, aged 60, applied for advice on account of tinnitus, referred to the left ear, with reduction of hearing to 10 in. on both sides. Both tympanic membranes were much sclerosed, their state sufficiently account-

ing for the deafness and noises complained of. Examination for any additional cause revealed a considerable enlargement of the right middle turbinate, the left naris being apparently healthy. The swelling was yellowish in colour, and hard to the touch, except at its lowest aspect, where the mucous membrane over it was thick and soft. The free border of the inferior turbinate was markedly hypertrophied, and encroached on the lumen of the inferior meatus. Removal of these obstructions was advised, although the deafness was probably due more to primary sclerosis of the tympanic structures than to the nasal growth, and the prognosis as to its relief therefore unfavourable.

Various circumstances prevented anything being done at that time, and the patient was not seen again till November, 1909, when she came again, now complaining of decided obstruction to breathing on the right side. The enlargement of the middle turbinate was found to have greatly increased, the anterior part of the middle meatus being almost entirely blocked up. In addition to the middle turbinate enlargement, there depended from the lower border of the inferior turbinate a large cauliflower-like growth of a pinkish-grey colour and œdematous appearance. Such growths are occasionally met with in this situation, but are not true polypi, the latter almost invariably springing from the middle or superior turbinates. Histologically, they consist of erectile tissue, infiltrated with granulation tissue, and are a feature in some forms of hypertrophic rhinitis.

On November 16 the upper tumour was removed, under local anæsthesia, by means of the galvano-cautery snare, with but trifling pain, and practically no bleeding.

It may be here mentioned that, in the writer's judgment, the value of the instrument just referred to cannot be overestimated. Instead of tearing through the morbid tissue, as the cold snare does, it cuts cleanly through it; the absence of hæmorrhage enables a clear view of the nares to be obtained, and thus more can be accomplished at one sitting, and the work more accurately done, than by other methods. The galvano-cautery has been objected to on account of the alleged possibility of steam being generated by its use, and the mucous membrane thus scalded; but, in an experience of

some twenty-five years, the writer has not met with a single untoward incident from its employment.

During removal, the growth crackled under the pressure of the snare, just as a breaking egg-shell. It was about the size of a large filbert, of a yellowish colour, and consisted of a thin, bony shell, covered with highly attenuated mucous membrane. Internally, its interstices were occupied by a mass of polypoidal tissue. The growth itself was obviously an example of that rare development known to rhinologists as *osseous cyst.*

A week after its removal, a polypus about the size of a grape was seen emerging from the stump, and was removed. The cauliflower growth from the inferior turbinate was likewise removed by means of the galvano-cautery loop, the operation being attended with but trifling inconvenience to the patient, and no hæmorrhage. The result was an absolutely clear breath-way, and immediate relief from the distress due to the obstruction. So far, there has been little or no improvement in the hearing power, though the patient states that the tinnitus is less, and at times ceases altogether. The operation, however, as already intimated, was not performed so much with a view to the relief of deafness as to that of the nasal obstruction.

It might very justly occur to the reader that, had the process observed in the middle turbinate continued for a longer time without surgical interference, the distension caused by the growing contents would have led to rupture of the bony wall, and thus to the cleavage described by Woakes, and, conversely, that earlier observation, on his part, of the divided spongy bones might have shown them to have been originally osseous cysts.

There is, however, a different pathological process underlying the two cases, and therefore leading to different results. What Woakes described as "cleavage" he attributed, and no doubt correctly, to *necrosing ethmoiditis,* in virtue of which areas of the middle turbinate actually perished. Continuity of surface being thus impaired, it is easy to understand that the developing polypoidal mass within should find a means of exit in the direction of least resistance, and thus lead to the division observed.

The process giving rise to osseous cyst, on the other hand,

is rather constructive than destructive, being that recognized as *osteophytic periostitis*, in which a slow growth of the bony wall takes place, not in thickness, but in gradually increasing expansion, so that, if not interfered with, the tumour may in time become very large, and even lead to great distension laterally of the bony walls of the nares and adjoining structures. In view of such possibilities, no time should be lost in getting rid of an osseous cyst when recognized. To delay till it has attained such large dimensions would involve a much more serious and difficult operation than when the growth is dealt with in its earlier stage.

Some idea of the rate of growth may be obtained from the circumstance that, in the case now recorded, between September, 1908, and November, 1909, the tumour had increased to about three times the bulk it had when first observed.

A diagnostic point of some value in the initial stage is the difference in texture and colour. In enlargement of the middle turbinate due to ethmoiditis, the mucous membrane is thickened, pink or red in colour, soft to the touch of the probe, and somewhat œdematous in appearance.

Osseous cyst is yellowish in colour, hard and resistant to the touch, and the mucous membrane covering it exceedingly thin. Curiously enough, it is said that the latter has only been observed in the female sex.

SOME EXPERIENCES WITH THE TWO HUNDREDS.

By T. MILLER NEATBY, M.A., M.D.Cantab.

Registrar and Assistant Physician to the London Homœopathic Hospital.

A MISSIONARY student at the London Homœopathic Hospital recently asked me, when I spoke of "*nux* 200," whether I meant "200 gr. of *nux vomica*"? I explained that that was not my meaning.

It is only very recently that I have taken to experimenting with the 200th centesimals, but my impressions of them are, so far at any rate, on the whole favourable. They have been used either in single or very infrequent doses, and it is of course possible to maintain that the infrequency of the dose was just as operative as the particular potency in producing the results such as they are. The latter, I am bound to admit,

are not of a very convincing nature, but still I think they are suggestive. The recency of the cases necessarily gives them an incomplete character.

(1) G. K., aged 20, female (domestic servant). November 10, 1909. Pain in "stomach" for five or six weeks, of doubling-up nature, sometimes starts while eating, sometimes half-hour p.c. "Stomach" is tender to touch. Meat brings on pain. Can take eggs and milk, but not rich things. No desire for acids or sugar. Wants food warm. Feels sick but never vomits. No melæna or blood by bowel. Bowels costive. Tongue rather pale. Catamenia scanty, but regular. *Puls.* 200, single dose.

November 24, a fortnight later.—Feels much better. Pains much less. Still feels sick. Bowels regular. *Sacc. lac.*

December 8.—No pain. Not sick at all now. *Sacc. lac.*

(2) L. B., aged 36, female (married). August 11, 1909. Aching in right hypochondrium. Pain immediately p.c. Tongue dirty in morning. Bowels costive. *Nux v.* 3, *t.d.*

August 25.—Piles. Headache. Costive. *Sul.* 30 *o. m.*, and *nux v.* 30 *o. n.*

September 8.—Piles, which prolapse at every stool. Backache. Bowels costive. *Æsc. h.* 3, *t.d.*

October 6.—*Æsc. h.* 30.

October 20.—Piles rather better, but has a good deal of hæmorrhage. Very costive. *Bell.* 30.

November 3.—Neuralgia in right side of face and head, erratic, pains going from spot to spot. Catamenia not seen since beginning of September (? pregnancy). Bowels costive. Indigestion better. *Puls.* 200, single dose.

November 17.—Much better. Neuralgia gone. Bowels much better. *Sacc. lac.*

[These two cases illustrate the truth that *pulsatilla*, though not supposed to be a constipation remedy, relieves constipation if the patient is on the whole a *pulsatilla* case.]

(3) E. O., aged 51, female (married). November 3, 1909. Bad pain in back of head. Aching in left leg, up into groin. Nasty taste in mouth. Tongue, white fur. Bowels costive, always takes salts (recently had some pills from a doctor that "nearly killed" her). Piles, hard and painful, not bleeding. *Nux. v.* 200, twice weekly for a fortnight.

November 17.—Head much better. Piles better. Pain under left scapula. Some aching in left leg. Bowels regular every morning since last date. *Sacc. lac.*

December 1.—Head very much better. Piles better. Tongue clean. *Sacc. lac.*

(4) E. P., aged 37, female (married). July 7, 1909. Transferred from Mr. Wright, who said there was no laryngeal ulceration. Patient was complaining of aphonia. A little more than a year ago coughed up a pint (?) of blood on two separate occasions. Sometimes tastes blood in the mouth. Has pain, sometimes of burning character in centre of chest. Appetite very bad. Tongue very sore and white. Losing flesh. Bad headaches. Bowels regular, occasional diarrhœa. Soon tired. Pulse 98, temperature 99°F. P.E. Physical signs of phthisis at left apex. Takes a lot of salt with her food. Food often does not taste right. Thirsty. *Nat. mur.* 200, single dose.

August 4.—Feels better. Tongue not nearly so sore. *Sacc. lac.*

[The patient did not come up for some time, though told to do so.]

October 6.—Voice has improved. Tongue better. Has lost the pain in chest.

[Patient has not been up again. I think she went into the country.]

(5) F. D., aged 19, female (candle-shade maker). November 13, 1909. For three months water has been very offensive. Pain in epigastrium, soon p.c. Appetite poor. Bowels costive, without desire. Urinalysis and physical examination revealed nothing. Catamenia regular, profuse, much pain. Chilly. *Silica* 200, single dose.

November 27.—Feels much better. Water is much better. No indigestion. Bowels regular. *Sacc. lac.*

(6) E. G., aged 16, female (baby's millinery). November 13, 1909. Indigestion for two months. Pain in "stomach" at various times, and at chest soon p.c. Flatulence. Face flushes. Bowels very costive, without desire; goes three or four days without action, then has diarrhœa, colic and sickness. Very thin. Catamenia regular, not much pain. *Bry.* 200, twice weekly for a fortnight.

November 27.—Much better. Bowels every day, except once since last attendance. *Sacc. lac.*

[In the last two cases the drug was chosen largely on the bowel symptoms. Constipation "without desire" I have learned to regard as a very important "particular."]

(7) C. M., aged 38, female (married). August 4, 1909. Cough and pain in chest on breathing at all deeply. Yellow or green offensive, solid phlegm, difficult to get up. Cough mostly in morning and evening. Breath short. Flatulence, Tongue, brown fur at back. Costive.

[This patient came up nearly every fortnight and received *bry.* 6, *ipec.* 6, *sil.* 30, *tuberculinum* 30, a single dose, *nat. mur.* 6, *senega* ϕ, and *caust.* 6, without much effect.]

October 20.—Caught fresh cold. *Hepar s.* 200, weekly.

[*Hepar s.* has amongst its symptoms great liability to catch cold.]

November 3.—Chest i. s. q. Coughs herself sick. Nausea and retching. *Ipec.* 200 weekly for a fortnight.

November 17.—Chest very much better during the last fortnight. Sickness and vomiting quite ceased.

[Up to time of writing patient has not been up again, which is in this case probably a good sign.]

(8) A. S., aged 29, female (machinist). August 28, 1909. Rheumatism of three years' standing, which is getting worse; joints of fingers and muscles of arms. Joints of fingers are slightly swollen as well as painful. Indigestion. Wind. Tongue clean. Bowels regular. Catemenia regular, but with great pain, sickness and diarrhœa. *Puls.* 6, *t.d.*

September 18.—Pain not so much in arms now, but in right leg and foot. The last catamenia was much better. *Puls.* 30, *o. m.*

October 9.—Much better in herself. Rheumatism in fingers this week. Catamenia worse again. *Puls.* 6, *t.d.*

[As she was "much better in herself," I think I ought to have gone on with *puls.* 30, or given *sacc. lac.* But *puls.* 6 had alleviated the menstrual pain before, therefore I repeated it.]

October 30.—Fingers and arms bad. Feels stronger and better in herself. Pain not bad at nights, but > exercise and < damp weather. *Rhus t.* 200, single dose.

November 13.—Has felt much better in herself. Arms not quite so bad. *Sacc. lac.*

November 27.—Much better. *Sacc. lac.*

(9) T. C., aged 49, female (married). Attended as out-patient first under Dr. Lewin, then under myself, from April 21, 1909, onwards, for chronic rheumatism. There was no material alleviation until October.

October 26, 1909.—Rheumatism < at night, > exercise. Feet warm, but knees cold. *Rhus t.* 200, single dose.

November 3.—Has felt much better than at any time since she attended. *Sacc. lac.*

[Patient has not been up again. The rapid effect of the last medicine would, I think, have encouraged her to come up again if the improvement had not been maintained. Still one never knows. I may add that *rhus* 6 had been given earlier but without effect.]

(10) A. R., aged 8, female. October 20, 1909. Mottled red rash on both legs (probably rheumatic in nature), not itching. Had sore throat ten days ago, which soon passed off. Tongue clean. Some aching in legs last night. No history of chorea or acute rheumatism. Father is subject to muscular rheumatism. *Rhus t.* 200, single dose.

November 3.—Much better. Pain gone. Spots entirely disappeared. *Sacc. lac.*

November 17.—No recurrence. *Sacc. lac.*

(11) J. D., aged 65, male. November 18, 1909. Right eye very bloodshot, with great photophobia. Has had it for a week badly, but more or less chronically for a good while. Is "gouty" and suffers from acidity. *Sul.* 200, single dose.

November 21, three days later.—Eye looks perfectly well. No pain.

December 5.—Eye still all right. Patient says that, whatever the medicine was, it seems to have acted on his bowels; goes twice a day, formed stools.

(12) N. H., aged 23, female (single). November 5, 1909. Occipital headache, resembles the rheumatic pain she gets in elbows and knees, < rising in morning, < going to bed. Soon tired. Appetite good. Flatulence. Bowels regular. Catamenia very profuse. Some time ago had "small boils or pimples," which were quickly got rid of by an allopathic doctor. *Act. r.* 200, single dose.

November 19.—Head has been better than for six months past, but there has been a return of pimples since last attendance. *Sacc. lac.*

[The reappearance of an old cutaneous manifestation coincidently with a marked improvement of health is interesting.]

(13) Mrs. S., aged 56. November 12, 1909. For a long time has had severe neuralgic exhausting headaches, mostly one-sided, with bad palpitation; cannot bear noise or light; come on after indigestible food, excitement, &c., > lying down, > application of cold rags. *Come on suddenly and leave suddenly.* Sometimes last for forty-eight hours. Flushes and sweats. Bowels costive. *Bell.* 200, single dose.

November 26.—Much better, and feeling much better in herself. Has had no headache since being here. Bowels regular. *Sacc. lac.*

[Here, in spite of the amelioration on lying down, which is against *bell.*, I was led by a general consideration of the symptoms, and by the marked "pains come on suddenly and disappear as suddenly," to prescribe *bell.*, with apparent relief, not only to the head but to the bowels.]

(14) This is a piquant case. L. F., a woman nearing middle life, had been coming as out-patient for some time with rather miscellaneous complaints. On August 14, 1909, on account of various symptoms, including omission of menses for over two months and falling of the hair, I prescribed *thuja* 30, to be taken every second morning fasting. The menses promptly recommenced four days later, and the hair started growing satisfactorily. On November 27, as there had been another amenorrhœic period (of about two months this time), remembering the (apparent) effect of the *thuja* 30 on the previous occasion, I prescribed, in the lightness of my heart, a single dose of *thuja* 200 to be taken at once. I was not prepared for the seismic effect of *thuja* 200. "That medicine that the dispenser gave me took nearly all the life out of me. I could hardly crawl home." Was it the *thuja?* Or was it the patient's own perfervid imagination? Or was it some baleful light in the dispenser's eye that so suddenly agitated to its depths the patient's "vital force"? I do not know. As Bernard Shaw says, "You never can tell." But this I know, that precisely four days later (as on the previous occasion) the menses started once more!

A CASE OF DYSMENORRHŒA.

By T. G. STONHAM, M.D.Lond., M.R.C.S.

Miss W., aged 37, sent for me on July 2, 1909, on account of severe menstrual pain. She was very ill thirteen years ago with sub-diaphragmatic abscess and empyæma of the right side, was operated upon, and the abscess drained through the chest wall and through the abdomen below the liver, and after some weeks made an excellent recovery. With this exception she has enjoyed good health, except at her monthly periods, which from girlhood have always been painful, and sometimes the pain has been so severe as to cause fainting. She does not faint now, but the pain is agonizing, and makes her feel weak and prostrate for days afterwards. The last few months the pain has increased in severity. The bowels are regular, sometimes a little inclined to be relaxed at the "period." No leucorrhœa. The catamenia have the following character: They occur regularly, with preceding feelings, lasting for two or three days, of being out of sorts, languid, and weak, and some aching in the sacrum. The flow then commences without pain. After a few hours it stops, and at the same time severe pain comes on in the hypogastrium and lasts several hours till the flow recommences, when the pain lessens and soon ceases. The rest of the period is without pain, but there is a very sore feeling in the hypogastrium at its site. The pain seems to be in the uterus, as it is mostly in the hypogastrium in the middle line, though sometimes there is also a little pain to the right of this, sometimes to the left. It is fairly continuous, cramping, forcing and pressing down. There is no extension of pain to the thighs. The flow is thin, bright, fairly profuse, and lasts about a week.

When I saw her on July 2 she had had the pain for several hours, and the attack was probably nearing its close, though still very severe. I gave *sulph.* 2, a few drops in a tumblerful of water, a dessertspoonful every two hours. This was given on account of the well-known action of *sulphur* to meet the symptoms arising from suppressed discharges. It was given temporarily, but the case being such a long-standing one, it was considered advisable to repertorize it carefully.

July 3.—She had passed the night without pain, but was

very sleepless; "too tired and exhausted to sleep"; keeps her bed. The reference to "Kent's Repertory" had given the following result, taking only the drugs printed in heavy type and italics: Cramping pain in the uterus during menses: *asaf.*, *calc.*, *caust.*, COCC., *coloc.*, *kali.-c.* Pressing pain in the uterus during menses: *acon.*, *ant.-c.*, BELL., *cocc.*, *lil.-t.*, *nat.-c.*, *nit.-ac.*, *plat.*, *puls.*, *sec.* Uterus sore during menses: *bry.*, *caust.*, *cocc.*, *con.*, *nux.-m.* Menses flow only in absence of pain: COCC. Menses intermittent: a number of drugs, amongst which *cocc.* appears, but not prominently. *Cocculus* was evidently the medicine indicated by the Repertory, and *cocc.* 3, pil. ii., night and morning, was ordered to be taken during the intervals between the "periods."

August 24.—The last "period" was three days late (a very unusual occurrence). There was no intermittence in the flow, and yet the pain came on just as bad as before, and was of the same character. It, however, did not last so long, only for five hours. She was not so weak and prostrate after the "period," which was itself of shorter duration. Since then she has been to the seaside for a fortnight and has come back in improved general health. Expects the catamenia next week. Has taken no medicine while away. Was ordered to take the *cocculus* regularly night and morning till the onset of the "period."

September 8.—The last period was a very good one; very little pain, loss profuse, and no intermittence. Repeat *cocc.* 3, pil. ii., n. and m.

October 6.—Writes: "I am away from home for a fortnight. The period is over again, and I am glad to be able to tell you that I had a very good time, hardly any pain, and I did not stay in bed at all. I have not had such a time for many months. I shall be glad if you will send me some more medicine; it is wonderful how much good it has done me. Repeat medicine.

October 24.—Another period just over. No pain at all.

January 5, 1910.—Subsequent periods have been without pain.

This seems to have been a case of spasmodic functional dysmenorrhœa. As she is a virgin, no vaginal examination was made, and the medicine was prescribed from the sym-

ptoms alone. There is, however, no probability of any organic disease being present, and the case must be regarded as a functional one. The pain which occurs in these cases of spasmodic dysmenorrhœa is often extremely severe, and, as in this case, the patient may go on suffering every month for years. It is gratifying to know that the properly selected remedy will effect a cure and save the patient from such operations as dilating the cervix, which are often very ineffectual.

AN INVOLUNTARY PROVING OF CHESTNUT (*CASTANEA VESCA*).

