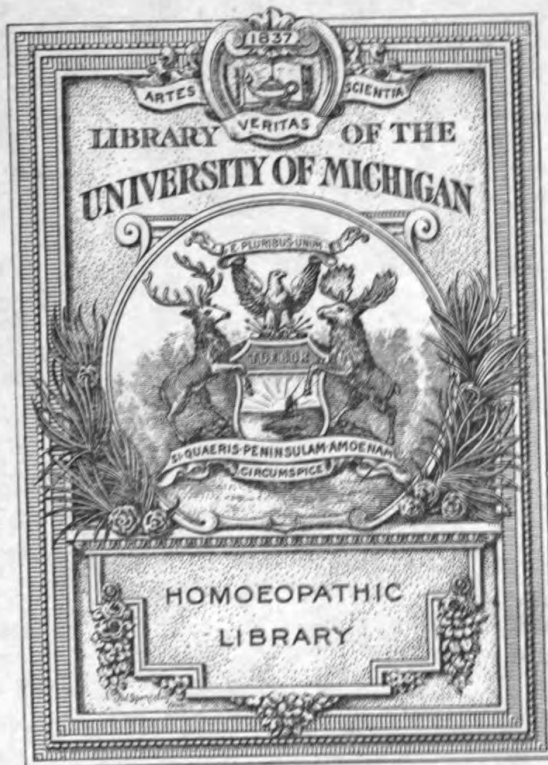




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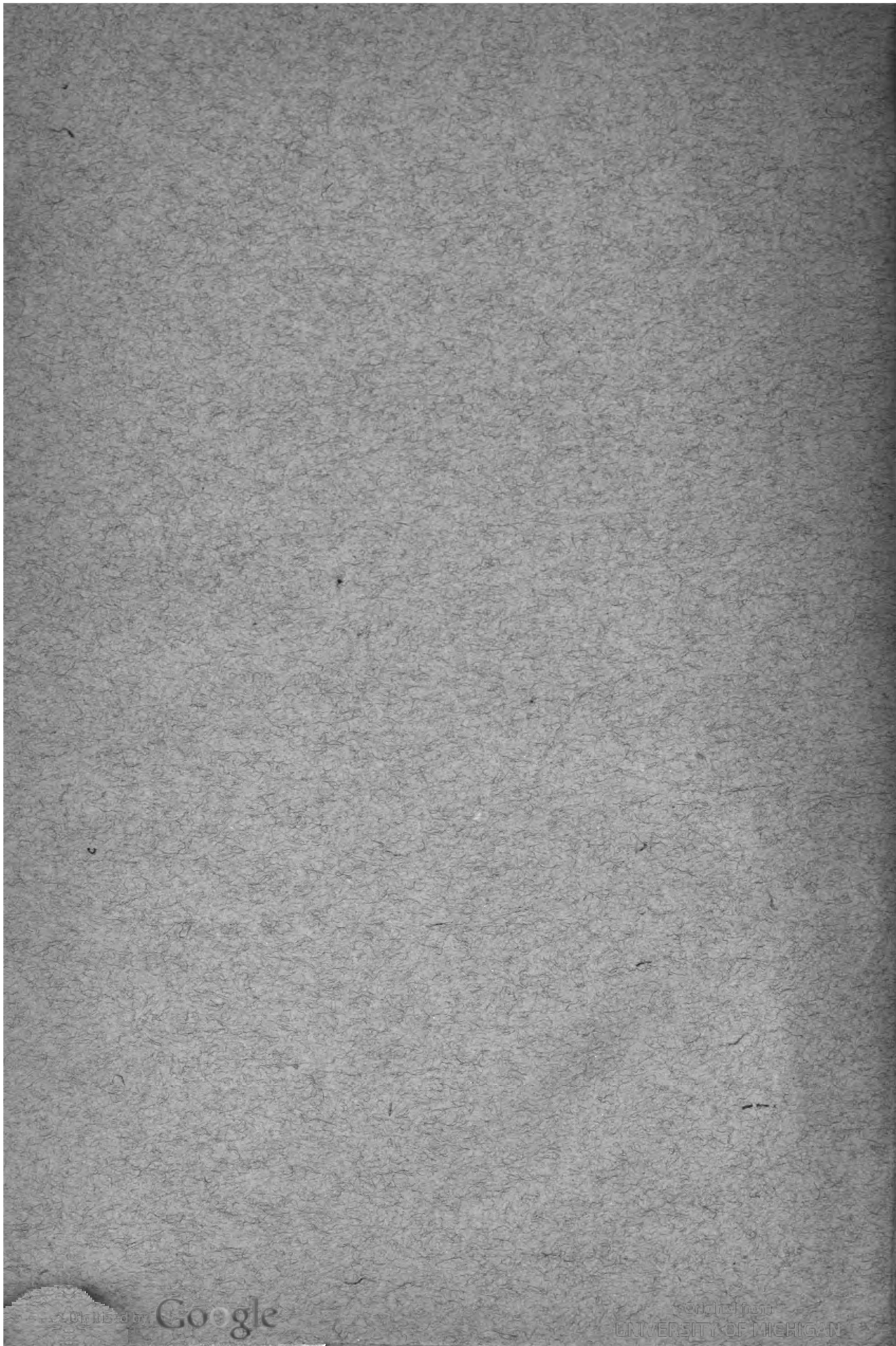


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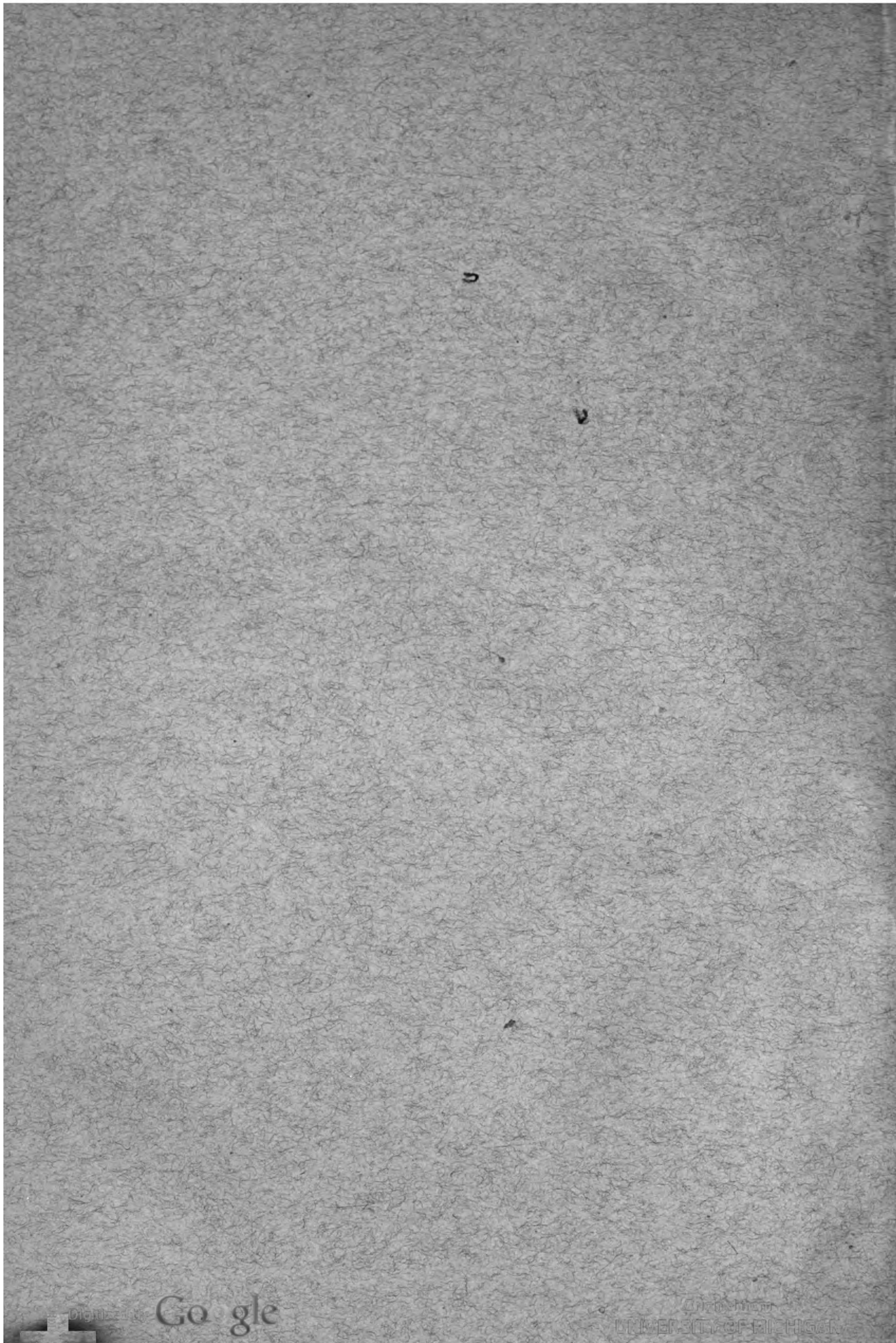
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OF THE

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EDITED BY

GILES F. GOLDSBROUGH, M.D.

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Homöopathische Monatsblätter.  
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Revue Homœopathique Française.  
University Homœopathic Observer.  
Zeitschrift des Berliner vereins Homöopathischer Aerzte.

## NOTICE.

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THIS volume comprises the Proceedings of the BRITISH HOMŒOPATHIC SOCIETY during its Sixty-fourth Session, 1908-9.

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- 1890 ALEXANDER, SAMUEL PHILIP, M.D., C.M.Glas., M.R.C.S. Eng. ; Tecumseh House, 20, Kent Road, Southsea.
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- 1907 BARLEE, HOBART JOHN WILLIAM, M.D.Lyons (1896) ; L.S.A. (1907) ; 6, Coates Crescent, Edinburgh.
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- 1872 BRYCE, WILLIAM, M.D.Edin. ; 34, Greenhill Gardens, Edinburgh.
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1867 †**CROUCHER, ALEXANDER RICHARD, M.D.St. And., M.R.C.S.**  
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1899 †**DAWSON, HARRY GEORGE FREDERICK, L.R.C.P.I., L.R.C.S.I.**  
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1892 \***DEANE, HERBERT EDWARD, M.D.Dur., M.R.C.S.Eng., L.S.A.;**  
Lt.-Colonel Royal Army Medical Corps (*Retired*); Assistant Physician to the London Homœopathic Hospital; 33, Weymouth Street, W. (C. 1907-8.)

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D.P.M. and H.Cantab.1908, Withycombe, Ashfield, Sydney, New South Wales.

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1906 **EADIE, JAMES, M.B., Ch.B.Glas.,** Assistant Surgeon to the London Homœopathic Hospital and Medical Officer to the Stratford Homœopathic Dispensary, 63, West Ham Lane, Stratford, E.; 11, Taviton Street, Endsleigh Gardens, W.C.

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Elected

- 1887 **ELLIS, JOHN WILLIAM, M.B., Ch.B.Vict. and Liv., L.R.C.P., L.R.C.S.Edin.;** Honorary Physician to the Hahnemann Hospital, Liverpool; 18, Rodney Street, Liverpool.
- 1900 **ELLWOOD, THOMAS ASHCROFT, M.R.C.S.Eng., L.R.C.P.Lond., D.P.H.Camb.;** 99, Tollington Park, N., and 12a, Finsbury Square, E.C.
- 1875 \***EPPS, WASHINGTON, L.R.C.P.Edin., M.R.C.S.Eng.;** Physician to the London Homœopathic Hospital; 55, Queen Anne Street, W. (P. 1899. V.-P. 1896-98. C. 1893-94-97, 1903-04.)
- 1906 **FAIRLIE, HENRY PRESCOTT, M.B., Ch.B.Glas.;** Ashfield House, 402, Sauchiehall Street, Glasgow.
- 1908 **FALCONAR, WILLIAM ERNEST, M.B.Dur.;** 35, Wellington Square, Hastings.
- 1904 †**FALLON, ROBERT HUME, M.D., C.M.Aberd.;** 3, Thistle Villas, 87, Somerset Road, Cape Town.
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- 1881 **GILBERT, SYDNEY, L.R.C.P., L.R.C.S.Edin., L.A.H., L.M. Edin. and Dub.;** Somersfield Cottage, Reigate.
- 1893 †**GILES, FREDERICK WILLIAM, M.B.Dur., M.R.C.S.Eng.**  
(*Address not communicated.*)
- 1881 \***GOLDSBROUGH, GILES FORWARD (Editor), M.D., C.M. Aberd.;** Physician, and Physician for Diseases of the Nervous System to the London Homœopathic Hospital; 82, Wimpole Street, W., and Churchside, Herne Hill, S.E. (P. 1895. V.-P. 1893-94. C. 1897-98, 1901.)
- 1892 †**GORDON, JOHN NEWLANDS, M.B., C.M.Aberd.;** 70, Upper Parliament Street, Liverpool.
- 1886 †**GOULD, EDWARD GARDINER, L.R.C.P.I.;** Northcot, Grange Road, Sutton, Surrey.

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- 1901 †GRACE, NATHANIEL, M.D., C.M.McGill Univ., Montreal, M.R.C.S.Eng., L.R.C.P.Lond.; Hon. Surgeon to the Tunbridge Wells Homœopathic Hospital and Dispensary; 2, Calverley Mount, Tunbridge Wells.
- 1892 \*GREEN, CONRAD THEODORE, M.R.C.S.Eng., L.R.C.P.Lond., F.L.S.; Fell. Roy. Instit. Public Health; Honorary Medical Officer to the Wirral Homœopathic Dispensary; Capt. Army Med. Reserve; Capt. R.A.M.C.T.; Certifying Factory Surgeon; Admiralty Surgeon and Agent; 31, Shrewsbury Road, Birkenhead. (P. *Liverpool Branch*, 1896, 1908. V.-P. 1899.
- 1892†\*GREEN, VINCENT, M.D.Edin.; Assistant Surgeon for Diseases of the Throat and Ear to the London Homœopathic Hospital; Physician to the Wimbledon and Merton Homœopathic Dispensary; Greyroofs, Wimbledon Hill, and 155, Fenchurch Street, E.C.
- 1906 GREENWOOD, J. W., M.B., Ch.B.Vic.; 1, Slade Lane, Longsight, and 8, King Street, Manchester.
- 1902 GREIG, CHARLES JOHN, L.R.C.P.Edin., L.R.C.S.Edin., L.F.P.S.Glasg.; Physician to the Ealing and West Middlesex Homœopathic Dispensary; Gordon House, 86, Gordon Road, Ealing, W.
- 1895 GREIG, WILLIAM, M.B., C.M.Aberd.; South Parade, Wakefield.
- 1876 HALL, EDGAR ATHELING, M.B., C.M.Edin.; Physician to the Surbiton, Kingston, and Norbiton Homœopathic Dispensary; Seacombe, Adelaide Road, Surbiton.
- 1892 †HALL, FREDERICK, L.R.C.P., L.R.C.S.I., L.M.; 18, Shakespeare Street, Nottingham.
- 1906 HAM, CHARLES EDWARD, M.D.Lond.; Swiss Villa, King's Road, Reading.
- 1859 †HARPER, JAMES PEDDIE, M.D.Edin., L.R.C.S.Edin.; Milburn House, Knight's Hill, West Norwood, S.E.
- 1902 HARRIS, HENRY ARTHUR CLIFTON, M.R.C.S.Eng., L.R.C.P.Lond.; Lieut. R.A.M.C.(T.); Hon. Physician to Factory Girls' Country Holiday Society; 20, Dyke Road, Hove, Brighton.

## Elected

- 1900 HARRIS, LILLIAN MAUDE CUNARD, L.R.C.P.I. and L.R.C.S.I. ;  
20, Dyke Road, Hove, Brighton.
- 1878 \*HAWKES, ALFRED EDWARD (*Liverpool Branch Representative*),  
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Soc. Med., Medical Officer for Diseases of Women to the  
Hahnemann Hospital, Liverpool; 22, Abercromby  
Square, Liverpool. (P. 1905. V.-P. 1904-5. C. 1898-  
1908. P. *Liverpool Branch*, 1892, 1901. V.-P. 1893  
1903-4.)
- 1908 HAWKES, ALFRED ERNEST UNDERWOOD, M.R.C.S.Eng.,  
L.R.C.P.Lond., L.S.A., Bardsea, Penkett Road, Liscard,  
Cheshire.
- 1904 HAWKES, JAMES L., M.D.Liv. (1906), M.B., Ch.B.Vict. and  
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Cheshire.
- 1905 HAYES, FREDERICK WILLIAM, M.B., Ch.B. Vict. and Leeds ;  
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3, Reginald Terrace, Leeds.
- 1892 HAYWARD, CHARLES WILLIAMS (Barrister-at-Law), M.D.  
C.M.Edin., D.P.H.Camb., M.R.C.S.Eng., L.R.C.P.Lond. ;  
Surgeon, and Surgeon to the Throat, Nose, and Ear  
Department, Hahnemann Hospital, Liverpool ; 117,  
Grove Street, Liverpool. (V.-P. *Liverpool Branch*, 1902.  
P. 1903.)
- 1892 HAYWARD, JOHN DAVEY, M.D.Lond., M.R.C.S.Eng., L.S.A. ;  
Consulting Surgeon to the Hahnemann Hospital, Liver-  
pool ; Leyfield Priory, West Derby, Liverpool.  
(P. *Liverpool Branch*, 1897. V.-P. 1899.)
- 1868 \*HAYWARD, JOHN WILLIAMS, M.D.St. And., M.R.C.S.Eng.,  
L.S.A., M.D. (Hon.) New York ; Consulting Physician  
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Road, Birkenhead. (P. *Liverpool Branch*, 1895. V.-P.  
1897. C. 1892-97.)
- 1904 HEY, CLARENCE GRANVILLE, M.B., C.M.Ed. ; Assistant  
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## Elected