By GEORGE BLACK, M.B.Edin.

A YOUNG farmer, strongly built, with fair hair, light grey eyes and florid complexion, consulted me a fortnight ago on account of swelling of the cervical glands on the left side of the neck. The evening that I saw him he went up into the park and picked up seven or eight chestnuts and ate them raw. Later on, on getting home, he was seized with diarrhœa and vomiting and had not less than six stools between Friday night and Saturday morning, and three or four on the Saturday during the day. "The water," he says, "went a queer colour and was very thick." He was very thirsty. On Sunday and Monday there was across the back a feeling as of lumbago, there was a sense of great weakness, and when he got up he could hardly stand upright. Loss of appetite—"during this time," he said, "I did not want anything to eat."

THE TREATMENT OF EPILEPSY FROM A HOMŒOPATHIC STANDPOINT.[1]

By GILES F. GOLDSBROUGH, M.D.Aberd.

Physician for Diseases of the Nervous System to the London Homœopathic Hospital.

THE subject conveyed in the title of this lecture is a very wide one, and covers a discussion of the etiology, clinical history, and, to some extent, the prognosis of epilepsy, but it is not my purpose to regard it from the latter points of view, except incidentally. A knowledge of the ordinary features of

[1] Remarks introductory to a post-graduate lecture demonstration.

this disease, if it can be so called, is assumed for my present purpose, and in any case would not call for consideration in a post-graduate course. I wish to select a certain point of view of the treatment of epilepsy, namely, the homœopathic, which on account of the character of the latter will include, not merely a review of cases treated homœopathically, but a consideration of the wisdom or otherwise of an avoidance of the bromide treatment. Everyone is familiar with the bromide treatment, but every medical man is not familiar with the fact that the treatment of this malady may be successfully undertaken without bromides. My remarks will not be intended to prove that bromide treatment is bad practice or should never be resorted to, but in view of the unsatisfactory results of all known methods of treatment I wish to show that the homœopathic treatment is worthy of serious consideration; that modern knowledge points to the latter mode of treatment as being more scientific than a routine treatment by bromides, and that, granted attention is given to the homœopathic standpoint, certain facts in relation with knowledge of the disease assume an importance which they do not possess when the subject of treatment is considered in a routine fashion, or that one drug only, or at the most very few drugs, are called for in all the cases which come under the care of the practitioner.

I.—I first wish to draw attention to the fact that epilepsy may be regarded from various points of view as regards its clinical history. Gowers used to teach that the first fit was the disease and that subsequent recurrence was simply an obedience to a law of nervous function that when once a morbid syndrome was set up in some part of the nervous system highly developed, but also highly unstable, recurrence was inevitable. But recent views are much more comprehensive.[1] To-day the disease is held to cover the inheritance, or otherwise, of a predisposition, the prodromal symptoms, the first fit with its attendant phenomena, recurrences of both a major and minor type, frequency of the attacks, post-paroxysmal symptoms as well as mental and other sequelæ. The aim in treatment undoubtedly is to obtain an arrest of the

[1] In this connection, a monograph on epilepsy, "A Study of the Idiopathic Disease" (by William Aldren Turner, M.D.Edin.; London: Macmillan and Co., 1907), may be consulted.

seizures, but this is of small concern at the cost of mental integrity or efficiency. And the question arises immediately whether homœopathic treatment secures the former without injury to the latter, compared with prolonged bromide treatment as securing more certain arrest of the seizure with inevitable mental failure or enfeeblement. Compared with the routine treatment by bromides, the *a priori* adoption of which as the only orthodox treatment leaves little room for individualization of cases, the homœopathic practitioner will consider his patient first and the disease only secondarily as an object for treatment, and hence the constitutional state and the totality of the symptoms compared with the urgency of the seizures as advancing or otherwise towards the status epilepticus and epileptic dementia will engage the attention of the homœopathic practitioner rather than the violence or actual severity of the seizures as constituting the facts in his patient's history of the greatest importance.

With regard to pathology, the eventual incurability of such a large number of cases is due to pathological states which have already taken place when the treatment is begun. Stated generally, these consist of changes in the form of degeneration which have overtaken the cortical cells, and the sclerosis which accompanies such degeneration. But in reference to this ultimately hopeless view of particular cases, it must never be forgotten that the earliest changes are relatively transient. This is evidenced by spontaneous arrest which takes place in some cases, and the respite which others undergo in the course of an intercurrent attack of infective disorder, such as pneumonia, scarlet fever, typhoid, &c. A general view of the treatment of all cases will, of course, depend partly on the age incidence of the malady, and the length of time a patient has been suffering before coming under treatment. In hospital practice cases have to be taken as they come. Selection from the point of view of prognosis is out of the question. Most of the cases which come to the London Homœopathic Hospital have received treatment by bromides elsewhere, therefore it is almost impossible to show the relative benefit of homœopathic treatment through the whole course of the disease. For the purposes of demonstration I have requested twenty-two patients who have attended the hospital during

the past six weeks to come here specially to-day. These have been requested to come, without selection or exclusion, so that all the points of interest and importance in the treatment of the disease might be illustrated as in a random series of cases which might occur at any time.

II.—Before examining these cases I will briefly review the treatment which has been adopted under the various aspects which, from the homœopathic standpoint, all cases might be viewed. This part of my subject will be dealt with under three heads: (1) Whether there is any constitutional malady in the background of the case, which appears in any way to have determined the incidence of the seizures, such, for example, as tuberculosis, syphilis, vaccinosis, &c.; (2) the presence or otherwise of a strongly marked neuropathic disposition, including the stigmata of hereditary transmission, as well as the signs of developed neurosis; (3) the totality of the symptoms, including the seizures and their sequences, but specially symptoms present other than the seizures.

(1) (*a*) It is not often that cases are met with in which epileptic seizures are concurrent with tubercular disorders. The most important relation of tuberculosis to epilepsy is that of the transmission of a tendency to epilepsy from parents who have suffered from some form of tuberculosis. And in cases of epilepsy affording such a history the nosode *tuberculinum* should always be thought of. I have had a few recent cases of this character where *tuberculinum* 200 given in infrequent doses, never more than once weekly, appears to have had an immediate effect in preventing recurrence or at least retarding it. Under the improving course of their disease these patients have returned on a few occasions and then have been lost sight of.

(*b*) With regard to syphilis, hereditary or acquired, the history is at once more difficult to elicit, and in my opinion pure idiopathic epilepsy, the result of syphilis, is extremely rare. Organic syphilitic disease of the brain may be accompanied by *seizures*, but in those cases the seizures are to be regarded as one symptom merely, and the view of the case as calling for treatment would be determined by other manifestations. Still it is quite possible cases may arise where a strongly syphilitic history may have been present as a hereditary factor,

and then antisyphilitic remedies would have to be considered, specially *kali iod.* in homœopathic attenuation and the nosode *syphilinum.*

(*c*) I believe vaccination with cow-pox vaccine to be quite capable of inducing epilepsy. I have seen several cases in which the convulsions have begun about two weeks after the vaccination at the beginning of defervescence. In one case in private practice in connection with which there was no reason to think the child would develop a convulsive tendency, and the course of the vaccination appeared normal in every way, clonic spasms of the limbs began at about the time named, which developed subsequently into fits. These became very numerous, violent, and continued for many months. The growth of intelligence was retarded. The child became an idiot, lived for eight or nine years, and then succumbed. I do not wish to suggest that vaccination was the sole causative factor in this case, but that it was the apparent exciting cause there can be no doubt. In epileptic cases careful enquiry should always be made in reference to the patient's vaccination history and sequelæ, and treatment by *vaccininum* or by *thuja* considered and adopted if necessary.

(2) With regard to the inheritance of a neuropathic disposition and its relation to the occurrence of epilepsy, the following remark of Dr. Aldren Turner is very much to the point. He says: "In those who have inherited the epileptic tendency a 'convulsive habit' may be established either in the course of natural development or as a result of certain occasional or accidental causes. Once the convulsive habit has been established there is a tendency to its perpetuation in the form of recurring epileptic seizures. Thus, infantile convulsions are frequently the starting point of subsequent epilepsy either as a direct sequence of the convulsions, or in later years at or about the onset of puberty. The eclampsia associated with the onset of infantile hemiplegia was in 78 per cent. of the cases followed by epilepsy in later life."[1] Thus, when hereditary predisposition to nervous disorder is very strongly marked, the occurrence of convulsions in early life is due to causes extraneous from the nervous system and becomes a very important fact to be con-

[1] *Op. cit.*, p. 64.

sidered later when epileptic patients present themselves for treatment. But in relation to hereditary influence not only convulsions in childhood render later epilepsy most probable but certain other causes occur, which to persons of a stable nervous constitution might be relatively innocuous. These special causes are psychical influences and development, especially in childhood, at the period of puberty and adolescence, and less markedly at the climacteric, trauma, or nervous "shock" merely, syphilis, organic disease of the brain of any kind, toxæmia from the blood, lymphatic or renal systems or intoxications, especially from alcohol. Now for treatment the chief significance of the complexity to the case which the foregoing peculiar relationship of epilepsy to other disorders suggests lies in the necessity to remove as far as possible all extraneous causes before beginning treatment homœopathically. In reference to the urgency or otherwise of the occurrence of fits, it is not the least likely that medicine selected homœopathically on the basis of the symptoms "fits or convulsions" can have a favourable effect uutil extraneous causes have been removed. On the other hand, intrinsic causes such as nervous instability with its attendant phenomena and a developed convulsive habit will not fail to be considered as part of the totality of the symptoms when extraneous causes have been removed, or after remedies had previously been selected from symptoms suggesting an origin along any of the etiological lines indicated.

(3) But now supposing effort in the removal of causes has covered the whole range of possible causes in a particular instance, and that probably one or more conditions of the kind suggested above have been dealt with, and yet, notwithstanding, which is usually the case, the fits continue, or supposing the causes are so intrinsic to the patient himself that they are irremovable except on the basis of a treatment of the patient as distinct from any local condition from which he might be suffering, we have to enquire whether there is any special view of the totality of the symptoms which will enable the practitioner, by means of homœopathically selected remedies, to successfully cope with the malady. It is no part of my duty to dogmatize in this connection; rather have I to suggest all possible views which may come under the cog-

nizance of the practitioner, and as the range of application of the principle *similia similibus curentur* is exceedingly wide, it remains for each man to follow the rule as completely and as best he may. A question might be asked at the outset whether an adoption of the repertorial numerical method of selecting the remedy will suffice to guide to a successful selection. In answer to such a question, I should say, yes, in recent cases, if the considerations brought forward above have been allowed due weight. The following principles have usually guided my own thinking out of the necessities of a case: (*a*) Consider first the constitutional predisposition and condition of the patient with its various appearances, symptoms, concomitants and aggravations. (*b*) Give attention to a preliminary cure of collateral conditions which may be believed to have acted as exciting causes of the fits, provided, of course, that the frequency and urgency of the seizures are not pressing for first consideration; but even if the latter be the case a thorough search for causes should always be made. (*c*) Weigh well the nature, frequency and severity of the fits as the feature of the case for which relief is sought; but which as symptoms are to be considered in the light of the constitutional state of the patient, any collateral condition requiring treatment, and the totality of the symptoms from which the patient may be suffering.[1]

Before undertaking the treatment of any case, if a chronic one, it would be well to inform the patient that to obtain benefit a prolonged course of careful treatment will be absolutely necessary. Patients not infrequently come to the Hospital after attending for some time elsewhere, and if they do not experience an immediate improvement in the frequency of the fits they become easily disappointed and refuse to give homœopathy a fair trial. In some cases I have had, the outlook at the beginning would usually be regarded as quite hopeless, but with a continuous attendance over a period of years a great change has been wrought in the whole aspect of

[1] In regard to recent articles which have appeared on the selection of the remedy, it is probable that the whole syndrome *convulsion as recurrence* should be regarded as a general symptom, whereas peculiar variations of the fits, with their conditions of occurrence and concomitants, could be accepted as particulars.

the patient, in addition to a reduction in the number and severity of the fits.

I propose now to place in groups the medicines which have proved most useful, and from these one or other will probably be selected in the majority of cases by all practitioners. But the list is not presented as by any means a complete one. Indeed, no homœopathic practitioner should regard any list of medicines as a complete one for a particular disease. As a fact of experience, he will find that a certain group of medicines usually come to be selected with reference to a particular disease, but at the beginning of treatment the mind should be open to the whole materia medica as a possible field for selection. The medicines are named, as far as my experience has gone, in the order of their importance.

Group I.—*Nosodes:* Tuberculinum, syphilinum, vaccininum.

Group II.—*Constitutional remedies:* Calcarea carb., calcarea phos., calcarea iod., silicea, sulphur, thuja, zincum, stannum, pulsatilla, bufo, sepia, ignatia, &c.

Group III.—*Remedies for the fits:* Belladonna, stramonium, ignatia, cuprum, cicuta, opium, hydrocyanic acid, œnanthe crocata, cocculus, absinthum.

When I first began to make a special study of this class of case, I usually gave a constitutional remedy daily or weekly, and an additional remedy at night, with a view, if possible, of immediately checking the number of seizures. I do not now so often adopt this practice, and suggest that every practitioner must suit his method to the gravity of the case, always remembering that the sphere of influence of all remedies is beyond our immediate observation and that if one remedy will do what is required so much the better, and it will probably do it more quickly if given alone. But from the point of view of this clinic it must not be forgotten that taking all cases of the disease which may present themselves the study and application of homœopathic remedies to epilepsy is still in its infancy.

In conclusion, I may be expected to say something in reference to the relation of general metabolism and the occurrence of fits, especially in the light of the recommendation of a restricted diet, or a diet free from the addition of common salt. The only remarks worthy of notice from these points

of view are as follows: First of all, the occurrence of convulsions as the result of habit has an origin in the function of the brain and nervous system of a deeper character than the immediate relationship of such function to general metabolism, and if considered at all the question of metabolism should be thought of in reference to collateral disorders of digestion, assimilation or elimination, rather than in relation to the fits themselves. In reference to diet, the chief point of importance is the avoidance of stimulation in any direction. For this reason the avoidance of red meat is certainly a point worth attention and should be considered in any case. Conversely, for purposes of elimination plenty of muscular exercise is usually of benefit to epileptics. With regard to a salt-free diet, the metabolic influence of the chloride of sodium in the human economy is not fully known, but it is known that salt in excess is injurious and productive of pathogenetic effects. Excess in the addition of salt to the food should be enquired about and guarded against, but with homœopathic treatment I cannot say we are called upon to eliminate all added salt from the food, or that by so doing our remedies will be aided in their effects towards cure.

The cases who are attending specially to-day as referred to in the Hospital notebooks will now be gone over one at a time and the various points of interest noted as suggested by the foregoing remarks. The cases having been taken at random no selection has been possible, and as *bromide* treatment has always been avoided, the results so far allow the conclusion to be forthcoming that their progress is highly encouraging to further effort in the direction of preferring homœopathy to other methods.

AN INVOLUNTARY PROVING OF *NATRUM MURIATICUM*.

By T. G. STONHAM, M.D.Lond., M.R.C.S.

Last Easter a gentleman, aged 42, consulted me on account of irritation and smarting of the eyes. I found that he was myopic, and was suffering from granular conjunctivitis. There was increased secretion of mucus from the lids, and the palpebral conjunctivæ, particularly of the lower lids,

were reddened, and presented the characteristic granular condition. He had been troubled with this affection for several months, and besides having had the lids cauterized with first nitrate of silver and then sulphate of copper, had used various eye lotions, and was still using one of weak boracic acid. I directed him to continue his boracic acid lotion, and prescribed *natrum muriaticum* 30, pil. ii., night and morning. He returned the next day to Brussels, where he lived, and I heard no more as to the result of my treatment, till he called upon me again this month (January, 1910), when he told me the following story. On going back to Brussels he took the *natrum muriaticum* pilules as directed, regularly night and morning. After about a week he noticed that his bowels had become loose; he passed three or four copious, pappy stools daily. They were passed quite easily, and were not preceded or accompanied by any griping or other discomfort, and occurred at irregular times during the day. He felt, too, that he was getting weaker, and not so well able to go about his work. He, however, made no change in his habits, and continued to take the medicine. During the next fortnight he continued to suffer from loose stools, and became weaker and thinner every day, grew very depressed, and thought he would have to give up work. He noticed that he came over chilly in the afternoons, and one afternoon it occurred to him to take his temperature, when he found the thermometer registered 39·1° C. (102·3° F.). On the morning following it was lower but not normal, and rose every afternoon and evening to a height varying from 101° to 103° F. He had no idea that his condition could be in any way due to the medicine, and had gone on taking it regularly, but now thought it high time to call in a doctor. The doctor examined him very thoroughly, and could find no physical disease, but the persistent evening rise of temperature and the marked loss of flesh and strength led him to suspect that there must be tubercle somewhere, and he called in a consultant to elucidate matters. The consultant, after a very careful examination, could also find nothing objectively wrong, but also thought the condition suspiciously indicative of tuberculosis. He ordered him to bed, and sent him some cooling powders to take, and told him to leave off taking the pilules (the nature

of which both patient and doctor were ignorant of). After three days the patient felt better, the stools had become normal in character and frequency, and the evening rise in temperature had ceased. The doctors were, however, still of opinion that there might be some latent though undetected tubercle, and advised him before returning to business to go for a month to a sanatorium in the Alps. This latter advice my patient did not follow, but returned to business and rapidly regained his usual health.

The conjunctivitis became worse with the illness and better again when he recovered, but, though there has been improvement in the condition of the eyes since the poisoning, the conjunctivitis is not cured.

In the "Cyclopædia of Drug Pathogenesy" soft stools of increased frequency and feverish feelings, with chilliness, most marked in the afternoon and early evening, are found recorded as experienced by the provers of *natrum muriaticum*, both with the crude drug and with the potencies, but there is no record amongst the provings of any definite rise of temperature as indicated by the thermometer. The above case supplies this deficiency in the provings, and shows that, in a susceptible subject, *natrum muriaticum* in so high a potency as the 30th is capable of causing a very definite degree of fever, even reaching 103° F.

My patient appears to be a "sensitive" as regards homœopathic medicines, for on a former occasion I prescribed *kali bichromicum* 30 for a cough, and he wrote soon after to tell me that he had had painful stools containing blood-stained mucus, and that his cough had been much worse. These symptoms ceased on discontinuing the medicine. He can take ordinary allopathic doses of medicine without experiencing any unusual results. It is only homœopathic attenuations to which he is so sensitive.

A NEW METHOD FOR THE TREATMENT OF INOPERABLE TUMOURS.

By WILLIAM H. DIEFFENBACH, M.D.

We desire to place on record this preliminary report of a new technique in the treatment of inoperable tumours, the present status of which promises much in the relief of supposedly hopeless cases.

In October, 1908, Mr. E. C. H., aged 59, patient of Dr. A. M. Haight, White Plains, was referred to the writer by Dr. W. T. Helmuth for X-ray treatment for an inoperable tumour of the right inguinal region. The tumour could be readily palpated anteriorly, and also manually through the rectum, and in size was fully 6 in. in diameter. The Röntgen ray was utilized for its inhibitive action, the tumour being rayed through a chamois filter in all directions, the dosage being regulated so as to avoid dermatitis and still secure deep action. The growth of the tumour after three months' treatment was apparently checked, but, in spite of precautions, the prolonged radiation caused marked irritation of the skin, so that treatment was suspended. After the cessation of the X-ray treatment, within a few weeks the growth took on new life, and apparently developed in another direction, for extensive œdema of the right thigh resulted.

We were now at our wits' end. Surgery had been deemed of no avail, the condition of the skin precluded further X-ray treatment, and the condition of the patient was gradually getting worse.