- 1885 **HILBERS, HERMANN GERHARD**, B.A.Camb., L.R.C.P., L.R.C.S. Edin., L.F.P.S.Glas. ; Honorary Physician to the Sussex County Homœopathic Dispensary ; Honorary Physician to the Crescent House Convalescent Home ; 49, Montpelier Road, Brighton.
- 1901 **HILL, WILFRED GRANTHAM**, M.D.Brux., L.R.C.P.Lond., M.R.C.S.Eng., L.S.A. ; Anæsthetist and late Assistant Physician to the London Homœopathic Hospital ; 49, High Road, Chiswick, W.
- 1887 **HILL, WILLIAM REED**, M.B., C.M.Edin. ; 38, Berners Street, Ipswich.
- 1902 †**HUGHES, EDMUND**, M.R.C.S.Eng., L.R.C.P.Lond. ; Medical Officer to the North Homœopathic Dispensary, Liverpool ; 102, Queen's Road, Liverpool. (P. *Liverpool Branch*, 1907-8.)
- 1892 †**HUXLEY, JOHN CHARLES**, M.D., C.M.Aberd. ; Honorary Surgeon to the Birmingham and Midland Homœopathic Hospital and Dispensary ; 91, Harborne Road, Edgbaston, Birmingham.
- 1904 **HYND, ALFRED JAMES**, M.B., C.M.Aberd., D.P.H. ; 11A, Standishgate, Wigan.
- 1904 **HYND, THOMAS CHALMERS**, M.B., Ch.B.Aberd. ; 11, Standishgate, Wigan.
- 1882†\***JAGIELSKI, VICTOR APOLLINARIS**, M.D.Berlin, M.R.C.P. Lond. ; 14, Dorset Square, N.W.
- 1894 \***JOHNSTONE, JAMES**, B.A., F.R.C.S.Eng., M.B., C.M., D.P.H. Aberd. ; Assistant Physician for Diseases of Women to the London Homœopathic Hospital ; 26, Sheen Road, Richmond, Surrey. (P. 1904-05. V.-P. 1902-04. C. 1896-97, 1900, 1908. S. 1898-1901.)
- 1887 †**JONES, DAVID OGDEN ROEBUCK**, M.D.Trin. Coll., Toronto, L.R.C.P.Lond. ; Physician to the Grace Hospital (Homœopathic) ; Surgeon for Diseases of the Eye, Ear, Nose, and Throat to the "Nursing at Home Mission" Dispensary ; 126, Carleton Street, Toronto, Canada.

## Elected

- 1893 JONES, GEORGE REGINALD, L.R.C.P.Lond., M.R.C.S.Eng., Medical Officer to the Homœopathic Institution, Manchester ; Medical Officer to the Manchester Warehousemen and Clerks' Association ; 73, Withington Road, Whalley Range, Manchester.
- 1866 †JONES, JAMES, M.D.Edin., M.R.C.S.Eng., L.R.C.P.Lond., 157, Lewisham Road, S.E.
- 1881 JONES, THOMAS REGINALD, L.R.C.P.I., L.M., M.R.C.S.Eng. ; late Consulting Physician to the Wirral Homœopathic Dispensary ; Wayside, Colwyn Bay.
- 1901 †LEWIN, OCTAVIA MARGARET SOPHIA, M.B., B.S.Lond., M.D.Chicago ; Assistant Physician and Registrar to the London Homœopathic Hospital ; 25, Wimpole Street, W.
- 1907 LOWE, EDWARD CRONIN, M.B., B.S.Lond., 31, Church Street, Southport.
- 1908 McCULLOCH, HENRY D., M.B., C.M.Glas. ; Physician in charge of Electrical Department, London Homœopathic Hospital ; 25, New Cavendish Street, W.
- 1902 †MACDONALD, DAVID, M.D.Glas., M.B., C.M.Glas. ; Hon. Physician to Hydropathic Hospital and North of England Children's Sanatorium ; Rivington, Hoghton Street, Southport.
- 1886 †McKILLIAM, ROBERT, M.D., C.M.Aberd. ; 6, Grote's Buildings, Blackheath, S.E.
- 1892 McLACHLAN, JOHN, M.A.(Oxon.), B.C.L., M.D., C.M., B.Sc. Edin., F.R.C.S.Eng., L.S.A. ; Physician to the Oxford Homœopathic Dispensary ; 3, Keble Road, Oxford.
- 1893 \*MACNISH, DAVID, M.A., M.B., C.M.Edin. ; Physician to the London Homœopathic Hospital ; Physician to the Kensington, Notting Hill, and Bayswater Homœopathic Dispensary, W. ; 4, Leinster Square, W. (C. 1901-02-04-1905, V.-P. 1907-8.)
- 1895 †MARCH, EDWARD GERALD, M.D.Brux., F.R.C.S.Edin., M.R.C.S.Eng., L.R.C.P.Lond. ; Hon. Medical Officer to the Box Grove Sanatorium, Tilehurst ; Camden House, Castle Hill, Reading.

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- 1885 †MASON, HENRY, M.D., C.M.Glas., M.R.C.S.Eng.; Medical Officer to the Leicester Homœopathic Cottage Hospital and Dispensary; 66, London Road, Leicester.
- 1893 MEEK, WILLIAM OMBLER, M.B., C.M.Edin.; Oxford House, 70, Nelson Street, Oxford Road, Manchester, S.E.
- 1893 MILLER, ROBERT GIBSON, M.B., C.M.Glas.; 10, Newton Place, Glasgow.
- 1902 †MINTER, LEONARD JNO., M.D.Brux., M.R.C.S., L.R.C.P.: Lond., L.S.A.; 54, Marine Parade, Brighton.
- 1892 †MITCHELL, JOHN JAMES, L.R.C.P.Lond., M.R.C.S.Eng.; 1, Howard Place, Stoke-on-Trent.
- 1882†\*MOIR, BYRES (*Council*), M.D., C.M.Edin.; Physician to the London Homœopathic Hospital; 16, Upper Wimpole Street, W. (P. 1894. V.-P. 1891, 1892. C. 1892-99, 1900-03-08.)
- 1892 MOIR, DOUGLAS, M.D., C.M.Aberd.; 333, Oxford Road, Manchester.
- 1889 MOLSON, JOHN CAVENDISH, M.D.Exam., Hering Med. Coll., Chicago; L.R.C.P.Lond., F.C.S., F.R.G.S.; 82, Wimpole Street, W., and 17, Vernon Terrace, Brighton.
- 1877 MOORE, JOHN MURRAY, M.D., C.M., L.M.Edin., M.R.C.S. Eng., M.D.New Zealand, F.R.G.S.; Pres. B. H. Congress, 1908; Priory House, Church Street, Leamington Spa.
- 1867 †MORGAN, SAMUEL, M.D.St. And., M.R.C.S.Eng., L.S.A.; Consulting Physician to the Bath Homœopathic Hospital; Consulting Physician to the Bristol Hahnemann Hospital; 15, Oakfield Road, Clifton, Bristol.
- 1897 MUNSTER, HAROLD VALDEMAR, M.D.Edin.; Medical Officer, Visiting Surgeon and Anæsthetist to the Croydon Homœopathic Dispensary; Hollywood, 109, St. James's Road, and 40, George Street, Croydon.
- 1882 MURRAY, JOHN, L.R.C.P., L.R.C.S., L.M.Edin.; Physician to the Folkestone Homœopathic Dispensary; 15, Trinity Gardens, Folkestone. (C. 1900.)

Elected

- 1895 **NANKIVELL, BERTRAM WRIGHT, M.R.C.S.Eng., L.R.C.P.**  
 Lond.; Surgeon and Registrar to the Hahnemann  
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 Cotlands Road; Visiting Surgeon and Physician to  
 the Bournemouth Homœopathic Dispensaries; Con-  
 sulting Surgeon to the Victoria Home for Crippled  
 Children, Westbourne; Honorary Physician, Y.M.C.A.,  
 Bournemouth; Honorary Surgeon to the Bournemouth  
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 Bournemouth.
- 1888 **NANKIVELL, FRANK, M.D., C.M.Edin., M.R.C.S.Eng.;** 161,  
 Auckland Road, Upper Norwood, S.E.
- 1888 \***NANKIVELL, HERBERT, M.D.Edin., M.R.C.S.Eng.;** Consult-  
 ing Physician to the Hahnemann Convalescent Home,  
 Bournemouth; Penmellyn, Richmond Hill, Bourne-  
 mouth. (P. 1903-04. V.-P. 1901-02.)
- 1893 **NEATBY, ANDREW MOSSFORTH, L.R.C.P., L.R.C.S.Edin.,**  
 L.F.P.S.Glas.; Mandale, Sask., Canada.
- 1885 \***NEATBY, EDWIN AWDAS (Hon. Secretary), M.D.Brux.,**  
 L.R.C.P.Lond., M.R.C.S.Eng.; Fell. Roy. Soc. Med.  
 Physician for Diseases of Women to the London  
 Homœopathic Hospital; Consulting Physician for  
 Diseases of Women to the Buchanan Hospital, St.  
 Leonards-on-Sea, and to the Leaf Cottage Hospital,  
 Eastbourne; 82, Wimpole Street, W. (P. 1897.  
 V.-P. 1894-95-96. C. 1896-1903-04. *Librarian*, 1890-  
 1899.)
- 1904 †**NEATBY, THOMAS MILLER, M.A.Cantab., M.A.Lond., B.C.**  
 Cantab., M.R.C.S.Eng., L.R.C.P.Lond.; Late Assistant  
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 Hospital; 2, Marlborough Road, Manningham, Bradford.
- 1898 **NEILD, EDITH, M.B.Lond., L.R.C.P., L.R.C.S.Edin., L.F.P.S.**  
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 bridge Wells.
- 1885 **NEILD, FREDERIC, M.D., C.M.Edin., L.R.C.P.Edin.;** Con-  
 sulting Physician to the Tunbridge Wells Homœo-  
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 House, Tunbridge Wells. (C. 1905-06.)

## Elected

- 1891 NEWBERY, WILLIAM FREDERICK HOYLE, M.D., C.M. University of Trinity College, Toronto, L.M.S.S.A.Lond.; Senior Physician and Physician for Diseases of Women to the Devon and Cornwall Homœopathic Hospital; 8, Queen Anne Terrace, Plymouth.
- 1892 † NICHOLSON, THOMAS DICKINSON, M.D., C.M. Edin., M.R.C.S. Eng.; Physician to the Clifton Homœopathic Dispensary and Hahnemann Hospital, Bristol; 2, White Ladies Road, Clifton, Bristol.
- 1876 † NORMAN, GEORGE, M.R.C.S. Eng., L.S.A.; 12, Brock Street, Bath.
- 1893 \* ORD, WILLIAM THEOPHILUS (*Vice-President*), L.R.C.P. Lond., M.R.C.S. Eng.; Physician Hahnemann Home, Bournemouth; Physician Bournemouth Homœopathic Dispensaries; Greensted, Madeira Road, Bournemouth.
- 1895 † ORR, FREDERIC LAYTON, M.D. Lond., M.R.C.S. Eng., L.R.C.P. Lond.; 23, Clifton Hill, London, N.W.
- 1886 PINCOTT, JAMES COLE, M.R.C.S. Eng., L.R.C.P., L.M. Edin.; Hon. Surgeon to the Tunbridge Wells Homœopathic Hospital and Dispensary; Culverden Grange, 12, St. John's Road, Tunbridge Wells.
- 1902 POWELL, JOSIAH CECIL, M.R.C.S. Eng., L.R.C.P. Lond.; Anæsthetist and Clinical Assistant to Ophthalmic Department, London Homœopathic Hospital; 5, Alfred Place West, Thurloe Square, S. Kensington, S.W.
- 1898 † PRITCHARD, JOSEPH JAMES GAWLER, L.R.C.P. Lond., M.R.C.S. Eng.; Heathfield, West Park Street, Dewsbury.
- 1868 †† PRITCHARD, JOSIAH, M.R.C.S. Eng., L.S.A.; 77, Richmond Road, Montpelier, Bristol.
- 1898 † \* PRITCHARD, WILLIAM CLOWES, B.A., M.R.C.S., L.R.C.P.; Surgeon to the Buchanan Hospital, St. Leonards-on-Sea; Ophthalmic Surgeon to the Hastings and St. Leonards Homœopathic Dispensary; Roden House, Church Road, St. Leonards.
- 1893 PROCTOR, PETER, M.R.C.S. Eng., L.R.C.P. Edin., L.S.A.; 17, Hamilton Square, Birkenhead.



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- 1884 PULLAR, ALFRED, M.D., C.M.Edin.; 184, Sheen Road, Richmond, Surrey.
- 1883 PURDOM, THOMAS EADIE, M.D., C.M.Edin., L.R.C.P., L.R.C.S. Edin.; Senior Physician to the Croydon Homœopathic Dispensary; Ellerslie, 25, Park Hill Road, and 40, George Street, Croydon.
- 1908 PURDOM, WILLIAM PERCY, M.B.Lond.; M.R.C.S.Eng., L.R.C.P.Lond.; 25, Park Hill Road, Croydon.
- 1894 †RAMSBOTHAM, SAMUEL HENRY, M.D.Edin., M.R.C.S.Eng.; Fairstead, Ripon Road, Harrogate.
- 1892 REED, WILLIAM CASH (*President*), M.D., C.M.Edin.; Joint Gynæcologist to the Hahnemann Hospital, and Honorary Gynæcologist to the Roscommon Street Dispensary, and to the Southport Dispensary; 15, Princes Avenue, Liverpool. (V.-P. 1900-01-06. P. *Liverpool Branch*, 1902.)
- 1872 †REID, LESTOCK HOLLAND, M.R.C.S.Eng., L.R.C.P.Lond.; 472, Palmerston Avenue, Toronto, Ontario, Canada.
- 1894 RENDALL, JOHN MURLY, L.R.C.P., L.R.C.S.Edin., L.F.P. & S.Glas.; 2, Coates Crescent, Edinburgh.
- 1885 †RENNER, CHARLES, M.D.Würzburg, L.R.C.P.Lond., M.R.C.S.Eng.; 75, Upper Gloucester Place, Dorset Square, N.W.
- 1908 ROBERTS, ARTHUR, M.D.St.And., M.R.C.S.Eng., L.S.A. Lond., D.P.H.Lond. Conjoint; Albert House, 16, Albert Street, Harrogate.
- 1893 ROBERTS, WILLIAM HENRY, L.R.C.P., L.R.C.S.Edin., L.M.; Physician to the Dublin Homœopathic Dispensary; 63, Lower Mount Street, Dublin.
- 1878 \*ROCHE, ELEAZER BIRCH, L.R.C.P.Lond., M.R.C.S.Eng., L.M.; Physician to the Norwich Homœopathic Dispensary; Honorary Medical Officer to the Orphans' Home, Norwich, and to the Norwich City Mission; 27, Surrey Street, Norwich. (C. 1897.)
- 1892 ROCHE, WILLIAM, M.R.C.P.I., L.M., M.R.C.S.Eng.; The Limes, 10, Warwick Road, Upper Clapton, N.E.

## Elected

- 1901 ROSS, PERCY ALEXANDER, B.A.Cantab., M.R.C.S., L.R.C.P.  
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- 1891 ROSS, WILLIAM, L.R.C.P., L.R.C.S.I., L.M.; Physician to the Northampton Homœopathic Dispensary; 87, St Giles' Street, Northampton.
- 1892 ROWSE, EDWARD LEOPOLD, M.D.Brux. (Honours), L.R.C.P. Lond., M.R.C.S.Eng.; Garryowen, Putney Hill, Putney, S.W.
- 1880 SANDBERG, ARTHUR GREGORY, M.D.Verm., L.R.C.P., L.R.C.S., L.M.Edin.; 72, Streatham Hill, S.W.
- 1893 SANDERS, HORACE, L.M., L.M.S.S.A.Lond.; Clinical Assistant to the Gynæcological Department, and Clinical Assistant for Diseases of Children, London Homœopathic Hospital; 156, Haverstock Hill, Hampstead, N.W., and 77, Camden Road, N.W.
- 1892 †SCRIVEN, GEORGE, M.D., B.Ch.Dub., L.M., J.P., F.R.G.S.; Physician to the Dublin Homœopathic Dispensary; 33, Stephen's Green, Dublin.
- 1885 SEARSON, JAMES, M.D.Brux., L.R.C.P., L.R.C.S.I.; Assistant Physician to the London Homœopathic Hospital; 64, Seymour Street, Portman Square, W.
- 1884 SHACKLETON, HENRY, B.A., M.D.Dub., M.R.C.S.Eng., L.M.K.Q.C.P.I., L.M.Rot.Hosp., Dub.; 12, West Hill, Sydenham, S.E.
- 1883 \*SHAW, CHARLES THOMAS KNOX (*Council*), L.R.C.P.Lond., M.R.C.S.Eng.; Senior Surgeon and Ophthalmic Surgeon to the London Homœopathic Hospital; Consulting Surgeon to the Buchanan Cottage Hospital, St. Leonards; to the Tunbridge Wells Homœopathic Hospital; to the Phillips Memorial Hospital, Bromley; to the Lansdown Homœopathic Hospital, Bath; to the Hahnemann Hospital, Bristol; and to the Devon and Cornwall Homœopathic Hospital, Plymouth; Consulting Ophthalmic Surgeon to the Hastings and St. Leonards Homœopathic Dispensary; 19, Bentinck Street, Cavendish Square, W. (P. 1891. V.-P. 1890. C. 1900-08. S. 1892-98, 1900-04.)