The Department of Physical Therapeutics of Flower Hospital, under the leadership of Dr. W. H. King, have been among the first to test the value of radium in disease, and the writer had had abundant opportunity to test its value in numerous superficial lesions, such as epithelioma, rodent ulcer, and lupus. Impressed with its great value in these conditions, It was suggested to the patient that if radium could be brought into contact with the tumour some good might result. The use of radium gelatine solutions having been clinically verified during the past three years in local carcinomatous recurrences, it was suggested that injections of this compound into the tumour, after opening the abdomen, might be of value in

checking, inhibiting, or destroying the growth. *It is for this suggestion that we claim priority for ourselves and for Flower Hospital*, and, if subsequent results corroborate the first trial, the technique as developed will deserve a place in medical history. The matter was fully discussed with the patient, and the question of the action of the absorption of some of the compound into the economy thought over. It was stated to the patient that the experiment might prove fatal, but, inasmuch as no other treatment seemed available, the patient courageously assented to the trial. He also gave permission to have the operation performed before the graduating class, before whom the whole aspect of the new technique was explained.

Dr. William Tod Helmuth was consulted in the matter, and agreed to perform the surgical portion of the work.

The preparation of radium used in this case consisted of 40 mm. of a weak strength of radium bromide (25,000 activity) mixed with 1 oz. of sterile gelatine.

This mixture was preserved in a wide-mouthed bottle, and when about to be used was placed in a basin of boiling water so as to render the gelatine fluid for injection.

Under ether anæsthesia on February 6, 1909, Dr. Helmuth opened the abdomen over the central portion of the tumour and, when the growth had been exposed, excised a small portion for pathological examination. This excised portion was subsequently examined by Dr. E. Wells Kellogg, who pronounced it a small round and spindle cell angiosarcoma, which diagnosis was confirmed by Professor Heitzmann. A second section, examined later on, was diagnosed as round cell and alveolar sarcoma with hæmorrhagic extravasations, and also confirmed by Dr. Heitzmann.

Dr. Helmuth palpated the tumour, and confirmed his previous diagnosis of inaccessibility of the growth to the knife, and by means of a medium-sized aspirator injected 1 and 1½ drachms of the fluid radium gelatine into each of three different sections of the growth. The aspirating needle was introduced *deeply* into the tumour, and the point of entrance of the needle was firmly sealed by means of a purse-string suture.

The abdomen was closed in the usual manner, a small

"cigarette" drain being placed in the lower aspect of the abdominal incision.

The reaction of the patient from the operation was a severe one, and he was seized with attacks of hiccough, which did not respond to the usual treatments. Finally, traction of the tongue, repeated slowly for five minutes, checked the attack, and when same was repeated later on the simultaneous application of ice to the epigastrium and hot-water bags to the spine between the fourth and tenth dorsal vertebræ gave relief. Whether this obstinate attack of hiccough was due to the radium or to the operative interference remains to be determined by subsequent experience.

The patient's condition after the first two days was not reassuring, and the edges of the wound showed marked granulations of an abnormal type, so that it was deemed advisable to apply radium locally to check any possible malignancy in that quarter. A radium-coated rod, 25,000 activity, was introduced into a small sinus of the incision and kept *in situ* by means of adhesive plaster for twenty-four hours. After the removal of the rod the tissue assumed a more healthy appearance and, aside from local dressings, required no further attention.

The patient made an uneventful recovery, and by March 17, after thirty-nine days, was able to return to his home in Tarrytown, New York, with the tumour much reduced in size.

On April 5 Dr. Helmuth, Dr. Haight, and the writer examined the patient, and the tumour was found to consist of merely a small, hard nodular mass about the size of a horse chestnut, apparently of fibrous connective tissue.

In some manner, not entirely explained, the results achieved in this case reached the newspapers, and the publicity in the matter, while from an ethical standpoint possibly objectionable, promises to focus attention to this method of treatment in inoperable cases, and, if the results in above cases are corroborated, will be the means of saving life in otherwise hopeless cases.—*Chironian.*

HOMŒOPATHY IN SOUTH AFRICA.

SOUTH AFRICAN HOMŒOPATHIC AND BIOCHEMIC ASSOCIATION.

THE South African Homœopathic Association was most successfully launched at an enjoyable social gathering held at the Y.W.C.A. on Monday night, under the chairmanship of the Mayor of Wynberg, Mr. T. Vollmer.

Dr. Fallon, in the course of a capital speech urging the need and desirability of the formation of a South African Homœopathic Association, moved the following resolution, which was enthusiastically adopted: "That this meeting of Cape Town homœopaths resolves that the time has come for the promotion of a South African Homœopathic Association, after the example of the British Homœopathic Association, to support, extend, and develop homœopathy in South Africa by the following means: (1) The establishment of fully qualified homœopathic medical practitioners in South Africa; (2) the forming of homœopathic hospitals and dispensaries; (3) the acquiring of premises as a central headquarters for the promotion generally of homœopathic interests; (4) the distribution of homœopathic literature."

A second resolution was moved by Mr. C. H. Ryall as follows: "That the following be appointed as a committee and officers for twelve months to carry out the object of such an association: Vice-President, Dr. Fallon; Hon. Treasurer, Mr. Ryall; Hon. Secretary, Mr. Tutt; Committee, Messrs. Seavill, Freemantle, Cooper, Lawton, Brooks, Vos, Smithers, with power to add to the number; and a ladies' branch, with a committee of the following: President, Miss Green; Hon. Secretary, Miss Rose; Committee, Mrs. Freemantle, Mrs. Brand, Miss Edith Steytler, Miss A. M. Steytler, Miss Van Staveran, with power to add to their number."

This was also adopted unanimously.

An enjoyable musical programme was submitted during the evening, the contributors to which were Miss Connie Thomas, Mr. Phillips, and Mr. Stephenson.

A DISPENSARY is about to be started in premises secured in the Royal Hotel Arcade, Plein Street, and will open on December 1, 1909, to bring within the reach of the sick poor of Cape Town and district the benefits of homœopathic and biochemic treatment.

THE Cape Town Committee, in conjunction with Committees that may be formed in other centres in South Africa, will endeavour to carry out the terms of the above resolutions as far as possible, and earnestly invite the support of the friends of homœopathy and biochemistry throughout South Africa to this end.

RAMSBOTHAM MEMORIAL FUND.

ALL who knew Dr. Ramsbotham, of Leeds and Harrogate, will be glad to hear that a movement is on foot to ensure that the good work he has done for homœopathy in the North of England shall have some permanent memorial, and that a Committee has been formed to collect subscriptions, in connection with which they are sending out the subjoined circular.

4, WOODHOUSE SQUARE, LEEDS,
1909.

DEAR ——,—Since the lamented death of Dr. S. H. Ramsbotham, it has been felt by his patients and friends that a Memorial should be raised to his memory in Leeds, and it is considered that the most suitable form such a Memorial could take would be to perpetuate Dr. Ramsbotham's name in some way connected with the Leeds Homœopathic Dispensary, in which he was so deeply interested.

A Committee has been formed, any member of which will receive gifts for this purpose, or the same may be paid to the account of the Ramsbotham Memorial Fund, Lloyds Bank, Leeds.

Donations to the amount of upwards of £250 have already been promised.

The form which the Memorial will take will be decided by the Committee at a later date and announced to the Subscribers.

For the Committee,
AMELIA MOORE,
Hon. Secretary.

Obituary.

WE regret to record the death, on December 24, 1909, of Arthur Llewellyn Williams, L.R.C.P., L.M., who for some years past has carried on a homœopathic medical practice in Oldham, Lancashire. The following account is taken from the *Oldham Standard* of January 1, 1910:—

"DEATH OF DR. A. WILLIAMS.

"The medical profession is the poorer, and Oldham has lost a much-respected citizen by the death of Dr. Arthur L. Williams, of Union Street West, which occurred on Christmas Eve. Of a quiet, unostentatious manner, the deceased had cultivated a far-reaching friendship, and those who sought his ministrations found in him a friend and adviser. Though not actively concerned in public life, he led a busy career, and those who knew him best esteemed him most. His demise was due to acute pneumonia, and as his illness was of brief duration his relatives, naturally, are much shocked.

"Dr. Williams resided in Oldham fourteen years and has an extensive practice, and studied for his profession in Liverpool. When qualified he entered into practice in the Mersey City, in connection with his brother, and later he became Medical Officer of the Hahnemann Hospital, Hope Street, and Consulting Officer to the Northern Dispensary, Liverpool. Dr. Williams' varied experiences and his studious disposition resulted in a store of knowledge to be envied, and as a gentleman he was genial and kindly. He was an L.R.C.P., L.M. Edin. Much sympathy is felt with the bereaved relatives in the great loss they have sustained. The funeral took place on Wednesday morning at Chadderton Cemetery."

Reviews of Books.

Life of Dr. Mahendra Lal Sircar. By Sarat Chandra Ghose, M.D., Corresponding Member of the British Homœopathic Society, &c. Published by Jnanendra Nath Bose, the Oriental Publishing Home, 11, Issurthakur Lane, Calcutta. 1909. Price, Rs. 2, excluding postage.

This book is an interesting biography of the late Dr. M. L. Sircar, by his enthusiastic disciple and colleague, Dr. Sarat Chandra Ghose, the well-known Editor of the *Indian Homœopathic Reporter*, and author of several homœopathic works, viz., "Plague," "Therapeutics of Cholera," "Diabetes," "Ague," and of a "Characteristic Materia Medica of Homœopathic Remedies in Bengali." Besides giving the biography of Dr. Sircar, Dr. Ghose deals with the rise and development of homœopathy in India, the establishment of the Indian Association for the Cultivation of Science, and the Hindusthan Institute of Indigenous Drug Proving (of which he is the founder and moving spirit). Anyone who has read the book through will have gained a good idea of the history of homœopathy in India, of its present status and its future prospects. The history of Indian homœopathy is largely summed up in the life of Dr. Sircar, who was its foremost champion and most able exponent almost from the first. Born on November 2, 1833, in Paikpara, a village 18 miles west of Howrah, he early lost both his parents, his father when he was 5 years old, and four years later his mother, who died at the early age of 33. He was brought up by his maternal uncles, and at the age of 8 was sent to David Hare's School, in which the students were given free education. He studied at this school till he was 16, when he secured a junior scholarship and was promoted to the Hindu College. He read in this college five years, till the beginning of 1854, and became a favourite pupil and won the good graces of Mr. Sutcliffe, Principal and Professor of Mathematics, and of Mr. Jones, Professor of Literature and Philosophy. He then obtained admission to the Medical College, and the next year married. He read hard for six years in the Medical College, at the end of which time he passed the L.M.S. examina-

tion. As at school, so at college, he became the favourite pupil of all the professors, and at the request of Dr. Fayrer he appeared at the M.D. examination in 1863, and came out first. He was the second M.D. of the Calcutta University. The same year the Bengal Branch of the British Medical Association was established, and on the opening day he delivered a speech denouncing homœopathy. He was elected Secretary to the Branch, and after three years one of its Vice-Presidents. He rapidly rose in fame and popularity. One day a friend handed him a copy of Morgan's "Philosophy of Homœopathy," and asked him to review it for the *Indian Field*. He consented. The first perusal of the book convinced him, however, that it could not be easily and logically reviewed without a previous practical acquaintance with the system. Dr. Morgan appealed to facts and figures, and, accordingly, the system must be placed under a systematic observation and scrutiny before it could be proved to be founded on illogical principles. This led him to watch the progress of cases treated by Babu Rajendra Dutt, a wealthy lay homœopath who practised extensively in Calcutta and had made many remarkable cures. What he saw soon convinced him that there was truth in the system, and he began to study homœopathy thoroughly. He became a convert, and made an open confession of his belief in an address which he delivered at the Annual Meeting of the Association in February, 1867. The address was entitled, "On the Supposed Uncertainty in Medical Science and on the Relationship between Diseases and their Remedial Agents." The allopathic profession in Calcutta were taken completely by surprise, but their bigotry and intolerance rose to a high pitch. Dr. Sircar was excommunicated from the medical associations, and was forsaken by nearly all his patients. For six months he had scarcely a case to treat. He devoted his now copious leisure to perfecting himself in homœopathy, and as the orthodox journal, the *Indian Medical Gazette*, would not admit his replies to the attacks made upon him, he started a journal of his own, the *Calcutta Journal of Medicine*, which, with occasional intervals of suspended animation, he carried on during the greater part of his life. He gradually made headway and appreciation and medical practice returned. He established

the "Indian Association for the Cultivation of Science." In 1870 he was appointed a fellow of the Calcutta University and was placed on the Faculty of Arts. Eight years later, in 1878, he was, by a resolution of the Senate, placed on the Faculty of Medicine. The members of the Faculty protested against his nomination, but their opposition was overborne. Public honours also awaited him; in 1887 he was made Honorary Presidency Magistrate, the responsible duties of which post he discharged with characteristic zeal for twenty-five years, and in the same year the Government appointed him a Member of the Bengal Legislative Council; and he was nominated in all for four terms. The title of C.I.E. was bestowed upon him in 1883, and he was made Sheriff of Calcutta in 1887. He was the only medical man who was honoured with the bestowal of the Honorary D.L. Degree of the Calcutta University, and he obtained this degree in 1898. He suffered much from ill-health and had four bad attacks cf fever. During the last eleven years of his life he was obliged to retire from active practice and was for some years before his death the victim of asthma and strangury. He died peacefully on February 23, 1904, aged 71.

Such are the main outlines of Dr. Sircar's life as narrated in this book. Homœopathy in India has lost much by his death, for there is no one of like eminence and attainments to take his place. We gather from Dr. Ghose's chapter on the "Rise and Development of Homœopathy in India" that the chief hindrance to the progress of homœopathy in India is the want of unity amongst its practitioners. There is much jealousy and rivalry, which lead to the establishment of more institutions than can be properly supported or worked. For instance, there are three different homœopathic medical schools in Calcutta, none of which can be said to be in a flourishing condition. In fact, there is not a single well-equipped homœopathic medical college in India, and students go to America for due qualification. There are also several homœopathic medical journals, but none of first-class rank. Less scattering of forces and more working together are required all round.

Considering that the author is using what is to him a foreign tongue, this book is very creditably written, but he

would have acted wisely had he handed his manuscript to some English scholar for revision before sending it to press, as thereby some curious expressions would have been avoided and some redundant rhetoric pruned.

A Guide to the Twelve Tissue Remedies of Biochemistry. The Cell-salts, Biochemic, or Schuessler Remedies. By E. P. Anshutz. 91 pages, cloth, 75 cents. Postage 5 cents. Philadelphia: Boericke and Tafel. 1909.

This is a handy, nicely-printed little book on the tissue remedies. Its scope is outlined by the following quotation from the preface: "This book is but an orderly and more convenient arrangement of the material left by Schuessler, and of accumulated experience of others, laying no claim to much original material. The skill of the physician must be shown in tracing a given case of illness to its disturbed salt; when that is done the remedy is apparent." The book is divided into three parts. Part I. treats of the theory, dosage, &c., of Biochemistry; Part II. comprises the Materia Medica; and Part III. is a therapeutic section in alphabetical order.

Notices, Reports, &c.

BRITISH HOMŒOPATHIC SOCIETY.

THE fourth meeting of the Session was held at the London Homœopathic Hospital on Thursday, January 6, 1910. Dr. Macnish, the President, was in the chair, and was warmly welcomed on his return in good health from his long voyages.

Harold Fergie Woods, M.R.C.S.Eng., L.R.C.P.Lond., was unanimously elected a member of the Society, and formally admitted by the President. Drs. Ridpath, of Sunderland, and Ramsbotham, of Harrogate, were proposed for membership.

Dr. BURFORD, of London, then gave "A Short Demonstration of Some Points in Technique Accessory to Operation, as Recently Observed in Vienna Surgical Clinics." In the course of his demonstration Dr. Burford showed a mouth

guard of a new pattern to be worn by the operator and assistant during an operation; also a special pattern of head-gear, comprising a combined cap and veil, which was worn in Vienna by surgeons during abdominal operations, as well as indiarubber gloves of the usual pattern, but which are covered by cotton gloves, worn over them in order to increase the holding power. Patterns of sterilized aprons, trouser coverings, and goloshes were also shown. Dr. Granville Hey, at Dr. Burford's request, put on all these antiseptic coverings in order to show the meeting by a practical demonstration the precautions against septic infection taken by the Vienna surgeons.

Dr. Burford then showed a new needle-holder in use in Vienna, which combines the advantages of giving a very firm hold, good leverage, and fine working, and which admits of being grasped in three different ways according to the character of the manipulation required. Other points with regard to the Vienna clinic are that the nail-brush has been discarded, and the cleansing of the patient's skin is done by means of wood fibre moistened with alcoholic soap, and by the application of a strong solution of iodine to the area to be operated on just before the first incision is made. An unlimited supply of sponges is used; as no sponge is used more than once, there is no washing of sponges. There is, of course, complete sterilization of instruments. Silk is used and never catgut. Though all these precautions are completely successful in preventing sepsis, there is a high mortality from post-operative pneumonia, a cause of which may possibly be found in the fact that the patient lies in wet packs for some hours before the operation.

Remarking on the thoroughness with which the work is done, and of the good use to which a hospital museum of specimens can be put, Dr. Burford mentioned Wertheim's operation for the removal of cancer of the uterus. Wertheim has performed his operation on 500 cases within the last ten years, and all these specimens are preserved in the museum collection; 250 specimens where there has been recurrence are placed together on the shelves on one side, and 250 specimens that have not recurred so far on the other side. Every case is followed up and written to at stated intervals, so that Wertheim may be kept *au courant* with the after progress

and present condition of each case operated on. Stained and mounted sections of each case are also kept properly tabulated for reference.

A discussion followed Dr. Burford's demonstration, to which Drs. EADIE, JOHNSTON, BYRES MOIR, HEY, NEATBY, ALEXANDER, KNOX SHAW, and WRIGHT took part.

Dr. BURFORD, in replying, pointed out that the elaborate technique in use in Vienna had the effect of eliminating the personality of the operator, which some members considered to be an important factor in the causation of sepsis. He agreed that post-operative pneumonia might sometimes be due to the careless manner in which it is customary in Vienna to give the anæsthetic, which is usually ether. Notwithstanding this faulty administration of anæsthetics, the whole practice of the Vienna surgeons showed a strenuous striving for perfection, most commendable in itself, and an example which we should do well to follow.

Mr. KNOX SHAW then read a short paper on "The Present Position of Prostatectomy." He began by remarking that there is often a tendency to run a good thing to death, and that this is the case with the operation of prostatectomy. Urinary incapacity with residual urine is not always due to a large prostate; it may be owing to the presence of a stricture, to locomotor ataxy, or even to simple neurosis. In prostatic cases the catheter has still a useful place, and should not be lightly thrown aside for the operation of removing the prostate, an operation the mortality of which varies from 7 to 16 per cent. For instance, the following class of case of prostatic obstruction should not be immediately operated upon: The condition where there is gradually increasing difficulty and frequency to micturition, a good deal of indigestion, pale urine of a low specific gravity, though without albumin, the bladder perhaps chronically over-distended. These cases need careful handling; they should be treated with the catheter, and the bladder emptied at least once a day. Operation is also not immediately advisable in cases of acute retention, where perhaps a chill or some error in diet brings on an attack of retention, and where on examination the prostate is found to be enlarged. If it is impossible to pass a catheter in these cases, repeated aspiration should be had recourse to

or supra pubic cystotomy. Free hæmorrhage into the bladder and septic absorption would be likely to follow prostatectomy.