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- 1885 **SHAW, FRANK HERBERT, M.R.C.S.Eng.**; Surgeon to the Buchanan Hospital, and to the Hastings and St. Leonards Homœopathic Dispensary; The Gables, Pevensey Road, St. Leonards-on-Sea.
- 1888 **SIMPSON, THOMAS, M.D.St.And., M.R.C.S.Eng.**; Honorary Consulting Physician to the Hahnemann Hospital, Liverpool; Hon. Physician to Southport Homœopathic Dispensary; Hon. Physician to the Evangelization Society; 2, Palatine Road, Birkdale, Lancs.
- 1885\*†**SMITH, GERARD, M.R.C.S.Eng., L.S.A.**; Medical Officer of Health, Hobart, Tasmania.
- 1896††**SMITH, PHILIP DOUGLAS, M.B., C.M.Edin.**; Launceston, Tasmania.
- 1892 †**SMITH, ROBERT GORDON, M.B., C.M.Aberd.**; Honorary Medical Officer to the Hahnemann Hospital, Liverpool; 164, Upper Parliament Street, Liverpool.
- 1893 **SOUTHAM, JOHN BINNS, M.R.C.S.Eng., L.S.A.**; 9, London Street, Dunedin, New Zealand.
- 1899 **STACEY, FREDERIC GEORGE, B.A., M.B., B.C.Cantab., M.R.C.S.Eng., L.R.C.P.Lond.**; 719, Ecclesall Road, Hunter's Bar, Sheffield.
- 1892 **STACEY, HERBERT GLEESON, M.D.Brux., L.R.C.P., L.M. Edin., M.R.C.S.Eng., L.S.A.Lond.**; Honorary Physician to the Leeds Homœopathic Dispensary; 28, Park Square, Leeds.
- 1908 **STEINTHAL, WALTER OLIVER, M.R.C.S.Eng., L.R.C.P. Lond., L.S.A.**; Gwynant, Withington, Manchester.
- 1890 **STANCOMB, ERNEST HENRY MURLY, M.B., C.M.Edin.**, Westbourne, College Place, Southampton.
- 1889 \***STONHAM, THOMAS GEORGE (Vice-President), M.D.Lond., M.R.C.S.Eng.**; late Assistant Physician to the London Homœopathic Hospital; 128, Broadhurst Gardens, West Hampstead, N.W. (C. 1898, 1901, 1906.)
- 1887 **STORAR, WILLIAM MORRISON, L.R.C.P., L.R.C.S.Edin., L.M.**; 3, Sion Hill, Ramsgate.
- 1892 **STUART, PETER, L.R.C.P., L.R.C.S.Edin., L.M.**; Physician to the Hahnemann Hospital, Liverpool; 36A, Rodney Street, Liverpool.

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- 1877 \*SÜSS-HAHNEMANN, FREDERICK LEOPOLD ROBERT, M.D.,  
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- 1892 THOMAS, BERNARD, M.B., C.M.Edin.; Port Cygnet, Tas-  
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- 1886 THOMAS, EDWARD JOHN HAYNES, L.R.C.P., L.R.C.S.Edin.;  
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- 1891†\*THOMAS, HAROLD WYNNE, M.R.C.S.Eng., L.R.C.P.Lond.;  
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- 1895 †THORNTON, FRED WHITFIELD, M.R.C.S.Eng., L.R.C.P.I.;  
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- 1896 TINDALL, ERNEST EDWARD PATRIDGE, R.N., M.R.C.S.Eng.,  
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- 1904 TYLER, MARGARET L., M.D.Brux., L.R.C.P., L.R.C.S.Edin.,  
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- 1886 †VAWDREY, THEOPHILUS GLASCOTT, L.R.C.P.Lond., M.R.C.S.  
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- 1900††WARREN, WILLIAM, M.R.C.P.I., L.R.C.S.I., L.M.;  
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- 1895 \*WATKINS, FRANK AUGUSTUS, M.R.C.S.Eng., L.R.C.P.Lond.,  
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- 1907 †WATKINS, WALTER, L.R.C.P.Lond., M.R.C.S.Eng., L.S.A.;  
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- 1862 †WATSON, CHARLES GEORGE, L.R.C.S., L.R.C.P.I., L.M.  
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- 1897 WATSON, JAMES, M.B., C.M.Edin.; Honorary Physician to  
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## Elected

- 1894 †**WHEELER, CHARLES EDWIN** (*Council*), M.D., B.S., B.Sc.Lond., M.R.C.S.Eng., L.R.C.P.Lond.; Assistant Physician, London Homœopathic Hospital; 5, Devonshire Street, Portland Place, W. (C. 1907-8.)
- 1861 ††**WHEELER, HENRY**, L.R.C.P.Lond., M.R.C.S.Eng.; "Hazel-dene," Christchurch Road, Eaton, Norwich.
- 1901 **WHITE, ADAM CRAWFORD**, M.D., C.M.Glas., 31, Union Street, Oldham.
- 1893 †**WILDE, FREDERICK GEORGE STANLEY**, L.R.C.P., L.R.C.S., L.M.Edin.; Physician to the Cheltenham Homœopathic Dispensary; Ingleside, Bayshill, Cheltenham.
- 1893 †**WILDE, HERBERT, M.B.**, C.M.Edin., L.R.C.P., L.R.C.S.Edin.; Medical Officer to the Brighton Homœopathic Dispensary; 18, Clifton Terrace, Brighton.
- 1891 \***WILDE, PERCY ROBERTS**, M.D., C.M.Aberd.; Physician to the Lansdown Hospital and to the Bath Homœopathic Hospital; 23, Circus, Bath, and 64, Seymour Street, London, W.
- 1891 †**WILDE, ROWLAND STANLEY**, M.B., C.M.Edin.; Physician to the Weston-super-Mare Homœopathic Dispensary; Park House, Weston-super-Mare.
- 1892 **WILKINSON, ALFRED GEORGE**, M.R.C.S.Eng., L.S.A.; 28, Newland, Northampton.
- 1892 \***WILKINSON, CLEMENT JOHN**, M.R.C.S.Eng., L.S.A.; 3, Osborne Villas, Windsor. (V.-P., 1905. C. 1898-99.)
- 1892 †**WILLIAMS, LEMUEL EDWARD**, M.R.C.S.Eng.; Surgeon to the Skin Department and Honorary Assistant Medical Officer to the Hahnemann Hospital, Liverpool; 239, Boundary Street, Liverpool.
- 1896 **WILLS, REGINALD GRAHAM**, M.D., C.M.Aberd.; late Visiting Medical Officer to the Bath Homœopathic Hospital; 8, St. George's Place, Canterbury.
- 1902 **WILMOT, PHILIP MCKINNELL CORBOULD**, M.B.Lond., M.R.C.S., L.R.C.P.Lond.; Honorary Surgeon to the Devon and Cornwall Homœopathic Hospital, and to the Throat, Nose, Ear and Eye Departments; 6, Sussex Terrace, Plymouth.

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- 1892 WINGFIELD, JOHN, L.R.C.P., L.R.C.S.Edin., L.F.P.S.Glas.,  
Elmhurst, Wake Green Road, Moseley; and 60, Newhall  
Street, Birmingham.
- 1889 ‡WITHINSHAW, CHARLES WESLEY, L.R.C.P., L.R.C.S., L.M.  
Edin.; 12, York Street, St. James's Square, S.W., and  
The Hydro, Bromley Hill, Kent.
- 1893 ††WOLSTON, CHRISTOPHER, B.A.Lond., M.D.St. And., M.R.C.S.  
Eng.; 7, Porchester Place, Hyde Park, W.
- 1877 WOLSTON, WALTER THOMAS PRIDEAUX, M.D.Edin., M.R.C.S.  
Eng.; 6, Coates Crescent, Edinburgh.
- 1876 ‡WOOD, HENRY THOROLD, M.R.C.S.Eng.; Connaught Club,  
Marble Arch, W.
- 1889 \*WRIGHT, DUDLEY D'AUVERGNE, F.R.C.S.Eng., M.R.C.S.,  
L.R.C.P.Lond.; Surgeon, and Surgeon for Diseases of  
the Throat and Ear to the London Homœopathic  
Hospital; Consulting Surgeon to the Leaf Homœo-  
pathic Hospital, Eastbourne; Consulting Surgeon  
to the Leicester Homœopathic Hospital; Consulting  
Surgeon for Diseases of the Throat and Ear to the  
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Bentinck Street, W. (P. 1900. V.-P. 1896. C. 1895-  
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*All communications and exchanges to be sent to*  
**DR. GOLDSBROUGH, 82, Wimpole Street, London, W.**

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ESTO VIGILANS.

THE PRESIDENTIAL ADDRESS TO THE BRITISH HOMŒOPATHIC  
SOCIETY, DELIVERED AT THE OPENING OF THE SESSION  
1908-9.