On the other hand, the case may be one in which the patient has long led a catheter life; there is chronic cystitis, the passage of the catheter is frequent and painful, the patient is in such discomfort that he is willing to run the risk of prostatectomy. The operation should be done without delay, but if there is much cystitis a preliminary cystotomy, to drain and wash out the bladder and so reduce the cystitis, is advisable.

From 5 to 15 per cent. of all prostates removed are found to be the subject of carcinoma. One lobe feels dense and hard and different in texture from the other. Often carcinoma is not suspected till the operation, when the capsule is found hardened and thickened.

Removal of a carcinomatous prostate, if performed in the early stages of the disease, is often successful, but not when the disease is advanced. In this country the suprapubic is the route usually chosen for the operation, but in America the perineal route is much in vogue. Mr. Knox Shaw did not consider the perineal route to offer any advantages over the supra pubic as far as the operation itself is concerned, and to be much more liable to be followed by unpleasant sequelæ, especially incontinance of urine, which, when occurring through the perinæum, is particularly unpleasant. He thinks the most suitable cases for prostatectomy are those who have had a catheter education, those in which the prostatic enlargement is of the large adenomatous variety, and where cystitis has not produced secondary changes in the kidneys. He recommends a preliminary cystitis in old and feeble patients, in emergency cases, and in those where there is cystitis. In successful cases the patient has complete freedom from all further need to use the catheter, and usually also from cystitis. With regard to the operation, the chief points he noted were —that sutures should be put through the skin and bladder wall on each side of the incision and tied to approximate the bladder to the abdominal wall, that the drainage tube should be dispensed with, that the bladder should be syringed out through the wound for five days, and that then a soft catheter should be passed by the urethra into the bladder and the

bladder wound dressed with cellulose dressing. In the discussion which followed, Drs. Dudley Wright, Cronin, Byres Moir, Eadie, Hey, Stonham, Sandberg, Green, Alexander, and Burford took part. Mr. Knox Shaw replied.

THE BRITISH HOMŒOPATHIC ASSOCIATION (INCORPORATED).

SUBSCRIPTIONS and Donations received from December 15, 1909, to January 15, 1910 :—

GENERAL FUND.

	Subscriptions. £ s. d.	Donations. £ s. d
The Earl of Dysart (for Scholarships in connection with the Honyman-Gillespie Course)	—	75 0 0

COMPTON BURNETT FUND.

Mrs. Synyer	—	1 0 0
F. Langham Robart, Esq.	—	2 2 0

LADIES' BRANCH.

Sale of Work...	—	0 5 6
Mr. and Mrs. Henry Wood... ...	5 5 0	—
Madam Erba (Collected)	—	1 0 0
The Misses Raffles	1 1 0	—
Mrs. John Willis	0 5 0	—

A meeting of the Advisory Committee was held on Thursday, December 16, at 4.30 p.m., and the usual meeting of the Executive Committee was held on Wednesday, January 12, at 4.30 p.m.

[LADIES' BRANCH.]

KENLEY STREET DISPENSARY.

The numbers at the Dispensary fell considerably during December, only 188 attendances. This we attribute entirely to the absence of our doctor. Also we shut from Friday to Tuesday, December 24 to 28, losing three working days. We confidently expect a return to our larger numbers for January.

Patients for December, 57; attendances, 188.

BRITISH HOMŒOPATHIC ASSOCIATION.

PUBLIC LECTURE BY DR. ALFRED PULLAR, M.D.EDIN., ON "POPULAR CONCEPTIONS OF MEDICINE AND THE AIMS OF HAHNEMANN."

This lecture was delivered by Dr. Pullar at the rooms of the Association, Chalmers House, 43, Russell Square, on the evening of Wednesday, January 19. The rooms were well filled by an attentive and appreciative audience.

Dr. Pullar began his lecture by giving a sketch of the ancient *régime* in medicine and took his audience back to the days of blood-letting and blistering, of moxae and cauterization, of emetics and purging; the days when disease was regarded as an entity to be forcibly expelled from the body, when diseases were classified as hot or cold, sthenic or asthenic, to be treated with depressants or tonics as the case might be. He noticed how the various theories of disease conflicted with one another, and how their advocates fought to make them dominant, with the result that chaos in medical belief ensued, and illustrated this by a remark of Dr. Gregory, of Edinburgh, of "Gregory powder" fame, that "he did not know of any disease or remedy which had not been the subject of controversy."

In 1755 occurred the birth of Hahnemann, a genius who was destined to revolutionize the practice of medicine, not by promulgating a new theory of disease which would only have added to the existing medley, but by building on facts true and tested. It was the practical side, the curative side of medicine which interested him. He was not greatly concerned with the names of diseases or their classification, which in his view were mere expressions; but he found that disease differed in every patient, that each patient's disorder was a subject of study in itself, and considered cure to be the object. To quote his own words: "The physician's high and only aim is to restore the sick to health.

Hahnemann was led by his observations to the conclusion that diseases were capable of being successfully dealt with by minute observation of the symptoms alone, and that theories respecting diseases were misleading. They were, in fact, the

chief causes of the erroneous methods of treatment in vogue in his day. Physicians evolved theories of disease from their inner consciousness, basing them on unsound premises, a proceeding which necessarily resulted in inefficient practice. So inefficient was medical practice that Hahnemann at one time decided to relinquish it, as he could not conscientiously pursue it. After twenty years of unrecognized, unselfish and unsparing labour during which he proved no fewer than twenty-five drugs on his own body, besides collecting from literature all the effects of drug action therein recorded, he at last was able to enunciate his great law in terms as clear cut and defined as an axiom in geometry, so plain that it could be at once tested by all who would take the trouble to do so. But to induce men to take this trouble was the difficulty then as it is still. There is dislike to leave the beaten tracks. The acceptance of so novel a theory would be destructive of many vested interests and would break down conceptions that had been prevalent for ages. Like all pioneers homœopaths have had to pay a heavy price for being in advance of the science of their time. Dr. Pullar concluded by asking, What of the Future? Is Homœopathy to be absorbed in a crude form by the profession and be buried amongst the general allopathic teachings of medicine. Emphatically no! Homœopathy is true and immortal. He asked that the votes of the audience should be given on behalf of the therapeutic reform embodied in homœopathy.

The next public lecture will be given at Chalmers House, 43, Russell Square, on Wednesday, February 9, by Henry Festing Jones, Esq., and the subject will be "Samuel Butler" (Author of Erewhon).

NOTICE TO CORRESPONDENTS.

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

All MSS. should be in the hands of the 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. STONHAM, 128, Broadhurst Gardens, N.W.

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. STONHAM, 128, Broadhurst Gardens, N.W.

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

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 Médico-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 Médical, Revue Homœopathique Française, Revue Homœopathique Belge, The London Graduate.

THE BRITISH
HOMŒOPATHIC REVIEW.

MARCH, 1910.

Editorial.

VALE!

We regret to announce that this will be the last issue of the British Homœopathic Review.

The Review was started just three years ago under the auspices of the British Homœopathic Association at a time when the *Monthly Homœopathic Review*, which had been the chief organ of British Homœopathy for many years, was getting into difficulties and on the point of ceasing publication.

The new Review was planned on more ambitious lines than its predecessor, and liberally financed by the British Homœopathic Association, who hoped by improving the character and enlarging the size of the journal to gain the support of the whole body of homœopathic practitioners in this country as well as many in the colonies, and to attract the attention of some outside the profession who are interested in homœopathy, and that in a year or two the Review would become self-supporting.

These hopes have unfortunately not been fulfilled to the extent necessary to place the Review on an independent footing, and the result has been a considerable financial loss to the Association, which that body feels it is no longer justified in continuing to incur.

For a time, therefore, British Homœopathic journalism will be represented by *The Homœopathic World* and the *Journal of the British Homœopathic Society* alone.

We are glad to know, however, that this time is not likely to extend over more than a few months, for a movement is on foot, and a committee in course of formation, for the establishment of a new journal (probably with another name), to follow on with the work hitherto carried out by the BRITISH HOMŒOPATHIC REVIEW.

We believe our readers will consider that the Review has performed a most useful function by stepping into the breach when the old *Monthly Homœopathic Review* was expiring, and tiding over the years till time and circumstances are ripe for a renewed effort. We think that it has been a decided improvement on the former journal, that it has given its readers a broader outlook on what has been passing in both the homœopathic school and the general medical world, and that its volumes contain much of permanent interest and value.

With cordial thanks to our readers and subscribers for their support and interest during the past three years, we regretfully wish them farewell.

Editorial Notes and News.

Angina Pectoris.

WE made the suggestion in one of our notes[1] last month that possibly when the pain in attacks of angina pectoris is situated in the right side of the chest and down the right arm, the right side of the heart is the part principally affected. This suggestion derives some support from a case reported by Dr. Alexander Morrison in a paper read before the Harveian Society on "The Nature and Treatment of Angina Pectoris." The case is as follows: "A male, aged 20, suffered from severe attacks of pain over the heart, passing up to the right shoulder and down the right arm, being particularly felt at the tip of the right little finger. He had also frequently experienced pain of an acute and continuous character at the lower end of the sternum. He exhibited a double thrill on palpation over the second and third left rib cartilages, a double murmur of harsh character

[1] P. 52.

in the same situation, and a systolic bruit at the apex, which was not traceable outwards to the left. The patient died, and, on *post-mortem* examination, showed gross lesions of the pulmonary arterial valves, the base of the pulmonary artery, the tricuspid valve, and the septal wall of the right auricle."

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The Personal Factor in Septic Infection.

AT a recent discussion of the British Homœopathic Society some of the speakers laid much stress on the part played by the personal factor in cases of sepsis arising after operations. These remarks are confirmed in a striking manner in a recent paper by Sir W. Watson Cheyne, contributed to the *Lancet*, in which he gives the results, so far as septic infection is concerned, of all the "clean" cases operated on by him at King's College Hospital during the past eight years. There were 1,028 in number, and of these only nineteen became in any way infected. The remarkable point about these cases is that seven of them occurred during the reign of one house surgeon. The other twelve cases occurred during the periods of office of sixteen men—Sir Watson Cheyne having had seventeen house surgeons during the eight years. Several house surgeons had no septic case during their term of office; some had one case, and some had two. The after-dressing of the cases is left to the house surgeon, and in many of the infected cases the infection entered through a drainage-tube subsequent to the operation.

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Pellagra.

THIS disease was first noticed as occurring among the field labourers of Northern Italy. It is a chronic malady, and chiefly affects the cultivators of the soil. It usually commences in the spring with symptoms of general malaise, accompanied by a red rash upon the uncovered parts of the skin of the body, looking like sunburn. The symptoms disappear about July or August, to reappear the next spring, and with increasing severity each successive year. In time the patient's health becomes completely undermined, he looks like a mummy, with his skin shrivelled and sallow, his muscles wasted, his movements slow and languid, and his sensibility

diminished. Profound disorganization of the nervous system follows, there are partial paralyses, and mental symptoms ensue, such as melancholy, imbecility, and mania; so that a large number of peasants with the disease end their days in lunatic asylums.. Autopsies show general tissue degeneration of the brain and nervous system.

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Its Cause.

FOR a long time pellagra has been regarded as a food disease, and it has been generally considered to be due to damaged or diseased maize, which forms a staple article of diet among the Lombard peasantry. But further knowledge has shown that pellagra is by no means confined to Lombardy, or to areas where maize is much consumed; it has been identified in all parts of the world, in some of which maize is not eaten at all. It is common in Egypt, in Barbados, and amongst the Zulus and Basutos of South Africa. It has also been met with in Roumania, Gascony, Corfu, and parts of British India. More recently it has been observed to be spreading in the United States, increasing rapidly since 1906, and numerous cases have been reported in as many as thirteen States. This tendency to invade fresh territory reminds one of the sleeping sickness, and another point of similarity is the value of arsenic in its treatment. These considerations have led Dr. Sambon to formulate the hypothesis that the cause of pellagra is protozoal in origin, and this view has received the support of Sir Patrick Manson. The *Times* of February 4 reports the formation of a committee to study the subject, and a highly representative list of names is given, including the Italian Ambassador, Sir Thomas Clifford Allbutt, F.R.S., Sir Lauder Brunton, Sir Patrick Manson, Professor William Osler, Professor Ronald Ross, Dr. Sambon, the Editors of the *Lancet* and the *British Medical Journal*, and others eminent in science.

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Treatment of X-ray Ulcers.

THE ulcers caused by an overdose of the X-rays are most difficult to heal and the most painful of ulcers. They slowly form consecutively to a dermatitis caused by the rays, and spreading from a central necrosed point, usually assume

a more or less circular form. The pain is intense. Dr. Hall Edwards describes the pain from his experience in these words: "I have not experienced a moment's freedom from pain for more than two years. The pain is of a neuralgic character; it never ceases, and is intensified from time to time by sudden stabs and jumps."

Dr. John Hilton, in his work "Rest and Pain," mentions an exceedingly obstinate and painful kind of ulcer, which, though it could not have been caused by X-rays, may yet have had a similar pathological condition producing the pain. Dr. Hilton relieved the pain of these ulcers by passing a bistoury to divide the nerve between the spine and the painful part of the ulcer, and reading this gave a suggestion for a successful line of treatment to Dr. Agnes Savill, who reports to the *Lancet* a case of X-ray ulcers cured by Hilton's method. It was the case of a married woman, aged 30, who consulted her at St. John's Hospital for Skin Diseases for two X-ray ulcers on the left shoulder and upper arm, which had come on after two years almost daily exposure of the part to X-rays, applied for the purpose of curing scleroderma in that and other situations. The ulcers were situated on the sclerodermatous tissue, and had commenced as small pimples left after the subsidence of dermatitis. The pimples had scaly tops which came off frequently and grew again, but finally failed to re-form and left open sores beneath. The upper ulcer attained the size of a shilling, and the lower one of a five-shilling piece, and a depth of ½ in. For two years the patient was unable to obtain relief sufficient to let her have more than an hour's sleep at a time. The only treatment that afforded any relief was carbolic fomentations (1 to 100). The pain was steady, with occasional sharp darts, and extended from the ulcers up to the spine to a position 3 in. below the second dorsal vertebra.

Hilton's method was carried out as follows: A semi-circular incision, 1 in. deep, was made above each of the ulcers, and another semi-circular incision a little shorter, but of the same depth, across the centre of each ulcer. Free bleeding was encouraged and the gaping wounds stuffed with aseptic gauze, which was left *in situ* till the granulation tissue, swelling up from the bottom of the wounds, pushed the gauze before it.

The pain was at once altered in character, the patient improved rapidly and could get rest, and she was discharged from the hospital in three weeks with the ulcers almost healed and quite free from pain. They did not, however, completely heal for several months, a tiny nodule remaining in the centre. Fibrolysin was simultaneously injected to procure softening of the sclerodermatous tissue and was successful; all the thickened parts became softer and thinner. Other ways of treatment of these ulcers are by curettage and excision. If they become malignant amputation may be necessary.

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Acute Bronchitis in Children.

THE steam kettle has deservedly fallen into disuse as a routine proceeding, but it has its uses where there is a dry cough and the stethoscope discloses many dry sounds. Under no circumstances should the steaming be continuous, or the bed enveloped in a tent. The full benefit will be obtained by allowing the steamer to play over the bed from the far end for fifteen minutes at a time. Fomentations are much to be preferred to poultices, as, being more easily prepared, they are more likely to be applied hot. Fresh air is more important than medicine, and the room must not be filled with anxious friends, who simply use up the atmosphere. —*Dr. G. Sutherland.*

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"One" for the L.H.H.

THE customary pre-operative purge is strongly condemned by Dr. Walker, who says it is unnecessary in most cases, and should be given only when there is a clear indication for it. The practice is, he says, unnecessary and injurious; patients are made uncomfortable and are weakened. In addition to this, germ activity in the intestinal canal is stimulated just as in enteritis, so that if the intestine is opened during the operation the probability of infection from it is increased. There is also, according to this author, more post-operative tympany after purgation. A diet of digestible food for the twenty-four hours preceding operation, and a fast for the last eight to twelve hours, are what Dr. Walker recommends, except when there is an obstructive lesion of the intestine. In cases of milder fæcal stasis, short of obstruction,

he would allow a purge or a laxative a few days before operation, followed by enemata. But the routine use of any powerful drug is to be deplored, and the habitual pre-operative purge is indefensible. The author's objections to purgation apply apparently to medical cases as well as surgical, and he is convinced that much harm is done in general practice by the prescription of purges; he fails to consider how constipation is otherwise to be combated, and seems to regard it as a condition which may be left to itself, an opinion which most practitioners will decline to endorse.

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A Question of Courtesy.

NEARLY fifty years ago the British Medical Association passed certain resolutions at a memorable meeting held at Brighton. These resolutions condemned, in no measured terms, the principles and morals of a section of the profession. It is an excellent testimonial to the broad-mindedness and tolerance of the medical profession in this country that very few doctors know that such resolutions have ever been passed, and that still fewer refrain from expressing their astonishment that such resolutions were ever tabled and adopted. We have moved with the times, and it is no longer regarded as an insult for a consultant to be asked to meet a homœopath in consultation. There are many homœopaths who are members of the British Medical Association, and we venture to think that an endeavour to reiterate the sentiments expressed in the Brighton resolutions will be foredoomed to failure even at a divisional meeting. The profession, as most practitioners have found, is wide enough for all sections to dwell in amicably and peacefully, however much individuals may differ on broad principles of treatment. Nevertheless it is a fact that there flourish, here and there, hide-bound members of the medical profession whose ethical spirit is less tolerant than that of the most rabid Galenist, and whose professional courtesy ceases to exist where homœopathists are concerned. We have recently come across one of this minority, and we have no desire to meet with his similars in future. This practitioner was called in to attend a patient of a brother practitioner who happens to be a homœopathist. He attended to the case, but failed to notify his neighbour

of the event, and left it to friends and relatives of the patient to acquaint their family practitioner with the fact that, in the latter's absence, he had been called in. The homœopath wrote a courteous note, as is usual in such cases, and requested particulars of the case. To this his colleague replied by stating that he had omitted to inform him of the case, since he (the writer) was convinced that the ordinary rules of medical etiquette did not apply to homœopathists! The amazing effrontery of this statement needs no comment, but it is saddening to note that the spirit of intolerance which refuses the ordinary courtesies of professional life to a colleague on account of the fact that that colleague holds opinions which are not held by the majority of the profession, still exists in some quarters. No words can be strong enough to condemn that spirit, and it may well be asked whether a practitioner who shows himself so virulently animated by it is worthy of the professional courtesies which he refuses to extend to homœopathists.—*The Hospital.*

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Polonium.

WE find the following interesting piece of news in the *Times:* "According to a communication made on February 14 to the Academy of Sciences by M. Lippmann, Mme. Pierre Curie, the widow of M. Pierre Curie, the discoverer of polonium and radium, has at last succeeded in isolating $\frac{1}{10}$ mg. of polonium. In order to obtain this result Mme. Curie, working in co-operation with M. Debierne, has had to treat several tons of pitchblende with hot hydrochloric acid. The radio-active properties of polonium turn out to be far greater than those of radium. It decomposes chemically organic bodies with extraordinary rapidity. When it is placed in a vase made of quartz, which is one of the most refractory of substances, it cracks the vessel in a very short time. But a no less distinctive quality of polonium is the comparatively rapid rate at which it disappears. Whereas it takes 1,000 years for radium to disappear completely, a particle of polonium loses 50 per cent. of its weight in 140 days.

The products of its disintegration are helium and another body, the nature of which has not yet been ascertained, but Mme. Curie and M. Debierne are inclined to believe it to be

lead. Its identity, however, will shortly be established, and at the same time science will have had the experimental proof of the transformation of a body which had been believed to be elementary.

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The Honyman-Gillespie Lecture-Courses: The Inaugural Address.

It will be a matter of interest to our readers to learn that His Majesty the King has graciously accepted a Presentation Copy of the Inaugural Address delivered at the commencement of the Winter Session at the London Homœopathic Hospital by Dr. Burford. It is to the credit of James Urquhart, Esq., W.S., one of the Trustees of the Honyman-Gillespie bequest, that the initiative was taken, and we are glad to know that an argued defence of the power and place of homœopathy in the medicine of the future has been added to the Royal Library. Court favour, if rumour speaks correctly, has in past time been extended to men of light and leading among the homœopathic profession in this country, and a lucid statement of the hold we have upon the medical science of the future may properly be easy of access to all, in high place or in low, who desire to gain information at first hand.

Original Articles.

COFFEE AND COFFEA.

By C. J. WILKINSON, M.R.C.S., &c.

THERE is a legend concerning the discovery of coffee which is probably as true as some other legends, and even more suggestive. A holy Dervish observed that his goats were exhilarated after eating a certain shrub. He experimented on his own vile body, with such success that he was accused of drunkenness. He explained their mistake to his neighbours and introduced them to the coffee plant; and this was hailed as a good gift of Allah and a divine substitute for the forbidden alcohol.

Various morals may be extracted from this condensed legend. The most obvious of them is, that man will have

a stimulant of some sort; *man*, in this moral, distinctly includes woman.

But the neighbours of our Dervish were but crude observers; for the stimulus of coffee is primarily selective of the cerebral cortex, and only derivatively affects the heart. Alcohol, on the other hand, is primarily a cardiac stimulant and affects the brain through an increased action of the heart and a dilatation of the blood-vessels, in which the other organs have a common share.

Hahnemann, our founder, forbade coffee to those who would gain full advantage of the Law which he discovered. Indeed, the coffee habit was to Hahnemann as the proverbial red rag to a bull; his indignation concerning it vexed him as a thing that is raw. Nowhere, perhaps, do his powers of invective and irony move him to greater severity than in his essay, "On the Effects of Coffee, from Original Observations." He is scathing as he details the primary exhaltation and the secondary depression following an over-indulgence almost national in vogue. He depicts flushed cheeks, eyes abnormally bright, "a factitious liveliness, a wakefulness in defiance of Nature." "The most refined sensualist, the most devoted *debauchee*," he goes on, "could have discovered on the whole surface of the globe no other dietetic, medicinal substance, beside coffee, capable of changing our usual feelings for some hours into agreeable ones only, of producing in us for some hours rather a jovial, even a petulant, gaiety, a livelier wit, an exalted imagination above what is natural to our temperament, of quickening the movement of our muscles to a kind of trembling activity, of spurring on the ordinary quiet pace of our digestive and excretory organs to double velocity, of keeping the sexual practice in an almost involuntary state of excitation, of silencing the useful pangs of hunger and thirst, of banishing blessed sleep from our weary limbs, and of artificially producing in them even a kind of liveliness, when the whole creation of our hemisphere fulfils its destiny by enjoying refreshing repose in the silent lap of night." Sexual precocity, onanism, decay of the teeth, caries of the bones, abscesses, ophthalmia, an exaggeration of rickets, are all attributed to this cause. How much coffee the voluptuaries of Leipzic consumed in the year 1803 (the date of this essay) it would be

difficult to determine. At the present time the average Briton consumes rather less than a pound of coffee in the year; and, as he does not know how to "make" what he consumes, he suffers little from it. So, in addition to the pleasure supplied by a severe indictment of others, we gain, ungalled, material for pathogenesy. Had the fable been narrated *de tea*, our withers had not been unwrung.

The most active constituent of coffee is *caffeine*, and the flavour of the infusion depends on the prevalence of *coffeol*, an essential oil. Dr. Hutchinson tells us[1] that the process of roasting coffee eliminates some 21 per cent. of the caffeine and some 10 per cent. of the coffeol. He estimates that in an infusion of 2 oz. of coffee to a pint of water a teacupful contains 1·7 gr. of caffeine and 3·24 gr. of tannic acid. It must be remembered, however, that our tincture of *coffea cruda* is relatively more rich in caffeine, and that it escapes the presence of an uncertain amount of methylamine. Allen, recognizing this, very properly separates the pathogeneses of *coffea cruda* and *coffea tosta*, for, as we shall see, they differ considerably, and much of value may be found in each, which is wanting in the other.

The retarding influence of coffee upon digestion is probably due rather to its tannic acid than to its alkaloid, and is most marked in its effect upon the peptic action of the stomach. Coffee counteracts the effects of alcohol, and it enhances the flavour of tobacco. These considerations, in addition to the sense of *bien être* which it induces, explain the popularity of its post-prandial use.

In considering the pathogeneses of the raw and the roasted bean together, it will save time and space to mark the symptoms peculiar to *cruda* with the letters C C, and those peculiar to the *tosta* C T. Those without special signification may be taken as common to both.

The primary exciting effect of coffee upon the nervous system are the important ones to remember. They exhibit themselves in all its departments as a temporary exaltation. The *emotions* are (as it were) raised in pitch; the fancies are lively and vivid; benevolence is excited, the religious sense is

[1] "Food and the Principles of Dietetics," p. 310.

stimulated; there is great loquacity, and, in a convalescent from rheumatism, a debauch of thirty cups of strong coffee in the day produced a condition strictly comparable to that of delirium tremens (C T). The *intellectual* powers are stimulated, both memory and judgment are rendered more keen, and unusual vivacity of verbal expression rules for a short time (C T). This stimulation is speedily paid for in failure of attention, hiatus, and inconsequence in thought.

The *head* suffers a sense of confusion, aggravated by the open air; there is vertigo with blackness before the eyes on stooping (C C). Hahnemann notes that the aggravation by open air is seemingly primary. He also gives a characteristically careful account of the coffee headache.[1] "If the quantity of coffee taken be immoderately great, and the body very excitable and quite unused to coffee, there occurs a semilateral headache, from the upper part of the parietal bone to the base of the brain. The cerebral membranes of this side also seems to be painfully sensitive. The hands and feet become cold, on the brow and palms cold sweat appears. The disposition becomes irritable and intolerant, no one can do anything to please him. He is anxious and trembling, restless, weeps almost without cause, or smiles almost involuntarily. After a few hours sleep comes on, out of which he occasionally starts up in affright." This is a portrait of not a few *migraines*, and gives substance to the advocates of a purin-free diet. I have met with headaches of this type which yielded readily to coffee, and with many more in which the indicated remedy failed to act, until the use of coffee as a beverage was abandoned. Where such a headache or an attack of insomnia is the direct result of coffee-drinking, *nux vomica* acts like a charm.

The *eyes* and *ears* suffer alike from the super-excitation of coffee. There is some photophobia towards artificial light (C T), and an unusual acuity of vision (C C). Loud music is intolerable, and the compass of hearing is diminished as regards notes of the upper register (C C). It seems probable that this symptom, given by Allen from Stapf's *résumé*, consists of a primary and a secondary phenomenon mixed. *Coryza* is

[1] Hahnemann's *Lesser Writings*, Ed. 1852, p. 395.

not infrequent in the provings, and the susceptibility to "catch cold" is increased.

There is a characteristic toothache associated with *coffea*. "No error in diet," says Hahnemann, "causes the teeth to decay more rapidly and certainly than the indulgence in coffee," and he remarks that there is a special incidence of decay upon the incisors. In the typical coffee toothache the affected tooth is apparently sound, but the pain is intense; it is relieved temporarily by holding cold water in the mouth (C T). There is marked intolerance to pain here as in other *coffea* symptoms.

Coffee stimulates peristaltic action and produces easy soft stools. For this reason many people prone to constipation take it for breakfast. I have not found that the use of *coffea* in abstainers from *coffea* is curative of that type of constipation which is said to occur as a secondary effect in those who use coffee to excess. This is one of the many examples through which habitual costiveness stands as an *opprobrium* to our craft.

Coffea has won its chief laurels in our school through its use in insomnia. It is in the sleeplessness of the first hours of night that it is useful, and especially in those who have overworked either brain or muscles during the evening. In spite of darkness and the habitual surroundings, the body is restless, and the mind is thronged by thoughts and ideas which repeat themselves and avert the patient from the process of sleep. The uneasy sleep which ends such nights as these is apt to be followed by migraine in those susceptible to it.

When *caffeine* is experimentally injected into the blood-stream after all the known nervous supply of the kidney has been divided, the renal artery dilates while the other arteries of the body are constricted; a large output of urine naturally follows. But if the experiment is often repeated the mechanism revolts and constriction of the renal artery occurs with consequent anuria. This is a beautiful example of the natural curative action, by which a poison in moderate doses carries within itself the stimulus which shall bring about its own elimination, and it has a bearing upon the homœopathic use of *coffea*. The anuria set up by the vaso-constrictive action of *caffeine*, or by experimental ligature of the renal arteries, is not

followed by true uræmia, but by a condition of marked and progressive weakness and abnormal temperature, dry, brown tongue and contracted pupils, with drowsiness which falls short of actual sleep. I have seen several cases of this condition late in chronic interstitial nephritis, and the use of *coffea* in increasing doses has been very beneficial. The diminished urine has increased in quantity, *pari passu* with an improvement in both the pace and volume of the pulse, and the state of ineffectual drowsiness gives way to refreshing sleep. The condition is not one in which cure is to be expected; but I have been gratified by the comfort which the *coffea* has induced.

There remains only to be noted the advantage with which coffee may be administered in the "teasing" and ineffective pain of early labour. The condition is one in which intolerance of pain is often sufficiently marked to suggest a homœopathic basis for the prescription. A cup of strong coffee (with milk to counteract the tannin) will relieve the pain, hearten the patient, reinforce the muscles, and hasten those effective pains which will bring the labour to a speedy end.

SOME OBSERVATIONS ON THE TREATMENT OF LUPUS VULGARIS.[1]

DR. LE HUNTE COOPER.

NOW that so much work is being done in the local treatment of lupus and other growths with radiotherapy and electrolysis, &c., the vital necessity for combating the constitutional taint which is responsible for such surface manifestations is for the most part entirely overlooked. Too often the patient, and I regret to say the physician, rests content with the disappearance of what is obvious to the vision, or the touch, and overlooks the fact that such a result by no means warrants the assumption that the patient is out of danger. How far the claim made for radium, that its local action on a malignant growth is attended by a constitutional effect, is justified, remains to be proved, but the cases so far published by no means satisfy me that such an assumption is

[1] Read before the Cooper Club, February 10, 1910.

correct, owing to the fact that they are all of too recent date to prove that the patient is in the true sense of the word "cured." The removal of a local growth by rays has one great advantage over excision with the knife, in that the local resistance of the normal healthy tissue is stimulated in the former case, whereas this is not so when the knife is employed. On the contrary, the local healthy cells are necessarily devitalized by traumatism in the latter case. However, this local effect of the rays is very different from a generalized systemic one, and it is in my opinion our duty in our patients' interests to avoid a sole dependence on any local measures for the cure of local conditions which are manifestly not the disease itself in its entirety, but merely indications of a generalized dyscrasia.

Of course, all such considerations are of no advantage to the old school, because they have no means at their disposal to cope with such constitutional states, unless the feeble and unscientific attempts to stimulate the organism by the administration of so-called "tonics" may be classed as such. True, their more advanced observers, who are slowly and laboriously re-discovering homœopathy by the help of the microscope, have made some headway in this direction, but it is only in one limited path, and it seems likely that many years will yet elapse before the bearing of these researches on the treatment of disease in general with remedies other than nosodal will be fully grasped.

On the other hand, the removal of local manifestations with internal remedies stands on an entirely different footing, for the organism itself either throws off or absorbs the morbid process, aided by the stimulation of the drug employed. But, before it can do so, the constitutional dyscrasia must be overcome; hence its results are permanent, and the process is altogether a more scientific one, and one which is in far closer accord with the natural laws governing the human organism. My own experience is that when a growth is finally dispersed in this way it neither tends to return in the same situation, nor is there any appreciable danger of its recurrence elsewhere throughout the system.

It is not always possible to stimulate the remedial powers of the body, so far as to induce entire dispersal of local morbid growths, as many circumstances, such as depressed vitality,

the long duration of the disease, &c., may act detrimentally to this desired consummation. In such cases one is justified in using local measures which will tend to assist the process by destroying the morbid tissue and stimulating the surrounding healthy cells to increased activity. Under such circumstances reasonable hope of complete cure is amply justified, for the disease has been attacked both at its centre and periphery.

It must be generally admitted that the cure of lupus by internal remedies is one of great difficulty even to homœopathy, and it is, of course, considered incurable by such means by the old school. It is for this reason that I consider I am justified in publishing the cases given below, for though they are by no means ideal for this purpose, they may yet be of assistance to those having similar cases to deal with.

My first case is, I regret to say, not as clear cut as I should like, owing to the fact that intercurrent conditions, such as acute attacks of bronchitis, influenza, ague, and gout, required remedies other than those which must be regarded as essentially responsible for the relief of the main trouble. Nevertheless, my observations on the treatment of it were responsible for the cure of the second case, so that they were by no means valueless. This patient had previously been under the care of my late father for a short time; he was a retired army officer, aged 66, of dark complexion and active habits, and I first made his acquaintance in September, 1903. I found him suffering from a lupus patch on the right side of the nose, which he told me had appeared three years before. It had been operated on (apparently by scraping), but as the surgeon was an allopath, no constitutional medicinal treatment was employed, and the trouble broke out again, and rapidly advanced up to the time my late father took him in hand.

I found an ulcer about 2 by 2 cm., involving the right ala of the nose; its upper and outer edges were marked by raised, smooth masses, over which small vessels could be seen coursing, while its inner edge was flattened and slightly cicatricial. A brownish scab covered the ulcer, and from fissures in this a slight watery discharge oozed. Later on, when the scab fell, I found that in depth the greater part of the tissue of the nose was involved, and that the floor of the

ulcer was covered by unhealthy-looking granulations. The internal surface of the nostril was raised into a convex projection corresponding with the base of the ulcer. Anterior to this ulcer and 1 cm. above the tip of the nose were two red projections, suspiciously like fresh points of infection; and another such projection could be seen higher up on the bridge of the nose.

The skin of the face generally was somewhat greasy, especially in the vicinity of the naso-labial folds, where numerous blocked sebaceous glands were evidenced by the black points commonly called "black heads."

For the rest, the patient was of the Anglo-Indian type, of sallow complexion, and subject to liver attacks. He had suffered severely from malaria while abroad, which still at times showed itself in slight pyrexial attacks, lasting for a few hours, and occasionally attended by some slight shivering. Added to this, he had suffered for years from chronic bronchitis and emphysema, and was obviously gouty. He was also a great sufferer from corns.

I commenced treatment with *sulph.*, followed later by *fer. pic.*, with benefit to his general health, but no manifest change was noticeable in the ulcer till *thuja* 3x was given three times a day. The effect of this was to *greatly aggravate the irritation in the ulcer for a few days, but after this the nose felt more comfortable;* at the same time *the bowels began acting better than for a long time past.* After this a cold, followed by aggravation of the bronchial symptoms, required attention till February 12, 1904, when I again gave *thuja*, but this time in unit dose, *thuja* ϕ A.

March 4, 1904.—He said he had felt the ulcer stirred up very shortly after the dose. It irritated for three to four days, but had not done so lately. On examination I found a slight, though *decided, improvement in the ulcer, the lump at the side being smaller, and its general appearance was certainly better.* However, though the next dose of the same remedy was followed by similar results, the drug after this apparently lost its effect, and the sore began to spread again.

The system could only make feeble, and more or less ineffective, attempts to combat the disease, and it was fairly

obvious that some restraining influence was at work which prevented the remedies from acting.

Whenever one is brought to a deadlock like this, it is well to look round for some deeply acting constitutional remedy with which to attack the obstruction, and it is on such occasions that the nosodes become such valuable allies from whom to seek support. I therefore decided to call in the aid of *tub. K.* 200 medicated in thirds, though my practice now is to give this remedy at much longer intervals. This I commenced on May 27, 1904.

Three weeks later I found *the two nodules above the tip of the nose were less red, and that on the bridge had become dried up and warty in character. The ulcer had also bled at times,* this not having previously been observed; added to which the patient's general health had improved.

After this, a continuance of the remedy failed to produce any marked change, though the condition was held in check. As I now had attacked the obstruction, I considered that a return to a more superficially indicated remedy might be attempted with greater hope of success, and, guided by the warty character of the nodule on the nose, the general tendency of the patient to corns and warts, and the old malarial dyscrasia, I decided on October 7, 1904, to give *fer. pic.* 3 x, *t.d.s.*

A fortnight later, I was gratified to find that *the warty excrescence on the bridge of the nose had dropped off.* The raised margins of the ulcer had dried to a certain extent, and they now looked less vascular and more wartlike in appearance; added to which, the whole ulcer appeared less active, and the lump inside the nose was smaller, as the patient himself detected. Continue.

A fortnight later.—Pieces of thick crust have fallen, *leaving no appearance of discharge beneath. The ulcer is altogether smaller and not nearly so inflamed,* and the raised portions are still less active. Continue.

December 9 (six weeks later).—My notes show that the nose was looking ever so much better, and *the ulcer was filling up from below, there being now no discharging surface.* The place where the excrescence dropped from the bridge was only marked by a little roughened skin, and the former raised

portions at the sides of the ulcer were represented only by two small semi-vascular projections on the outer lower and outer upper corners respectively.

Unfortunately, after this, owing to several attacks of influenza pulling the patient down considerably, the trouble in the nose broke out afresh, and his system appeared incapable of dealing with the disease unaided by local measures. I therefore called in the aid of Dr. Ashton, who obtained some slight improvement with the Finsen light, though attacks of gout and ague kept him back.

Dr. Ashton then retired from practice, and Mr. Dudley Wright carried on the local treatment, finally resorting to zinc electrolysis, the medicinal treatment being of course continued at the same time. To cut a long story short, these combined measures resulted in the final healing of the ulcer, but the patient eventually succumbed to an attack of pneumonia, which his already weakened lungs were powerless to resist. I may say that early in this case tubercle bacilli were found in the discharge from the ulcer.

It must be admitted that this man was immensely handicapped by his numerous dyscrasiæ, any one of which was ready to assert itself whenever the opportunity, afforded by some extraneous devitalizing cause, presented itself. Had this not been so, one is justified in believing, by the marked improvement which followed the treatment at first, and by the evidence afforded by the case which I am about to detail, that he would have entirely recovered long before without any local measures being necessary.

On October 15, 1904, a lady, aged 73, of dark complexion, active disposition, and spare habit, was sent by a friend of hers to consult me for lupus of the face, for which treatment had proved ineffectual for four years. She said she would not have come of her own accord, as she had long since given up all hope of obtaining relief.

It had apparently first come as a nodule on the side of the left cheek, which was thought at the time to be due to some hair-dye she was using. There was a history of a blow and lacerated wound on the left temple a year before this appeared, but none was forthcoming of traumatism directly affecting the left cheek. This nodule had broken down into an ulcer,

which had steadily spread in spite of homœopathic and other treatment.

I found a large, filthy-looking ulcer covering an area over the horizontal ramus of the jaw of no less than 2½ by 1½ in. Large warty-looking scabs covered two-thirds of its area at its anterior end, and deep ulceration was visible in the remaining third. From the latter, and from beneath the scabs, a thin, dark, offensive discharge oozed.

I was at once struck by the similarity of the skin of the face of this patient to that of the patient last described, only it was more greasy, and there were many more blocked sebaceous glands than in the former case. Indeed, the condition of the skin of the face, quite apart from the ulcer, made this patient positively revolting to look upon.