BY WILLIAM CASH REED, M.D., C.M.EDIN.  
*President of the Society.*

GENTLEMEN,—I am very sensible of the honour you do me by placing me in this chair, and when I recall the names of many distinguished men who have occupied it I congratulate myself that at least *one* qualification is left open to me, viz., the opportunity to display some measure of self-sacrificing energy arising from a residence nearly 200 miles from the Metropolis. But there is a special reason why I like to come up to London, for within the sound of Bow Bells, and where the New River winds its limpid way, I first saw the light.

To proceed now to the business of this chair.

I take it to be an endeavour to indicate a policy which shall be to the best interests of our body during the coming session. It may be said that as a scientific body we have

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nothing to do with politics; nor have we, except in so far as they are those of the "Minister of the Interior," who regulates his administration by the Imperial Standard, in other words, that of the whole medical profession. As regards essentials, viz., *ethics*, we have always conspicuously done so. We have, however, had thrust upon us, unwillingly, an autonomy which embodies certain specific duties and obligations on our part. Some even now ignorantly suppose that this autonomy is self-imposed. I need not waste your time by refuting this foolish misconception, but merely remark that it continues essential for us within the prescribed area of our administration to form our policy and play our part with patience and zeal.

I desire at the very outset of this paper once more to nail our colours to the mast, and to insist that this Society is, and must always be, essentially a *scientific one*. If it fail in this the *raison d'être* of its existence is gone, and the sooner its doors are closed the better.

Under the following headings I propose to consider how we may best "strengthen the things which remain":—

(1) By an "all-red" conference.

(2) By a widening of the *base* of our hospitals, and an endeavour thus to show that homœopathy has *no limitations*.

(3) By a further endeavour to foster the ideal of corporate life amongst our members, the keynote of this being *sympathy*.

(4) By a further enlightenment of the *profession* on the subject of homœopathy.

(5) By an endeavour to show the laity who evince a desire to learn what homœopathy is, and especially to demonstrate that it is not an oligarchy, but a form of constitutional radicalism.

(6) By anticipating the cataclysm which must inevitably ensue before long if we hold our hands, for homœopathy will be "rediscovered" and called by another name.

#### (1) AN "ALL-RED" CONFERENCE.

We have heard much recently of an "*all red*" route, in other words, one which shall connect every British possession



throughout the world. In order to accomplish this great feat, much "linking up" of existing agencies is essential. We have also heard a great deal of the recent "*Pan-Anglican Congress*," to which delegates from all parts of the globe came at their own charges to discuss matters of ecclesiastical polity for helping forward the work of their Church. More recently still we have witnessed a revival of the *Olympic Games*, which, though primarily appealing to the sporting instinct, have accomplished much, in spite of some coruscations of ill-will, to cement the friendship of the world. It may be asked, What have these three events to do with the policy of the British Homœopathic Society? I will try to answer. Underlying all three there is the spirit of *expansion*, of fraternity, of goodwill, and a better understanding of one's fellow-man than could otherwise be possible. As he becomes the object of our inspection there is fostered less of distrust and more of solicitude, less of hauteur and more of inquiry, less of detachment and more of propinquity. These results, though abstract, are of the profoundest importance to mankind, and are brought about by the contemplation of some common object of interest.

I should rejoice, then, to think that in a few years we might as therapeutic alienists find ourselves in a world's conference in London with many hundreds of others who profess the same heterodoxy. Different shades and degrees of this would be represented, for they depend largely upon environment, which varies so immensely in the case of one unit of the human race from that of another.

As it is not possible for any man to have even a *dual* experience, it becomes us as thinking men to inquire into that of another who has lived his life and done his work at the Antipodes, for example.

It is everywhere the same history of oppression, misunderstanding and often wilful ostracism, and, I believe, of *jealousy* also. The factors, however, which modify one's experience and make it valuable are the recipient of the disfavour himself and the surroundings in a composite sense in which he has lived his life. Thus we *must meet* to see the one and *hear* about the other.

I repeat, then, that one of my most cherished wishes is to see such a congress of practitioners of our own way of thinking met together for mutual light and energy. That the light would be extraordinarily illuminating, and the energy potential of great results I have no manner of doubt. What we need is to bring together the experience of all, and make its net result negotiable.

In speaking thus I have dwelt chiefly upon the *ethical* side of experience and its value to each and all for purposes of comparison. I have done so because of its prime importance, not because it has a monopoly of value. The fact remains that without a sympathetic hearing of this aspect of our lives we are ill prepared to profit by a merely scientific exordium.

(2) A WIDENING OF THE BASE OF OUR HOSPITALS, AND AN ENDEAVOUR TO SHOW THAT HOMŒOPATHY KNOWS NO LIMITATIONS.

I have always been a profound believer in the utility of our hospitals, not merely in a narrow and individual sense which few practitioners will dispute, but in the widest possible acceptation of the term. It seems strange that it should be expedient to emphasize a point apparently so obvious, and one which is so widely accepted by the profession as a whole. Yet there are some, *mirabile dictu!* who look upon hospitals as necessary evils, and begrudge the time spent within their walls. I have never been able to understand this position or to sympathize with it in the very slightest degree. I have always believed, and do so now more firmly than ever, that a man gets out of his hospital work exactly what he puts into it—no more and no less. I do not refer to pecuniary gain, though that is an almost necessary corollary, hence do not suggest anything so sordid as a profit and loss account on the workings of his hospital scheme. What I do mean is that the *sum* of his work as a whole, at any given period, is determined by the quantity and quality of his hospital work. It is sometimes contended that our hospitals should be more exclusively devoted to the direct demonstration of the homœopathic

law than appears to be the case. I say *appears*, because I am firmly convinced that the impression is an erroneous one, and exists merely in the minds of the really *unobservant* or those who are mentally astigmatic. Our hospitals are, of course, primarily for the demonstration of a principle, and if they fail in this respect they are meaningless. I believe, however, that a many-sided demonstration of a truth is of incalculable value, and that the more agencies employed—in other words, the more departments there are in our hospitals—the better for the promulgation of the principle of which we are the recognized exponents. To suggest for one moment a curtailing of the operations of this therapeutic law to a section of the public whose ailments show on selection a certain *a priori* appropriateness to its action is wholly dishonouring. Or, again, to seek to confine its operations to the narrow limits of a class of case which may be described as “unclassified,” and which is chiefly transcendental, is equally stultifying and inert. Seeing that the law is true, it becomes its custodians to demonstrate its many-sided application. I do not believe that any branch of medical or surgical science can fail directly or indirectly to be benefited by an *engrafted* homœopathy. It is unworthy of our principle to limit its applicability to a circumscribed area which it has never shown any inclination to enclose, though we in our myopic stupidity may have permitted a circumference to be drawn about it.

It may be objected that I am dealing in generalities, and not with details. If so, my reason is that this is not the place nor the time to cope with the latter. Our Council is more than competent to continue to do so; this is, however, an opportunity to seek an enthusiasm to inspire its future deliberations.

I am convinced that in order to appeal to the reason of the average medical man we must be able to show that the arsenal of homœopathy has vast reserves, and to give effect to this contention I should like to amplify the *scheme* of every homœopathic institution, leaving no single branch of medicine or surgery unrepresented. If, however, unfortunately there *should* exist a vacancy, it should be tolerated

solely because limitations exist in the resources of the institution in question. I should like to see a scheme for original research, without vivisection, in every hospital, whilst its armamentarium should comprise all and every instrument of clinical precision known to medical science. I cannot conceive limitations in a scheme of such vast importance. Should, however, any of the agencies to which I have referred in such general terms fail to mark or confirm the truth, such should rivet our attention and become the special object of our solicitude. With regard to the effect upon other medical men of these outward and visible signs, I think we often make a mistake in a self-absorbed way, which, after all, is a seductive form of selfishness. We do not give half enough credit to the shrewdness and real honesty of purpose of the casual medical observer. He often does not want to know what *we* think, but to look on and make his own deductions. The question is: "Are we really giving him the opportunity which fair play demands?" I sometimes think not. To put my meaning into a nutshell, the homœopathic hospital which has not, or does not intend to have, an all-round equipment to appeal to men of infinite variety of thought is not "playing the game."

An ill-equipped homœopathic hospital, so far as its influence is concerned, is like an insurance office which confines its attention to studies in permutation by its actuary and neglects to obtain the customers necessary to its existence. Homœopathy to be effective must illuminate, and every man possesses some avenue through which light may enter, though we may be as absolutely ignorant of it as we are of the site of the Tower of Babel. Give him time and opportunity, and the light may penetrate.

"Ubi fides ibi lux et robur."

- (3) BY A FURTHER ENDEAVOUR TO FOSTER THE IDEAL OF CORPORATE LIFE AMONGST OUR MEMBERS, THE KEY-NOTE OF THIS BEING SYMPATHY.