A slight amount of pain was felt in the ulcer, and there was a marked tendency to warts and corns, the latter even affecting the soles of the feet. One large, black, sessile wart was present on the back, and there were others of a similar character, though smaller, on both cheeks. The skin of the rest of the body tended to be too dry. The appetite was bad, with dry mouth, slightly coated tongue, and sore gums.

She said that her family had for the most part been unhealthy, her father having died from an abdominal tumour, and her mother from heart disease.

I directed her to keep the ulcer protected with a layer of dry boracic lint, and opened the campaign with *psor.* 30, medicated in thirds.

A fortnight later.—She described herself as feeling better, though she had suffered *more pain in the ulcer, which had discharged more freely.*

Some idea as to the character of this discharge may be gleaned from the fact that I noted at the time that it "smelt like a pigsty." I found that some black scabs had fallen, and the *skin of the face looked somewhat better.*

A fortnight later.—As no marked change was noticeable, I decided to give *tub. K.* 200 every night.

The patient unfortunately lived at a distance and could only come up to see me occasionally, so I had to depend upon written reports; and her observations on the local conditions were unfortunately worthless, as I discovered later.

A fortnight later (November 26).—She wrote to say that the ulcer was much the same, except for *increased pain and continuous discharge.* *Fer. pic.* 6x, every night.

A fortnight later (by letter).—Face very uncomfortable. *I cannot bear anything to touch it,* and the discharge is, I think, more in quantity.

This activity I regarded as favourable, though I could not be absolutely certain of this without seeing the patient. I continued the remedy.

A fortnight later.—Still good deal of pain. She does not notice any local change. *Bacil.* 200, unit. In a week resume *fer. pic.*

The reports after this continued much as before, and I continued the *fer. pic.* only, till February 3, 1905, when I had the opportunity of seeing the patient, and then found to my gratification that the ulcer showed *unmistakable signs of contraction.* Continue.

February 21 (fortnight later, by letter).—Less pain, though still a good deal of discharge. *Tub. K.* 200, once a week.

Fortnight later (by letter).—Cannot detect any change in the ulcer. *More pain the last few days. Feeling better in general health.* *Fer. pic.* 6x, *t.d.s.* *Tub. K.* 200 unit, in a week's time.

Fortnight later (March 23).—She again came to see me, and I found that contrary to her own observations the ulcer *was very markedly smaller.* A small scab over the left side was all that remained of the previous masses, the rest of the ulcer being much cleaner in appearance. *Fer. pic.* 6x, *t.d.s.*

Fortnight later.—Less painful. *Bacil.* 200, unit.

Fortnight later.—I found that the whole ulcer was protected by a thin scab, and that it had still further contracted. Discharge now is much less.

It would waste your time if I detailed any more reports, so I will content myself with saying that the healing action thus started continued without interruption to complete cure, though some other general symptoms required such remedies as *merc. sol.*, *sulph.*, *agrap. nut*, *lobel.*, *puls.*, and *nux.* The healing continued from left to right, leaving a lineal scar to mark its track, and on October 5, 1907, the last scab, which covered the extreme right of the ulcer, fell, leaving a clean scar to mark its former position.

The skin of the face was so much improved and her appearance thereby so altered that all her friends were astonished at the change. The skin was now no longer greasy, and the blocked sebaceous glands were much less noticeable. Added to which her general health was very greatly improved. When I last heard from this patient, last year, she was in excellent health, and there had been no further trouble with the face.

Remarks.—In both these cases I ascribe the cure of the disease mainly to *fer. pic.*, assisted by *tub. K.*; and have reason to believe, from watching the respective action of each, that neither alone would have brought about the desired result, and this is further borne out in the case of one of these remedies by the fact, which I afterwards discovered, that both cases had been given *fer. pic.* before coming under me, but no nosodes.

Cases like these necessarily take long to cure, and need a good deal of patience in their treatment, the rule, in my experience, being a fairly constant one, that the longer a disease takes to develop the longer it takes to cure, and *vice versâ*. The respective ages of the patients, 66 and 73, necessarily made recovery slower, as did the general ill-health of the first patient.

Finally, I should advise for future cases of this disease the administration of *tub. K.* 200, in unit doses at long intervals, and *fer. pic.*, low (about 3x), as frequently as three times a day, though, of course, if other remedies were better indicated they should be given the preference.

THE INVETERATE VOMITING OF PREGNANCY: A CASE, WITH ANNOTATIONS.

By GEORGE BURFORD, M.B.

Senior Physician for Diseases of Women to the London Homœopathic Hospital.

One by one the pillars of that remarkable but badly founded edifice of "distant reflexes" is being removed by the ceaseless efforts of physiological chemistry. The latest to go is that flying buttress, the "reflex vomiting of pregnancy" which has fled into the *Ewigkeit* as the advance of the new hepato-pancreatic chemistry covers more ground. The venue

is changed from the "unstable currents of the nervous system" to the more tangible if still somewhat elusive "toxæmia"; and the validation of the change is the wider outlook and the increasing issues of the treatment thus founded.

The alteration is somewhat sweeping from "utero-ovarian irritation" to "acidosis" and its congeners; but the new humoral pathology will have none other, and the validation, I repeat, is in the expanding vista of successful treatment thus disclosed. Yet it takes a little time for the mind to execute this *volte-face*, and from the new standpoint to think in new terms. But the advance is enormous. Up to this twentieth century every unfortunate woman afflicted with the so-called "malignant sickness of pregnancy"—the inveterate vomiting of the later months—died; the condition was as fatal as cancer. Some of the heaviest stresses of my consultative life have been these cases, the responsibility for which I have been called on to share with my colleagues. After the assiduous but useless exhibition of *phosphorus*, *arsenicum*, the *serpent-poisons*, *iris* and other hepatics, I have opened the abdomen, explored the gall-bladder and biliary passages, instituted a free efflux of bile from the cholecyst externally, but all to no purpose. I have practised intravenous saline transfusion, again and again, but with only a fleeting benefit. A temporary rally, an increased renal reaction, but in a few hours the symptoms of gravity returned with all their former stress, and *exitus lethalis* came with winged feet.

Now, in this year of grace 1910, how different the scene! The physiological chemist has exorcised Death with his sting where previously he had been supreme. The malignant vomiting of pregnancy has been shown to be concurrent with the presence of acetone and diacetic acid in the urine; and the ingestion of bicarbonate of soda, in limited but sufficient dose, will eliminate the acetone factor and banish the vomiting within a week. I have, with my colleague, Dr. Wynne Thomas[1] recorded just such a dramatic case. A family and personal history of renal inadequacy—inveterate vomiting threatening to be lethal alike to embryo and mother—acetone and diacetic acid demonstrated in the urine—the traumatic termination of

[1] BRITISH HOMŒOPATHIC REVIEW, April, 1906.

pregnancy apparently the forlorn hope—and lo! the whole situation was dramatically resolved by the simple expedient of sipping bicarbonate of soda solution for a few days. This brought about physical salvation—in a week the almost derelict patient was practically well. "Utero-ovarian irritation" had left many such as these—fœtus, or mother, or both, to die: "acidosis," however crudely, had saved the situation promptly and thoroughly.

I have stated that the modernity of the bio-chemical views accounts for the hitherto limited succour thus obtained in the visceral affections of pregnancy. Naturally, none are more desirous for progress than the unfortunate sufferers themselves, but few are gifted with the initiative to pursue the investigation in their own case. Dr. E. Petrie Hoyle[1] and myself have been conjointly responsible for a case where in each pregnancy nausea and vomiting were far more distressing than is usual. Both Dr. Hoyle and myself had independently worked out the symptoms on repertory lines, many a time and oft, but with only passing amelioration. In an earlier pregnancy the patient had had the advantage of the professional skill of Professor I. W. Ward, of San Francisco. His results were as ours.

The lady herself is a personality of remarkable intellectual gifts, and takes a keen interest in the problems of the medical art. By chance she came upon the narration of the case of Dr. Thomas and myself in a former number of the REVIEW, and her interest was aflame. In due course history again provided her with personal material for reflection. Though neither acetone nor diuretic acid were found, I had already systematically carried out the *natrum-bicarbonate* treatment—repertorizing proving of none effect—but with no tangible results. Now her courage rose with her distresses; she boldly experimented on herself with the *bicarbonate* in massive doses, inspired by a belief in its efficacy for her; and now I will quote Dr. Hoyle's personal account.

"She took as much as 640 gr. of bicarbonate of soda *per diem* for several consecutive days, after trials of 10 gr., 20 gr., and up to 100 gr. at a dose, with absolutely no effect.

[1] Dr. Hoyle was formerly Assistant Professor of Materia Medica in the Homœopathic College of San Francisco.

"The dosage which gave immediate and steady relief was a coffee-spoonful of *sodæ bicarb.*, which dose, carefully weighed, subsequently was found to average 160 gr. The method ultimately found of most value was this amount taken in half a tumbler of soda-water just before meals. This gave an immediate sensation of relief, at once allaying the heartburn, nausea, with disgusting taste as of rancid tallow, and allowing the patient to take a comfortable meal. This rancid tallow (oxybutyric acid) taste was, next to the incessant nausea, the most distressing feature of the case, and a few such doses of *bicarbonate* banished this odious symptom.

"After about one week the dose of bicarbonate was reduced in frequency to once or twice daily, as a preventive measure, and the pregnancy thus proceeded from about the fourth month to the eighth, with no further gastric distress. In previous pregnancies this had persisted almost without break. At the end of the eighth month the oxybutyric eructations and the sense of nausea returned; a few doses of bicarbonate given to the same extent as at first banished these recurrences entirely in two or three days.

"The subsequent history of the case you personally are acquainted with."

My contribution to the subsequent history is that the lady came to town for her accouchement, having had the misfortune to lose her last baby during childbirth. On this occasion she was more fortunate; the child was born at term almost without a pang, and weighed 9½ lb. The infant gained 8 oz. in weight during the first week on breast milk only, and has continued to thrive. The puerperium was practically normal, the most noticeable feature being a passing lactosuria, discovered on the sixth day, and for which *chelidonium* in low dilution was prescribed with excellent results.

Dr. Hoyle thus anticipates criticism as to the massive dose employed—

"The dosage adopted in this pregnancy was so considerable that we have set it down at your request; but this amount was only arrived at after two or three weeks 'fooling around' with smaller though increasing doses given and taken without relief. We were driven to the course adopted because of the complete prostration of the patient at that time.

The lady is now enjoying her usual health, not having the purgatory of an unbearable pregnancy as an abiding memory.

I have given this case as it actually occurred in practice. I make no comments on the detail other than to note that the armoury of Nature is more copious and more various than our philosophy sometimes wots of; and to praise the courage and the inspiration of the patient who thus experimented her way to her effective remedy.

HIGH *VERSUS* LOW POTENCIES.

By Dr. T. D. NICHOLSON.

I HAVE read Dr. T. Miller Neatby's cases illustrating the effects of the 200th potency in the February Review with interest and profit. It raises the old old question of high *v.* low dilutions of drugs, and I for one think that until it is satisfactorily settled, the more it is discussed the better.

The practice of a lifetime does not suffice for any one man to "prove all things" in the way of potencies and "hold fast that which is good."

The late Dr. Drury once told me he had varied his dilutions every ten years from high to low during a long practice with out-patients at the London Homœopathic Hospital. He was without prejudice, and he thought on the whole the low were the more successful. Such a statement, however, would influence but few without knowing the character of the man as well as the character of his practice.

Of recent years I think the great majority of homœopaths have depended on the lower dilution in acute cases, and only indulged in high or very infinitesimal ones in more chronic cases which had resisted treatment whether allopathic or homœopathic.

This has been, in my opinion, a good practice to follow, though I am willing to learn a more excellent way if there is one. It may be said that—firstly, it saves trouble; secondly, it has a consensus of opinion in its favour; thirdly, it has had a wonderful amount of success.

The saving of trouble may be objected to by the purist

who may describe it as laziness, but in a busy general practice, like most of our members have, it is a real thing.

Again, the stamp of authority becomes a strong motive for the iconoclast to protest against any rule or formula to keep even a novice within bounds, and induces him to go to extremes.

Thirdly, does the success of the axiom of low dilutions for acute cases justify us in resting content with it? Must we consider it a *chose jugée*, or rather must we not continually try and re-try it? We sadly want a good scientific reason for our faith, but in default of such at present we can only appeal to experience. I do not wish to criticize Dr. Neatby's cases. He has not over-praised his results, which he admits are not of a very convincing nature. But they may compare favourably with ordinary dispensary work and seem to be not less successful than low dilutions.

As a small contribution to the discussion which will, I presume, arise from the paper, or at any rate is being already carried on in the London Homœpathic Hospital, I will very shortly relate a few cases—mostly from memory.

(1) Veratrum in Diarrhœa.

This case occurred in my own person and I recollect the details well. I was in the country on a holiday—cycling, climbing, boating, &c.—and without any known cause had an attack of diarrhœa. There was some pain in abdomen before stool which was watery and occurred two or three times a day, but no other discomfort. I dieted myself, gave up fruit, and drank weak brandy and water, but without change. I did not take any medicine until about the tenth day when I found myself in a railway carriage with a sudden recurrence of the symptoms and with more violence. I then procured my medicine case and took one drop *verat. alb.* ϕ, the symptoms suggesting that drug.

In the evening, after six hours' travelling, followed by a good dinner, I felt perfectly well, and never had another symptom.

(2) Iris Vers. in Bilious Diarrhœa.

My next case is that of a young lady, a school teacher, pale and delicate-looking, but usually enjoying good health. She

had eaten some meat pie at a restaurant the previous day, and this, she thought, might have been the cause of a sudden attack of illness. When I saw her she had been ill all night vomiting bile, and had frequent bilious diarrhœa, and she was doubled up with pain. She was deadly pale, had a very quick pulse, and was evidently suffering. It looked like a case of ptomaine poisoning. I at once mixed two drops *iris* ϕ in half a tumbler-ful of water, and ordered a teaspoonful to be taken every few minutes. After the third dose all the symptoms ceased, and the following day she was convalescent.

(3) Bryonia in Lumbago.

Miss H., aged 80, was attacked three days previously by acute pain in loins radiating round to abdomen. She was very rheumatic, and never quite free of pain when in health. She was unable to get into bed without the help of two servants, but once quiet on a feather-bed was quite comfortable. The pains returned on movement the next morning, and lasted all day with the slightest movement.

I ordered *bryon.* ϕ, half a drop every four hours. She quickly improved, and on the third day after was moving about with comfort.

(4) Cuprum Met. in Muscular Cramp.

Lady, aged 70, rheumatic, general health fair. Complained of being suddenly wakened every night by severe cramp in the calf. She had to get out of bed and stamp the room for several minutes before getting relief. This had occurred nearly every night for two weeks. *Cupr. met.* 3x, 2 gr. doses at bedtime, repeated for several nights, entirely removed it, and there was no recurrence after the first dose. This, of course, is a common experience.

(5) Ipecac. in Sickness.

Woman, aged 70. Abdominal cancer. Vomiting with constant nausea, white furred tongue. The symptoms had persisted for two weeks or more. *Ipecac.* 1x, two drops every hour, controlled the vomiting at once, and the nausea gradually subsided also, although, of course, the cause could not be remedied.

(6) Hyoscyamus in Mania.

Woman, aged 80. Had several attacks of subacute mania —has illusions. Thinks she sees strangers in the room, is excited, loquacious, picks imaginary things on the bed. Pulse rapid and excited. Talks quickly and quite different from her usual quiet manner. I gave *hyoscyamine*, $\frac{1}{60}$ gr., every four hours, and the symptoms calmed down, and the patient was herself again in two or three days. These attacks recur at long intervals, but are readily controlled by what they call the "magic" medicine.

The above cases are not cited as in any way remarkable, but merely instances in every-day practice of homœopathic action of drugs in appreciable doses where the three desiderata, *tuto, cito et jucunde*, are all found, and which leave no room for a high dilution to improve upon.

URINARY DISTURBANCES ASSOCIATED WITH UTERINE FIBROIDS.

By EDWIN A. NEATBY.

Physician for Diseases of Women, London Homœopathic Hospital.

When a short time ago I was asked by my friend the Editor to give him a paper for the closing number of the Review, my thoughts reverted to one or two cases lately under observation. Searching for a title under which they might be grouped, the first to suggest itself was "Bladder symptoms associated with Uterine Fibroids." The word "symptoms," however, hardly met the case, for it conveys too much a subjective meaning, and I did not wish to limit myself to subjective conditions. The word disturbances, as covering a wider area, appeared more suitable, and was accordingly adopted, with what justification the readers will judge. In other words, the outline of the sermon was first sketched and then a text to fit it was sought for.

Before entering into the subject-matter of this article, I may explain the word pyknuria used herein from time to time. In rapid note-taking in the out-patient department any

abbreviation is welcome, and I sought for a single word which would express "frequency of micturition" and thus save writing. Not finding one ready to hand I proceeded to coin one on the lines of dysuria, replacing the prefix "dys" by that of "pykn," from πυκνός, frequent. I am told that this is a permissible invention, and from many years' experience I know it to be a convenient one.

It is, perhaps, because of their very commonness that bladder symptoms have occupied but a small place in the records of myoma cases in gynæcological literature. Yet they constitute, after menorrhagia, one of the most frequent troubles, rising from the level of mere inconvenience to the height of jeopardizing health or even existence. With a little discrimination, too, the bladder disturbance may occasionally give a clue to the diagnosis even before an examination is made. Of the mere inconvenience alluded to, the following will suffice as examples :—

W., aged 50, had a stationary tumour extending from the pelvis to well above the umbilicus. Besides pain, weakness, and loss of flesh, this patient has "very constant urging to pass water." In many cases this frequency causes soreness round the urethral and vaginal orifices, in most cases some hypertrophy of the muscular elements of the wall of the bladder. After removal of the tumour the urinary difficulty disappeared. In this case the mechanical effect of a tumour of considerable size pressing on the bladder accounted for the frequency.

In another case, Mrs. C., on whom I operated some years ago, the same symptom was induced by a very different condition. An interstitial fibroid, about the size of a walnut in its outer shell, growing in the anterior wall of the cervix just below the level of the internal os, projected into the cervical canal on the one hand and the upper part of the posterior wall of the bladder on the other. It had apparently the double effect of inducing sterility and pyknuria—the latter being more annoying to the patient than the former. Immediately after the removal by myomectomy, the vesical irritation disappeared, and within a year, if my memory serves me, the patient became pregnant.

In connection with fibroids, another very interesting con-

dition is familiar to gynæcologists and to all medical men who happen to come across many uterine tumours. It is the opposite condition to that already alluded to, viz., retention. In the class of cases I am referring to, the peculiar feature is that the retention of urine is intermittent, or perhaps, more strictly speaking, occasional. It occurs in semi-impacted uterine tumours lodged in the pelvis, and arises at or near the menstrual period. It is, in fact, due to the swelling up of the tumour on account of the hyperæmia preceding menstruation. Before the flow sets in the arterial tension is exalted, the quantity of blood contained in the tumour is excessive, and the size of the growth becomes perceptibly increased. Under ordinary circumstances the tumour fits the pelvis fairly closely, but when enlarged as described, it is so tightly packed that the soft parts, including the urethra, are actually compressed. As the hyperæmia passes off with the progress of menstruation, the tumour again lessens in size until the approach of the next period.

In some instances retention is only partial, and with much straining, or during or after stool, the bladder can be relieved, if not emptied. The weight of the tumour may sometimes be removed and the urine voided by the patient's adopting some peculiar posture, such as lying down or kneeling. In other cases the retention is complete and requires the catheter at every monthly period. It need hardly be remarked that when such a symptom is present, it constitutes a strong indication for operation. The back pressure, especially when of frequent occurrence, causes dilatation of the pelvis of the kidney, and may set up pyelitis and pyonephrosis—a well-known though happily not frequent occurrence. I have seen two cases of this extreme trouble. In one it necessitated nephrectomy, and in the other the patient died, being too ill for operation.