There are, as is well known, many lonely men in our fraternity who hold the outposts, and to convey now and again to these a cheery message is the part and privilege of

those who live in the denser professional atmosphere of the cities. Each of us can judge how best to encourage a colleague thus isolated, for the special circumstances of the case will give us the clue. Some we may personally visit, or invite to visit us, and it is a mere shiftless pretence to contend that such courtesies are uncalled-for and gratuitous. Anyone who has passed through the experience of isolation, as nearly all have, knows better. Our colleagues detached by distance are only too glad to see a friend, or if that cannot be, to exchange with him at the very least semaphore signals of fraternity. I have claimed as the keynote of these few remarks the quality of *sympathy*. It is, I think, Trench who divides sympathy into two varieties, viz., that of *contagion* and that of *congruity*. With the first we are not at this moment concerned, for it has to do with emotion. It is, though, a valuable asset to the practitioner who happens to possess it. The sympathy of *congruity*, on the other hand, is of a sterner variety and hardier growth. It speaks of mutual fitness, harmony, and correspondence, the running together in the same leash of mind and mind. It has a place—an important one even—in this rather harsh, self-seeking, and analytical age.

Gentlemen, I will not enlarge upon this theme, but leave it for your consideration, merely remarking that, as time goes on, I am more and more convinced that this is not the day to emphasize the differences in our own ranks, but to sink them, and to unite together more closely than we have hitherto done in the common interest which we believe makes for the benefit of mankind.

Of course, many will say, "Has not a man a right to his own opinions?" and they will expect the apparently inevitably reply, "Yes." I venture, however, to dispute the affirmative, but am equally unable to substitute the negative. The fact is, as a writer<sup>1</sup> has recently pointed out, it entirely depends upon how he came by his opinions, whether or no he is entitled to hold them. Broadly speaking, if he comes by them after an honest, persistent delving for the truth

<sup>1</sup> *Spectator*, August 29, 1908.

and a careful analysis of evidence, which have resulted, synthetically, in a *credo*, then I maintain he is entitled to his opinions. If, on the other hand, he has never even questioned what I may call a "birthright membership" opinion, then he lays himself open to the contention that he is *not* entitled to them. In fine, the system of therapeutics to which we adhere does not rest upon the exposition of any *one* man, and if we think it loses in vim by the erroneous exponent, and that we ourselves could do it much better, we have a consolation.

We may recall the fact that if any truth is to be judged by its worst exponent, no system, human or divine, could for one moment stand.

I cannot leave this subject of a corporate life without seeking something more of definiteness. The teaching of St. Francis of Assisi was the antithesis of *individualism*, hence, magnificent though it were, it had its limitations. That of George Fox was intensely individualistic, but was lacking, I venture to think, to this extent, that it took too little account of the larger life of the *community*. No vital propaganda dare ignore either of these factors, hence it is for us to cultivate in its highest ideal the combination of individualism and communism. The former is, of course, regulated by each man for himself; the latter must, to some extent be regulated by our Society.

The repression which an environment of oppression has had upon some who have embraced homœopathy has, after many years, had its effect in producing a scientific recluse more or less. I do not refer to its effect upon other natures, though *quot homines tot sententiæ* gives abundant scope for study.

I will merely content myself with suggesting two thoughts, which have impressed themselves upon me when contemplating the sociology of our body:—

(1) We want more *solidarity*, for we are not built, like the *Lusitania*, in watertight compartments, each self-sufficient and self-contained.

(2) When there is a sense of personal incompleteness we need a vital fellowship; and he will do much for our

Society who, with patient friendliness or with the tongue of a Mercury, can convince our colleagues that this fellowship is always within reach.

Gentlemen, I believe I am voicing the thoughts of many here to-night; the only regret is that my ability as an interpreter is so poor that I can do no more than render a free translation. I leave these hints, nevertheless, with you, feeling confident that if there be any value in them they must in your hands become fruitful, and in that fruition I shall rejoice to take my part.

(4) BY A FURTHER ENLIGHTENMENT OF THE PROFESSION  
ON THE SUBJECT OF HOMŒOPATHY.

We all object to personalities, and in these days of "quick delivery" they are specially unwise. But, in speaking on the subject just now before us, please do not assume that I am "talking into my hat" nor vapouring of what is merely chimerical. There is what I may call an *acquisitive willingness* on the part of the profession as a whole towards homœopathy. The socialism of the present day permeates even the sacred fame of medicine, and it is well that it should. There is a thinly obscured sympathy with, and almost an admiration for, the man who has the courage implied by the possession of alien views. This is, I believe, something new, and may well stimulate us to a forward movement in the direction of enlightening the profession. It is especially unnecessary in these days to assume the *rôle* of the didactic philosopher towards error, for we have merely to utilize the weapons of the opposition to his own undoing. The agency through which this is accomplished is, of course, the *medical Press*, which has done, and is still doing, the grandest work in the direction of advancing scientific homœopathy. It is often said with pensive air that our literature only reaches those who hold the truth as we do, but even if this were true—which it is not—it would equally apply to every form of *party* literature. Yet the consensus of public opinion is on the whole upward and not downward, forward and not backward—ever, indeed, making for what is better and not worse for the race. So even in

medicine. If the acquisitive willingness to which I have referred on the part of the profession as a whole be true, then we may take heart of grace in the knowledge that the meed of therapeutic purity, by our own party efforts, enjoys its own ratio of progression.

I have been profoundly impressed for many years by the fact that an enormous amount of medical teaching, priceless in value, and worthy to be graven in stone, falls upon arid soil, or, what is worse, merely strikes an irresponsible mutism.

Such golden precepts have no other warranty for permanence than the illusive storage power of memory. Thus, perchance, they might as well never have been uttered.

There is a pathos in all this, but there is a remedy also, if each one will do his part. There are many not of our ranks sitting on the hedge, or, perhaps I should say, *under the shadow* of it, because they are saved from the fierce light of criticism. These from time to time benefit the world by their discoveries, although post-dated about 100 years! What is to be done with these truisms to make them subservient to our cause?

First, they must be shown to be only the *foster*-children of the (so to say) "discoverer," who has dressed them in so strange a garb that their true parent would scarcely recognize them.

Then, having passed through the crucible of the journalist, they will be found to be nothing short of the philosopher's stone discovered more than 100 years ago by the master intellect of Hahnemann.

This work of rehabilitation is being constantly accomplished by our journalists, but I maintain that each member of the British Homœopathic Society owes a debt to the Press to supply it with the pabulum for renewed exertion. Medical literature is so vast and in so many tongues that we constantly find men reading journals which rarely, if ever, come before our own eyes. Thus it is the part of each one of us to embrace every opportunity to snatch from oblivion the undesigned homœopathy which surrounds us.

These "undesigned coincidences" have a tendency to



become merely the *voces et præterea nihil*, simply for want of a little trouble on our part. Let us, then, in this also be vigilant.

- (5) BY AN ENDEAVOUR TO SHOW THE LAITY WHO EVINCE A DESIRE TO LEARN WHAT HOMŒOPATHY IS, AND ESPECIALLY TO SHOW THAT IT IS NOT AN OLIGARCHY, BUT A FORM OF CONSTITUTIONAL RADICALISM.

I am sometimes much amazed to note how many men and women of "light and leading," although showing a profound interest in homœopathy, practically have very hazy ideas of what it really is.

From a utilitarian point of view their adherence is of priceless value, for they are those into whose care are committed the *lares* and *penates* of our hospitals. In other words, they are those who devote time, often of the greatest value, to attendance upon the committees of our institutions, and ungrudgingly expend energy which results in untold good to a great cause. Now and again, however, we are startled by a stringent criticism or a pertinent inquiry from these which necessitate the calling forth at a moment's notice of such reserves as we possess for a reply. That some men in whose hand is the ever-ready single-stick of repartee enjoy and even court such a position I do not doubt, but to others less gifted it may mean an uncomfortable ten minutes.

Nevertheless, it is a fact that the homœopathic physician has favourably impressed a section of the public, and I know no better proof of this than the terse and witty summing up of the professors of the two schools than that given by a lady of my acquaintance.

She said: "A homœopath is one who thinks he can cure people, and sometimes does; an allopath is one who knows he cannot cure anyone, and does not try." Now this lady was an *allopath*.

If a layman apply to an encyclopædia for information, he is liable to find a definition which, being but half the truth, may convey a whole untruth with a *souçon* of venom.

What is he to do? He seeks further enlightenment from

such literature as is obtainable, and finds himself illumined if it happen to be of the right kind. Happily this exists, but, unfortunately, the spurious also exists, and in greater abundance. If no such literature be forthcoming, he probably applies to his medical man. The outcome of this is too often that though loyalty to the latter is increased, his understanding is pretty much where it was.

My experience, at any rate, has been something like this, but it may be unusual. Not, however, possessing the *os rotundum* essential to effective debate, but, on the other hand, being rather "stinted in speech," I may fail to benefit the cause where others succeed.

I know the enormous difficulty of producing an effective memorandum dealing with homœopathy, yet it is being accomplished "in parts." What we need is an organic whole, and I have sufficient faith in our Society and its congeners to believe that this *magnum opus* will by-and-by be an accomplished fact.