When this occasional retention occurs at regular intervals, *i.e.*, at the epoch of the period, it may be described as almost pathognomonic of uterine myoma. I do not know any other growth or condition which would produce this, and in well-marked cases I have often (mentally) diagnosed the case by the history.

The case of A. K., a single lady, aged 39, on whom I

operated in 1903, showed the combination, or rather alternation, of frequent micturition with monthly attacks of partial retention. The tumour was not a large one—about the size of a man's fist—but it caused retroflexion of the uterus, and the cervix pressed against the pubic arch. Here, again, the symptoms were removed by the hysterectomy.

A few months ago I was asked by Dr. Epps to see a case in one of his beds at the London Homœopathic Hospital, where retention of urine could not be explained by spinal or other medical lesion. A fibroid was found displacing the uterus and inducing retention which, if I remember rightly, had necessitated catheterization.

In another case under my own care in 1902—that of a sterile married woman, aged 35—similar bladder troubles were present. She had pyknuria "if she took a cold," also whenever she walked or stood about, and she used to have to get up three or four times every night. She also had occasional retention, but the notes do not state whether or not this was periodical. For some reason, which I do not remember, double oöphorectomy was performed—as lately as January, 1903. I thought I had given up this faulty procedure before that date. Fifteen months after the operation she was "much better in every way, but still was disturbed two or three times at night to pass water." The tumour was still present.

In another case which came under my notice last year, occasional attacks of retention were brought about by a somewhat curious mechanism. They were not in this case periodical, and did not point to impaction. The patient could ordinarily micturate with ease, but on two or three occasions, after she had gone without passing water for an unusually long time, she found herself unable to do so when the effort was made, and the catheter had to be passed. She came to my out-patient department one day suffering in this way. The bladder was a good deal distended, and the patient had tried unsuccessfully while in the hospital to relieve herself. A vaginal examination was made and a biggish mass was found. bulging the posterior fornix. The size of the tumour could not easily be estimated, on account of the full bladder in front of it. After the passing of the catheter, the tumour rose out of Douglas' pouch and the uterus returned to the forward

position. In this case the growth occupied the fundus and caused the uterus to be top heavy. When the bladder became distended beyond a certain point the heavy organ fell over into a position of retroversion. The uterine supports being healthy, and not over-stretched, sufficed to draw the uterus forwards again into the normal position, when the backward pressure of the full bladder was removed. The urethra was thus set at liberty and micturition remained easy until the uterus became once more retroverted. I do not remember to have met just this condition before.

Traumatism similarly may cause retroversion or flexion of a myomatous uterus, as in one case I operated on at the Leaf Hospital, Eastbourne, with Dr. Croucher. Three years after hysteropexy and myomectomy, the uterus became displaced by a fall, and the patient had pain and inability to pass water without a catheter. Replacement and the use of a pessary relieved the urinary difficulty. This same patient had, before operation, suffered from frequency of micturition.

These different events of pyknuria, retention, and dysuria are all paralleled by what may happen with a retroverted gravid uterus. If it fails to right itself and becomes impacted, urination becomes frequent, the pressure of the enlarged and displaced uterus acting at first as an irritant. As the size of the womb increases the irritation gives place to pressure, and retention ensues.

Sometimes a fibroid will act like an enlarged prostate does in a man, by preventing the complete emptying of the bladder, so that some urine always remains in the bladder and cannot be voided. This residual urine gradually increases in quantity, until the distended bladder may reach the umbilicus. The fact that the patient passes *some* urine may throw one off the scent, and the "cystic tumour" in the hypogastrium with solid parts felt *per vaginam*, may obscure the diagnosis.

A sterile married lady, aged 48, was brought to me by a colleague for this condition. An abdominal tumour, partly solid and partly fluid, persisting after the patient had passed water, required explanation. A catheter which drew off 57 oz. of urine explained the "cystic" part of it, and a bimanual examination revealed a solid uterine tumour. A definite amount of albumin was present in the urine, but it was not measured.

It lessened before operation, and finally cleared up altogether; there was also bacteriuria, but the micro-organism was not isolated. A course of catheterism was resorted to, to restore the muscular tone of the bladder, and a little later the tumour was removed. The cœliotomy revealed many pelvic and intestinal adhesions, and the bladder was drawn up and adherent to the front of the tumour, from which it was peeled with some difficulty. For two or three days after the operation blood was present in the urine; this and the bacteriuria disappeared. Either the bladder was injured by the manipulations, or the hæmorrhage was due to loss of support of the vessels, from the bladder now being fully emptied, which was seldom the case before operation. Three months after the removal of the tumour there was no bladder difficulty left.

Pain during micturition or while wanting to urinate is not a frequent symptom of fibroids. In the case of slow-growing tumours like fibroids, the bladder manages to accommodate itself in a wonderful way in most instances.

Two conditions worthy of mention are frequently associated with urinary disturbances, viz., necrobiosis ("red degeneration") of a myoma, and pregnancy in a myomatous uterus. In 1906, Dr. Lewers related a case of the former before the Obstetrical Society, in which there were abdominal and pelvic pain, and retention of urine requiring the catheter. In the urine — coming from each kidney (tested by the segregator)—were pus, blood and granular casts. The albumin disappeared after the operation. The tumour was the size of a six months' pregnancy and had throughout undergone necrobiotic changes.

The latter condition was illustrated by a case sent to me some years ago by Dr. Epps, that of a lady known to have a uterine fibroid. Quite unaccountably the tumour began to increase in size somewhat rapidly. Micturition in the daytime was as frequent as every hour, but pain was not present. The sudden growth decided us to advise operation; as the patient was single the possibility of pregnancy did not occur to me, and I was surprised after removal of the tumour to find that the uterine cavity contained an embryo. The uterus had not been able to rise out of the pelvis on account of the fibroid, and it was beginning to press upon the neck of the bladder. The facility

with which the bladder rises out of the pelvis in pregnancy, and in the cases of many tumours, saves it from damage. Routh reported a case before the Obstetrical Society (*Journ. Obstet. Soc.*, vol. 42) where dysuria was a prominent feature in a case of myoma, with eleven weeks' pregnancy. The uterus was drawn up into the abdomen, the cervix being out of reach behind the symphysis. The case, nevertheless, went on to term before interference was necessary.

Cervical fibroids filling the pelvis and pushing up the uterus may carry the bladder up nearly as high as the umbilicus; interstitial or subperitoneal fibroids pulling the uterus upwards carry the bladder with them. Cystic and solid tumours of the broad ligament have the same effect. A case of intra-ligamentary hæmatoma, due to extra-uterine pregnancy, which was sent to me by Dr. Tindall, had this condition and was associated with some frequency, but no dysuria or retention. Where the cervix is found on vaginal examination to be behind or above the symphysis great care must be used in opening the abdomen lest the bladder be wounded.

In a certain number of cases there is loss of control, but I cannot personally recall such a case. Howard Kelly refers to seven cases in which this was present ("Myomata of Uterus," p. 376) and attributes it to the pressure of the tumour on the bladder. He also points out that the pyknuria in fibroid cases is quite different from the urging and tenesmus of cystitis. In the case of necrobiotic tumours and also in some cases of acute perimetritis with fibroids (due to infection from a pyosalpinx) cystitis may be a complication.

The most insidious danger of pelvic pressure due to fibroids, whether the ordinary uterine ones, or those growing from the fibro-muscular tissue of the broad ligament, is that of obstruction to the free flow of urine through the intra-pelvic portion of the ureters. A very striking example of the latter was published by Mr. Doran, where an enormous tumour of the broad ligament, weighing 44 lb., had caused great dilatation of the ureter and associated albuminuria. He also refers to a published case of a woman, aged 66, who died of uræmia, in whom the condition was induced by pressure on the ureters.

In a case of my own recorded elsewhere, a still larger uterine fibromyoma in a comparatively young woman, the

patient died of uræmia from pressure. She was admitted into hospital, but died before operative treatment could be instituted.

In this short paper it is impossible to enter in detail into the renal complications of myomata. Suffice it to say that it is their insidiousness which constitutes their danger. Far-advanced organic disease may result without any definite symptoms attracting the patient's attention.

No definite moral is intended to be drawn from the recitation of these cases. They are simply an account of conditions constantly met with in every-day practice, together with an attempt in some instances to explain their mechanism, and in others to indicate their importance and prognosis.

Correspondence.

To the Editor of the BRITISH HOMŒOPATHIC REVIEW.

DEAR SIR,—About a week ago I sent you a cutting from *The Hospital*, in which a writer, probably the Editor, justly waxes indignant over the treatment meted out to a homœopath by an allopath who certainly was no gentleman, whatever else he was. The writer also refers to an episode nearly fifty years old, and expresses his belief that in this respect, at least, the times are changed. It may interest your readers if I give my experience, though it may be that Oxford is fifty years behind the times in this matter, as she certainly is in so many other matters both inside and outside the University. Many of our men, I know, believe that the Ethiopian *has* changed his skin and the leopard his spots; but "I hae ma doots." I cannot blame myself for the state of affairs I am about to describe. I have been most careful to keep myself void of offence towards my professional brethren, and have always rigidly carried out the "golden rule" in all my dealings with them, direct and indirect, no matter what treatment was meted out to myself. Now for the facts :—

(1) The Professor of Medicine (Professor Osler) who, I believe, limits himself to consultation work, will on no account go to see a patient of mine either with or without me. To

have the advantage of his opinion I must give up the case to an allopath.

(2) None of the surgeons will help me, even in matters purely surgical, *e.g.*, a broken thigh. I have to make the case over to them before they will have anything to do with it. They are always quite ready to "annex" my cases, and, at least, on two occasions have bungled them rather badly, which would not have happened had I also been in attendance on the patients.

(3) It is understood that the two chief "Nursing Homes" (indeed the only two of any consequence) will not allow any patient within their walls to be attended by a homœopathic physician. These "homes" are open to all other physicians and surgeons in Oxford.

Such facts as these make one feel very thankful that a British Homœopathic Association exists.

Oxford, Yours very truly,
February 14, 1910. JOHN MCLACHLAN.

Obituary.

GEORGE WILLIAM CHAPMAN, M.R.C.S.ENG., L.R.C.P.LOND.

WE much regret to have to record the death of Dr. Chapman, of Margate, who died on January 13 from septic thrombosis after operation for appendicular abscess.

Dr. Chapman received his medical education at St. Thomas's Hospital, whence he took the M.R.C.S.Eng. and L.R.C.P.Lond. His first homœopathic experience was with the late Dr. Harris, of Camberwell, whom he joined as an assistant a few months before Dr. Harris died. Subsequently he worked with Dr. Pullar for a short time. He held in succession both the resident appointments at the London Homœopathic Hospital, and afterwards settled at Margate, where he has been in practice for the last twelve years. He was a good surgeon, a conscientious worker, and will be much missed by his friends, who valued his generous nature and kind heart. He had latterly been doing good work with ionization, and his death leaves a gap in our ranks which will not easily be filled.

Reviews of Books.

Pocket-book of Veterinary Practice. By A. von Rosenberg, D.V.S. 126 pages. Cloth, 75 cents. Postage, 4 cents. Philadelphia: Bœricke and Tafel, 1909.

This book does not belie its name; it is truly a pocket-book, being 6½ in. by 4½ in., and ⅝ in. thick. Its subject is Veterinary Therapeutics according to the law of similars. As the author remarks in his preface, great changes have taken place of late years in veterinary practice. "The old-fashioned idea that few diseases in the lower animals were curable, if at all recognizable, and that quart-bottle doses of some mixture or other were necessary to combat the same, is fast becoming obsolete. Scientific research has shown us that the lower animals are not only subject to the same diseases, but can be cured by the same methods, and with the same remedies, and with no larger doses than the human subject needs." It is advised that nearly all the remedies be given in the 1x or 3x potency; a few recommendations are given for the 6x and 12x. The liquid preparations are administered diluted with water with a half-ounce hard-rubber syringe, the triturates dry on the tongue with a spoon.

A code of common suggestive diagnostic symptoms is first given, and then comes the section of therapeutics of the various diseases to which animals are liable, arranged dictionary-like in alphabetical order. A few pages on surgical hints conclude the book. A glance through the therapeutic section shows the similarity between human beings and the lower animals, both in the diseases to which they are subject and in the homœopathic treatment for them.

We can cordially recommend this little book to anyone wanting to gain some idea of how to treat animal diseases and who has not leisure to study larger works. The book is well arranged, clearly printed, and free from errata—qualities which we are accustomed to meet with in the publications of the well-known firm, Bœricke and Tafel.

Notices, Reports, &c.

BRITISH HOMŒOPATHIC SOCIETY.

THE fifth meeting of the Session was held at the London Homœopathic Hospital on Thursday, February 3. Dr. Stonham, Vice-President, was in the chair.

William Robertson, L.R.C.P.S.Ed., L.F.P. & S.Glas., of Streatham Common, was proposed for membership by Dr. Sandberg, and seconded by Dr. Greig.

Henry Robert Ramsbotham, M.A., M.B., B.Ch.Oxon., of Harrogate, was unanimously elected a member of the Society, and formally introduced by the President.

David Ridpath, M.C., M.D.Edin., of Sunderland, was unanimously elected a member of the Society.

At the request of the Society, the Secretary undertook to convey the condolences of the meeting to Dr. Dyce-Brown who has for some time been unable to attend the Society's meetings in consequence of illness.

In reply to a question by Dr. Murray Moore with regard to the proposed new journal, the CHAIRMAN stated that the plans with regard to it were not yet matured, but that members would be informed in due course what is decided upon.

Dr. SPEIRS ALEXANDER showed a portion of quadrilateral cartilage and bone from the descending plate of the ethmoid, which he had removed by submucous resection. He remarked on the value of local anæsthesia in these operations, illustrated by the absence of pain in this case, though the operation lasted as long as three-quarters of an hour.

Dr. HARE gave notes of a case of empyema of two years' duration, which was successfully treated by injections made from the pus of the empyema.

Dr. J. MURRAY MOORE then read his paper entitled "Alternation of Remedies in the Practice of Homœopathy."

He considered a discussion on alternation would very suitably follow Dr. Ridpath's paper on the similimum read a few meetings ago. He had found the strict method advocated by Dr. Ridpath not always practicable, nor was it good policy to consult a repertory before the patient. He began to alternate when prescribing for out-patients in an extensive

dispensary practice, which gave no time for minute symptomatology, and where he had found prescribing on a pathological basis and alternating medicines had been very successful. On looking through his note-books he found on taking at random 140 cured cases, that in twenty-eight of them alternation was practised. Sometimes he alternated, not the medicine, but the dilution used. He had cured a crop of sycotic warts in an old man by alternating *thuja* 6 and 12, and a case of carious abdominal glands by alternating *calcarea* 6 and 12. He gave a list of alternations which he had found successful, viz.: bell. and merc.-sol. in ordinary sore throat; bell. and bary.-carb. in tonsillitis; bell. and merc.-bin. in diphtheria; apis and merc.-bin. in diphtheria; cantharis 3 and mer.-cor. 3x in albuminuria; bell. and kali bichrom. in diphtheria; aconite and phos. in acute pneumonia; acon. and bry. in pleurisy and rheumatism; acon. and puls. in measles; cannab. sat. and merc.-cor. in gonorrhœa; nux v. and carbo veg. in chronic dyspepsia; nux vom. and sulph. in chronic constipation and piles; ars. and verat. alb. in diarrhœa with copious watery stools; iod. and verat. virid. in meningitis; ferrum met. and puls. in anæmic girls. He mentioned that Dr. S. P. Alexander had found certain alternations very effective, for instance, bry. and rhus tox. in acute rheumatism; ars. and colocyn. or merc.-sol. and verat. alb. in chronic gastro-enteritis. Dr. Moore admitted that alternation of medicines was not in accordance with the teaching of Hahnemann, and quoted Section 169 of the *Organon*, which reads: "If, on the first examination of a disease and the first selection of a medicine, we should find that the totality of the symptoms of the disease would not be effectually covered by the disease elements of a single medicine—owing to the insufficient number of known medicines—but that two medicines contend for the preference in point of appropriateness, one of which is more homœopathically suitable for one part, the other for another part of the symptoms of the disease, it is not advisable, after the employment of the more suitable of the two medicines, to administer the other without fresh examination, for the medicine that seemed to be the next best would not, under the change of circumstances that has in the meantime taken place, be suitable for the rest of the symptoms

that then remain; in which case, consequently, a more appropriate homœopathic remedy must be selected in place of the second medicine for the set of symptoms as they appear on a new inspection." Hahnemann's practice, however, was not always in agreement with this dictum, and he recommended that aconite and coffea should be given in purpura miliaris; cuprum and veratrum alb. in cholera; and bry. and rhus tox. in choleraic fever. As an instance of alternation advised by some of the first homœopaths, he mentioned Bœninghausen's celebrated croup powders which were given in the following succession: acon., spong., hepar, spong., hepar.

Dr. Murray Moore's final conclusions on the subject were: that (1) alternation is not scientific; (2) it is often effective; (3) it is to be avoided on account of the impossibility of gaining knowledge of the action of remedies unless they are used singly.

A discussion then followed, in which, as might be expected, considerable difference of opinion was shown to exist as to the value and admissibility of alternating remedies. Drs. Wheeler, Eadie, Miller Neatby, Pullar, Knox Shaw, Day, Le H. Cooper, E. H. Neatby, Burford, and Weir took part in it. Dr. Murray Moore replied.

A paper was then read by Dr. WEIR entitled, "A Few Cases Illustrating the Homœopathic Philosophy."

The first case was that of a man, aged 67, a painter; had had scarlet fever when 18, syphilis when 20, for which he was treated allopathically, and no secondaries occurred. Lead colic at 40. Latterly he attended the National Hospital for tabes, but without improvement. The patient was thin and pale, had an anxious look, worried, dull aching pain in the left side, also a shooting pain in the left side, coming on suddenly and diminishing gradually; < cold, > hot applications. General tenderness down left side, touch <, hard pressure >. Patient was irritable, obstinate, and restless. Acute occipital pain. Hyperæsthesia in chest and downwards, < left side. Sensation of heat delayed; want of sensation in part; Rhomberg's sign present; ataxic gait; flatulence; constipation; stools in small hard balls with mucus.

General characteristics were: < change of weather, in winter, from cold, from exertion; > in open air, from gentle motion, from warmth, and in a warm room.

Taking the generals first, all were found under the four medicines: *ars.*, *carb.*, *sulph.*, *graph.* Of these the particulars indicated *arsenic.*

On April 28, *ars. m.* one dose was given.

May 1.—Aggravation of the pain, but the bowels were opened.

May 2.—The burning pain was gone, and the hyperæsthesia had gone except in the left wrist.

May 5.—No burning or shooting pains left.

May 22.—*Ars. m.* one dose.

May 25.—Return of the burning pains, which afterwards disappeared entirely.

The case was mentioned in order to illustrate the value of general symptoms. No "particulars" can throw out a well-marked "general."

Case of a blind man, aged 39, who became blind after meningitis. From 1897 he had been quite blind. Repertorial work on his case indicated *pulsatilla.*

On September 20, *pulsatilla* 10,000 was given in unit dose. There was soon slight return of sight.

On October 29 another dose was given. Colour sense came back. He can now see well enough to play cards, and is still improving. He will get no more medicine till improvement ceases.

A good sign of cure is for symptoms to disappear from above downwards and from within outwards. A highly potentized drug often succeeds where a lower dilution has failed. More cases are spoilt by too early repetition of the dose than by anything else.

Case of an engineer, aged 47, suffering from flatulence and distended abdomen, rumbling; < 4 to 7 p.m. Wakes from sleep 4 a.m.; > passing flatus; heaviness a few hours after food; likes salt; bowels fairly regular, sometimes stools of small, hard balls; itching of anus, < heat of bed and when constipated; throbbing headache from occiput to left eye, < lying, > warmth, pressure, in the dark; brick-dust sediment in the urine; likes open air and exercise; sweats on the least exertion, especially in the head; < stimulants, which nevertheless he desires.

The symptoms indicated *lycopodium,* and although he had

for years taken *lycopodium* 3x occasionally, he was now given *lycopodium* 10 M unit dose on January 10.

January 13.—Recurrence of flatulence, which gave great pain.

January 23.—Rheumatic pain in left leg, severe the next day. This was a return of old rheumatic pains which he had not had for twelve years.

January 25.—Left wrist weak and sore. He had had a severe pain twenty years ago in the left wrist from a twist.

This case illustrates how the rightly selected medicine will stir up and renew old complaints, and does so in the reverse order of their occurrence. Where serious tissue changes are known to exist it is safer not to use very high dilutions, as they excite too great a reaction.

A discussion followed the reading of the paper, in which Drs. Jagielski, Miller Neatby, Purdom, Eadie, and Wood joined. Dr. Weir replied.

BRITISH HOMŒOPATHIC ASSOCIATION.

PUBLIC LECTURE AT CHALMERS HOUSE, BY HENRY FESTING JONES, ESQ.

ON the evening of February 9 the monthly public lecture, given this winter under the auspices of the British Homœopathic Association, was delivered at Chalmers House by Henry Festing Jones, Esq., on Samuel Butler (author of "Erewhon").

The Association's rooms at Chalmers House were packed by an enthusiastic audience, who had come to hear what Mr. Jones had to say concerning the friend whom he had known intimately for many years. The subject of the lecture was a remarkable personality, an eccentric genius, many of whose ideas find more acceptance now than when he first uttered them. Mr. Festing Jones introduced him to us in a manner full of humour and of sympathy.

Samuel Butler, who should be confounded neither with the author of "Hudibras," nor of the Analogy, nor with the Master of Trinity College, Cambridge, was born in his father's rectory, near Bingham in Nottinghamshire, on December 4, 1835. His grandfather was Dr. Butler, of Shrewsbury School.

The first event in his life that made any great impression on him was a journey to Italy in 1843. It was when railways were only just commencing, and the journey across France was made in a carriage. When at Rome he was taken to the top of St. Peter's, and saw the ceremony of kissing the Pope's toe. In 1846 he was sent to school in Paris, and in 1848 to Shrewsbury, his chief memory of which was hearing the music of Handel, for which he at once took a great liking and a preference above all other composers which remained with him through life. In 1854 he again went to Italy, and in October of the same year entered at St. John's College, Cambridge. Here he steered the "Lady Margaret" boat to the head of the river, and came out fourth in the Tripos in 1858. Acceding to the wishes of his friends, he began to prepare for ordination, but when the time came to be ordained he declined on account of his disbelief in the efficacy of infant baptism. Many careers were then proposed to him, including that of becoming a homœopathic doctor, but he rejected them all and started in 1859 for New Zealand, where he remained four and a half years, chiefly in the Province of Canterbury, engaged on a sheep ranch. While here, in 1861, he wrote "Darwin Among the Machines." In 1864 he sold out his interest in the ranch, left the money in investments in New Zealand which returned 10 per cent. interest, and, returning to England, lived upon the proceeds. He adopted the life of a recluse, taking rooms in Clifford's Inn, which he never changed for thirty-eight years. He studied at the Schools of Art and attained considerable proficiency in painting, sending about twelve pictures to the Royal Academy.

While in New Zealand he had written home able descriptive letters; these he rewrote and enlarged his letter to the press on "Darwin Among the Machines." In 1865 he published a critical examination of the Resurrection in which he came to the conclusion that Christ swooned on the cross and did not die. About this time he attended spiritualistic séances with Professor Wallace, but did not pursue the subject, as he found it distasteful. In 1866 he consulted Dr. Dudgeon for noises in the head. Dr. Dudgeon ordered a period of rest and change, and consequently he went abroad in November, 1869. On returning he rewrote his New Zealand

articles, and gradually they grew into the book which has given him his fame, "Erewhon." This work was translated into Dutch in 1873 and into German in 1875. He was now fairly launched on a literary career. Dr. Dudgeon soon after wrote his "Journey into an Adjacent Country," and Butler was thought to be the author of it. Except for the fact that reading "Erewohn" may have inspired Dr. Dudgeon to write it, Butler had nothing to do with it. In 1877 Butler published "Life and Habit," a scientific treatise in which he propounded the theory that life is continuous through the generations, each life holding the memory of all its ancestors, and adding its own experiences to hand down to its successors. In 1880 he published "Unconscious Memory," and in 1886, "Luck or Cunning as the Main Means of Organic Evolution."

He took yearly holidays in Italy, always approaching Rome by a different route, so that there was not a road or a bye-path that he was not acquainted with. Mr. Festing Jones used to meet him in Italy every year. They collaborated in writing music and produced two oratorios, "Narcissus" and "Ulysses."

In December, 1876, Butler's father died and left him with ample means, but he made no change in his mode of life. He became very interested in the "Odyssey," visited almost every spot mentioned in it, and formed his own theories as to the authorship of the poem, coming to the conclusion that it was written by a woman.

In 1902 his health began to fail, and he started for Sicily for what proved to be the last time. He fell ill at Palermo, and then at Naples. His friends managed to get him home and placed him in a nursing home at St. John's Wood, where Dr. Dudgeon attended him. For a time he seemed to rally, but finally sank.

During the course of the evening Mr. Fuller Maitland played, and Miss Grainger Kerr sang selections from Butler's oratorios. Miss Kerr also sang one of Mr. Festing Jones's songs.

Dr. PULLAR proposed a vote of thanks to Mr. Festing Jones for his very interesting lecture, and also to Mr. Fuller Maitland and Miss Grainger Kerr for their musical illustrations.

It may be mentioned that Messrs. Streatfield are Butler's literary executors and the publishers of his books.

NOTICE.

THE last public lecture of this series will be delivered at 8.30 p.m. at Chalmers House, 43, Russell Square, W.C., on Wednesday, March 9, by Dr. Murray Moore, M.D., M.R.C.S., F.R.G.S., on "Rhus Toxicodendron and Rhus Radicans."

KENLEY STREET DISPENSARY.

ANNUAL REPORT.

THE Kenley Street Dispensary has issued its first annual report—in this case really a ten months' report, as it is thought desirable that the accounts should be made up to December 31, and the dispensary opened on March 1, 1909. During the ten months 503 patients have been treated. The work, very small at first, has continuously increased, and is becoming more and more appreciated in the poor neighbourhood of St. Clement's where the dispensary is situated. The balance sheet, duly audited, shows that receipts and expenditure are nearly equal, there being a small amount to the good. It is proposed to hold a yearly sale in November to raise part of the necessary sum of £150, which is required in addition to the patients' pence.

THE BRITISH HOMŒOPATHIC ASSOCIATION (INCORPORATED),

SUBSCRIPTIONS and Donations received from January 15 to February 15, 1910:—

GENERAL FUND.

	Subscriptions. £ s. d.	Donations. £ s. d
Mrs. von Stralendorff	1 1 0	—
Dr. Murray Moore	1 1 0	—
Miss A. F. Laird	1 1 0	—
A. J. Latham, Esq.	0 10 6	—
E. W. Quarty Papafio	0 10 6	—
H. Ewbank Smith, Esq.	0 10 6	—

LADIES' BRANCH.

Mrs. Luard	1 1 0	—
Mrs. Cator	1 1 0	—

A meeting of the Council of the Association was held on Wednesday, January 19, and the usual meeting of the Executive Committee on Wednesday, February 9.

An interesting lecture was given at Chalmers House on Wednesday, January 19, by Dr. Alfred Pullar, M.D.Edin., on "Popular Conceptions of Medicine and the Aims of Hahnemann."

A public lecture will be delivered at Chalmers House on Wednesday, March 9, at 8.30 p.m. by Dr. Murray Moore, M.D., F.R.G.S., on "Rhus Toxicodendron and Rhus Radicans."

[LADIES' BRANCH.]
KENLEY STREET DISPENSARY.

THE Committee have to announce, with much regret, the resignation of Dr. McCandlish, who is taking up work in the provinces. They have, however, been so lucky as to secure the services of Dr. Stirling Saunder, under whose charge we hope the Dispensary will continue to progress.

The numbers for January are: Patients, 75; attendances, 209; making a total of 1,541 for the eleven months we have been open.

NATIONAL HOMŒOPATHIC FUND.

	Donations.
J. Everitt, Esq. (per Dr. Burwood)	£0 10 6
Mrs. Field (per Dr. Stonham)	2 2 0

A meeting of the Executive Committee was held at Chalmers House on Tuesday, February 15.

LEICESTER HOMŒOPATHIC DISPENSARY AND COTTAGE HOSPITAL.

THE annual meeting was held at the Town Hall, Leicester, on Tuesday, February 7.

The report which was presented gave an account of another year of good work. Fifty-five patients were treated in the hospital during the year, and in spite of the extreme gravity of many of the cases, there were no deaths. During the year seven radical cures of hernia were performed, giving the unusual percentage of 12·7 of the total cases.

The Hospital still finds itself in debt each year to the amount of about £50 or £60 over income. The Committee gratefully acknowledges its appreciation of the invaluable aid rendered by the British Homœopathic Association. The generous support thus given to such provincial institutions cannot fail to be productive of much good work, and as nothing can extend the knowledge of the advantages of homœopathic treatment more widely than a local hospital, it would be difficult to conceive a more practical and useful application of the funds.

In connection with the National Homœopathic Fund, inaugurated by Sir George Truscott, Dr. Clifton has succeeded in collecting £100, which sum will be ear-marked for the ultimate use of the Leicester Cottage Hospital.

HOMŒOPATHIC HOSPITAL FOR SOUTHPORT.

THIS week a new homœopathic hospital will be opened at premises in Fleetwood Road, Southport, adjoining the Hesketh Golf Links at the north end of the town. The cost will be about £6,000, of which £3,500 has been raised. Chief among the promotors is Dr. Simpson, J.P., of Birkdale, who practically started the scheme with a donation of £900. The institution will be mainly supported by voluntary subscriptions, and will be available for three classes of patients: (1) The sick poor, for whom free treatment is essential; (2) patients of the middle classes in reduced circumstances, or who are otherwise unable to defray the entire cost of their treatment; and (3) patients able to pay for private wards.

The Hospital was thrown open last week for public inspection, and it is satisfactory to report, that in spite of the strong gales, which made access to the Hospital somewhat unpleasant, there were 700 visitors shown over the place, who expressed their enthusiastic appreciation of the arrangements made for the welfare and comfort of the patients.

There are already two patients in the women's ward, and further applications are expected and will be gladly entertained whether from near or far.

The dispensary, which has worked so well for nearly five

years, will now become the Out-patient Department of the new Hospital. It will, however, be carried on as before at No. 10, Post Office Avenue, its central position making this essential.

Faithfully Yours,

JULIET K. VON STRALENDORFF,
Hon. Secretary.

33, Park Crescent,
Southport.

LIVERPOOL HAHNEMANN HOSPITAL.

THE annual meeting of this Hospital was held on February 16, at the Town Hall, Liverpool, under the presidency of the Lord Mayor (Alderman W. H. Williams). The annual report showed a considerable increase in the number of in-patients. The appeal for funds for remodelling the mortuary and *post-mortem* rooms had met with a generous response, Mr. T. Sutton Timms having given £100, and the Earl of Dysart £25.

The Treasurer (Mr. E. Shorrock Eccles) reported a balance of expenditure over income of £449, and regretted that the loss by death and other causes of old subscribers was not made good by new ones.

NOTICE.

WE are glad to observe that Dr. Burford has published his Inaugural Address to the Honyman-Gillespie Course, entitled "The Medicine of the Future," in book form. The address was delivered on an important occasion to a large audience, and ably sums up the present status of therapeutics and indicates the line of future advance to be in consonance with the homœopathic law. Its issue in a permanent form will be welcomed by all who heard it as well as by many who were unable to be present at its delivery.

NOTICE.

BRITISH HOMŒOPATHIC SOCIETY—GOLF.

ANY member wishing to enter for the golf tournament this year should send his name without delay to the Hon. Sec.,

H. WYNNE THOMAS,
Thornbury, High Street, Bromley, Kent.

Therapeutic Digest.

TWO EYE REMEDIES.—Dr. F. J. Newberry, of Los Angeles, California, calls attention to the eye symptomatology of *jaborandi*. There is contraction of the pupil, constantly changing state of the vision; everything at a distance appears hazy; vision becomes more or less indistinct every few moments. This is a set of symptoms very closely simulating spasm or irritability of the ciliary muscle, and may be caused by eyestrain of any character. In cases of myopia or other refractive error, this remedy has pronounced action on the eyes, causing spots in the visual field, especially on stooping. The eyes easily tire from the slightest use. Nausea is produced on looking at objects moving. Heat and burning in eyes on use. Headache and smarting and pain in the globe on use. Dim vision and twitching of lids. Retinal images retained long after using the eyes. In accordance with this train of symptoms Dr. Newberry has found *jaborandi* a most valuable remedy in eyestrain from whatever cause. It is of service also in cases of irritation from electric or other artificial light, and in patients with slight strabismus or a heterophoria, who complain of headache and nervous disturbance.

An analogous remedy to *jaborandi* is *ruta graveolens*. It has for eye symptoms: pressure deep in the orbits; pain, as from a bruise, in the tarsal cartilage; pressure over eyebrow; sensation of heat in the eyes, and aching while reading; eyes fatigued after reading long; vision weak; eye strained. This remedy is also very useful for strained eyes, especially from use in very fine work. The chief differentiation between the two remedies is that with *ruta* there is often a rheumatic tendency, while with *jaborandi* ciliary spasm is more pronounced.—*Pacific Coast Journal of Homœopathy*, November, 1909.

POISONING FROM A WASP-STING.—Dr. Miller, of Rayleigh, Essex, sends the following case to the *Lancet*: "On September 5 last, I was called to see a lady, aged 34, who had been taken suddenly ill. It appeared that she had been suffering from a slight cold for some weeks. About midday on September 5 she was stung by a wasp at the root of the second

finger of the left hand. She applied a "blue bag." About ten minutes later she had a paroxysm of sneezing, and as it passed off felt very ill and faint, and was, with some difficulty, got to bed. When I saw her, about three-quarters of an hour later, she was propped up in bed, somewhat cyanosed, the respirations were 30 per minute, and characteristically asthmatical, the pulse was 120 per minute, regular, but very soft and small, and the limbs and trunk were covered with large urticarial wheals. It was said that she was then better than she had been. Small quantities of brandy were given, and a spray, containing *atropine* and *cocaine* in a saturated solution of hyponitrous acid gas, was used frequently. Under this treatment the asthma subsided. The site of the wasp-sting was freely scarified, and a compress applied. An hour later I was hurriedly summoned, as "the uvula was displaced and choking her." The nettle-rash was now fading, the respirations were 20 per minute and slightly noisy, but not asthmatical, there was a constant dry cough, the pulse was 100 per minute, regular, but very weak, and there was considerable cyanosis. She had fainted once before my arrival. On examining the throat the uvula was seen to be very swollen, œdematous, and to a large extent blocking the isthmus faucium; the soft palate was also œdematous. I immediately swabbed the palate and uvula with a solution of *adrenalin chloride*, 1 in 1,000, and as the patient fainted, gave a hypodermic of *digitalin*. For an hour her condition remained most critical, she being almost pulseless. She gradually improved. During the next fortnight there were slight asthmatical attacks, which were controlled by the use of the spray. There was no history of any previous asthma. There had been several previous wasp-stings during the past summer, none of which had any constitutional sequelæ. On examining the site of the sting it was seen to be immediately over a small cutaneous vein, and it would seem possible that some poisonous matter may have been introduced directly into the circulaiion.—*Lancet*, November 27, 1909.

MYOCARDITIS AND ADRENALIN.—It has been shown that *adrenalin*, in homœopathic doses, is indicated in the treatment of arteriosclerosis, arterial hypertension, and acute congestion of the lungs. This medicine should also be tried in myocar-

ditis, for it produces in animals lesions of myocarditis more frequently than it does those of arterial atheroma.

MM. Fleischer and Loëb, having noticed that animals that had received an intravenous injection of *spartein* and *adrenalin* exhibited injury to the left ventricle, instituted a new series of experiments.

If one injects into the veins of a rabbit *sulphate of spartein*, of a dose 12 mg. per kilogramme of body-weight, and two or three minutes afterwards an intravenous injection of 0·2 c.c. of a 1 in 1,000 solution of *adrenalin*, one notices at the end of some days the lesion of the left ventricle mentioned below. One can also replace the *spartein* by a double dose of *caffein*. The interval between the two consecutive injections should not be too short, as thereby one would risk killing the animal.

Of eighty-two rabbits treated in this way, forty-nine, *i.e.*, nearly 60 per cent., presented to naked-eye examination a lesion of the left ventricle after a period varying between four days and six weeks. A certain number of hearts, which appear normal to the naked eye, show more or less extensive alterations on microscopical examination. It seems, therefore, that the truly typical lesion produced by injection of *adrenalin* is not aortitis but myocarditis. This latter is, indeed, more frequent, more constant in its characters, and sooner produced than the alteration in the aorta.

The lesions of the myocardium consist essentially in hypertrophy of the muscular fibres, with increase in the number of nuclei, and disappearance of striation. One notices also a very early proliferation of the connective tissue, and a process of degeneration of the muscular fibres, which becomes especially marked in the somewhat more advanced type.

To sum up, there is a remarkable analogy between these experimental results and the modifications found in hypertrophy of the heart, whether following valvular lesions the result of experiment, or those in man due to any pathological condition. In their initial phase, the alterations in question seem to resemble those caused in the peripheral muscles by fatigue. Their situation also in the left ventricle, in the neighbourhood of the auriculo-ventricular ring, is in favour of this view, and would lead us to suppose that overwork of

the cardiac muscle is an important factor in the anatomico-pathological process in question.

The above-mentioned lesions cannot be obtained by means of injections of *sulphate of spartein*, of *caffein*, or of *strophanthus* alone; the addition of a small quantity of *adrenalin* is absolutely necessary.

Clinical experience can alone decide whether this indication, provided by experiments on animals, brings us a useful medicine, and in what dose it should be employed.—Dr. Marc Jousset, *L'Art Médical*, January, 1910.

POISONING BY MERCURIUS CORROSIVUS: DRY PERICARDITIS.—Miss X. took six powders of corrosive sublimate each containing 0·25 gm., for the purpose of bringing on an abortion. The following symptoms were produced: great pain in the stomach, scanty vomitings, bloody dysenteric diarrhœa, intense stomatitis, oliguria, albuminuria, and complete apyrexia. On the fifth day after the poisoning, symptoms of abortion and hæmorrhage, which necessitated curetting of the uterus. The symptoms became more and more accentuated; there was considerable wasting, pallor of the face, stomatitis, oliguria, and profound anæmia. The cultures taken from the blood gave negative results. Precordial pain came on, with friction sounds, dyspnœa, and quick pulse. For fifteen days one could watch the evolution of a pericarditis, which commenced on the tenth day of the poisoning, and terminated in recovery at the end of three weeks. This pericarditis was of toxic and not of infectious origin, that is to say, there were no microbes concerned in it throughout.—*L'Art Médical*, October, 1909.

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