The two chief difficulties in the way appear to me to be that in these days people do not take the *ipsissima verba* of another as necessarily true, however poignant; and secondly, that with the ever-advancing tide of scientific information, some details will require readjustment from time to time, though the main proposition must remain ever the same. Why, however, concern ourselves with the second and third edition of our memorandum, when we have not the first? *This* is for our generation, the next will bear its own burden.

We have hitherto, I think, been too easily content to let the truth proclaim itself. This is our slow English method, but we shall do well to aid and abet its beneficent proclamation by freeing it from a few impedimenta.

For instance, it may be more clearly insisted upon that we ask for no *submission* of any man's *reason* to homœopathy. What we ask is for an intelligent and honest inquiry. Nor are we obstructionists who stultify progress by setting up an impossible shibboleth. On the contrary, all inquiry is as free as air, and as welcome.

Lastly, our methods are not *inquisitorial*, but consist in offers of demonstration by all means within our power.

It is proverbially a supremely difficult task to teach anyone who does not wish to learn, hence perhaps it is that militant homœopathy directed at the *profession* has hit the mark with less effect than we had a right to expect.

In taking a retrospective glance at the history of homœopathy, both of what I know and of what I have heard, it seems to me that the one quality which has ever been its motive power is, as one would expect, *enthusiasm*. The way the truth was at first promulgated was very frequently by lonely men with profound convictions, and in whom were found more or less the scientific and the analytical spirit. Without this triple qualification, viz., conviction, science, and reason, in a teacher, his mission has no permanence, or at the very best, is but truncated. Where the chief qualification to disseminate knowledge is merely loud talking and "push," the effect must be thin and transitory, because it depends merely upon one man's strident reiteration.

There were crises in those earlier days, as there are occasionally now. They arose when men, relying upon the advice of a friend, had "got homœopathy into their houses," and some member of the family was sick unto death. The recipient of the new truth would look around and wonder and ask: "Was he doing everything for the best?"

Who has not seen and been impressed by the attitude of, say, a stockbroker in a great crisis, when the markets are jumping up and down like peas on a hot shovel, or like a hectic fever chart. The little man goes under with petulance and nerves, but the really great man directs the helm unflinchingly. There is no great exhibition of prowess, but by a calmness of demeanour which is contagious he disarms the pusillanimity of the rest.

Such an instance is known to the writer. When a crisis arose in the illness of one of his family, this man had the suggestion made to him by an allopathic friend that he would surely not depend upon homœopathy in so grave a case. He replied "Because the illness is so grave is the very reason why I rely upon homœopathy and nothing else."

I wish to conclude this section of my paper, dealing with homœopathy and the laity, by making some practical sug-

gestions. I have said that homœopathy is not an oligarchy dispensed by the few for the weal or woe of the community. This is one point upon which we may sometimes insist with advantage. It is true that homœopathy in its perfection and "true inwardness" is known best to its most gifted exponents, yet that in a crude and often unknown form it is practised by every physician is equally true. Hence in therapeutics the homœopath is merely a constitutional radical.

To revive enthusiasm, I think that the teaching of homœopathy should emphatically start from within our hospitals and extend to the outside; in other words, that it is best accomplished not by seeking accretion at the periphery, but by crystallization at the centre. Is it treason to speak of the ignorance of homœopathy which is found amongst our nurses? We have ready to hand in them a valuable channel for the dissemination of the truth. It is true there are a vast number of exceptions to the indictment I have brought. Such exceptions are found amongst those who have had the opportunity to *compare systems* of therapeutics. With the majority, however, such an opportunity is naturally frequently lacking, and this accounts for the *laissez-faire* attitude towards therapeutics so frequently observable. I do not know what is done in London, Birmingham, and elsewhere, but for ourselves I should like to see a course of lectures for the nurses on homœopathy pure and simple.

To these I would invite all members of committees, ladies as well as gentlemen, who incline to attend. Questions should be asked and discussion promoted. Thus the *raison d'être* of our position would be better defined, and a larger knowledge infused, which would grow and extend. Of course, what I have suggested should not in the least curtail those lectures to nurses which are essential for their life's work and for the granting of certificates.

I can bear testimony that, as regards Liverpool, this last is carried out in a way which is an example in efficiency to any hospital.

This special kind of lectureship to which I refer is far

from an easy one—in fact, I think it extremely difficult. The lecturer must not be too didactic, on the one hand, nor too vague on the other. He must be free from discursiveness, and yet not laconic. He must not be too technical, on the one hand, nor commonplace on the other. Finally, and above all, he must not descend to anything vituperative. I should myself like to listen to an ideal lecture to nurses and laity combined. I believe it would contain the elements of enormous good, present and prospective. Such lectures might well be taken down in shorthand, and when revised form the basis of the memorandum to which I have elsewhere alluded.

Before coming to the last section of my paper, I should like to address a few words to the *veterans* of our Society, who, from various causes, are unable to be with us. There are many who have of late noiselessly slipped from the militant ranks of our body, and who can now merely look on. In their younger days they were members of the military band which stirred the enthusiasm of some of us by appealing to the emotions. It must be a source of infinite satisfaction to these to know that not one of the *positive* principles which they enunciated can be shown to have failed. Whether the Society of Homœopaths, of which we are the latter-day representatives, is as compact, forceful, and persistent as in their day is another matter. That it is less belligerent is certain, though the absence of this quality may be merely a feature of present-day ethics. The difference, probably, is one of tactics. I think it was Darwin who said that his memory, “though extensive was hazy.” Of the *patres conscripti* of whom I speak we may say that if their memories be less extensive, they certainly are anything but hazy. They trusted in clear-cut principles, and left the consequences, and now the fruition is indeed anything but commonplace. The extraordinary thing, as it seems to me, is that though our pioneers lost a strong sense of external authority in matters of belief, yet at the same time they retained a degree of inward self-restraint which in the history of beliefs is one of the rarest qualities.

Thus to those who are no longer able to be with us we

convey our best wishes and the warm assurance that so far as we are able to do so their work shall be carried on.

And now I come to the last section of my paper, viz. :—

- (6) BY ANTICIPATING THE CATAclysm WHICH MUST INEVITABLY ENSUE BEFORE LONG IF WE HOLD OUR HANDS, FOR HOMŒOPATHY WILL BE “REDISCOVERED” SO TO SAY, AND CALLED BY ANOTHER NAME.

That homœopathy will be eventually recognized is as sure as that before long the air will be freely and fearlessly navigated. That it will remain as the leading law in medicine is as sure as that Galileo's discovery is permanent. That it will be subject to some modification is not unlikely. That it will be scientifically *explained* is quite another matter, though I believe that eventually even this will be accomplished. But the matter of explanation does not in the least affect the question, nor modify our position in the slightest degree.

When we are invited to explain homœopathy we are asked to give what we have never offered to present. If by some mischance we seek to explain, we are soon lost in a maze of illogical verbiage.

It is the part of a wise man to admit to himself that his armour is imperfect when so it is. There are here and there weak points, where he is vulnerable. Given time, however, all repairs may be made good, and the truth affirmed on scientific grounds. Whether or no we live to see it is nothing to the point. A life's work is not judged by what one has accomplished, but by what one has initiated.

Thus, gentlemen, in the spirit of this imperfect paper, I invite all to a closer harmony in our work during the coming session. May *expansiveness* be its keynote, and may we at its close have the satisfaction of knowing that we have accomplished something not by way of wresting truth, but by further submission to its leading.

It is sometimes suggested, either directly or indirectly, that we should do well to sink our differences and join the opposite ranks, for “*after all the difference is merely one of therapeutics.*” To some this argument has already appealed, and done its best, or its worst. It is specious, but it contains

an element of corruption which we may well recognize before taking action. In those who have yielded and left us, I think one finds an element of dissatisfaction in the fruition. In those who have gone through inquisitorial fires and purgation in order to sever their outward connection, surely one finds a note of humiliation, and in those who have held the truth in such light esteem that they have adopted merely a nodding acquaintance with it as a former friend, a touch of insincerity.

But my contention is that until homœopathy *as the greatest medical truth*, though unproven, *be admitted* there is no justice, and without justice there can be no amalgamation, nor can there be any prospect of permanent peace. There would be a mixture but no fusion, a compound only resulting which would require "to be shaken before taken." As the merely superficial dressing of a deep wound violates one of the first canons in surgery, so justice in the present order of things precludes cohesion.

One can no more juggle with *justice* than can the benevolent old gentleman who interferes in a boys' quarrel put the matter right by merely patting the combatants' heads. If he have not the wit or power of self-effacement to get at the root of things, he had better leave them alone.

No, there is no market competent to assess the surrender value of our position, and there cannot be, for it is not marketable. Each man holds his own personal equation of self-respect, and surely few are willing to barter that?

If we hold our hands homœopathy must be "discovered," so to say, by-and-by, and will doubtless be called by another name. Where we come in then will depend entirely upon the generous, or otherwise, impulses of the time.

I do not feel personally much concerned as to the amount of praise and recognition then meted out, but what I am concerned with is that loyalty to so great a cause should abound at the present time.

If we make no protest now against the existing state of things, judgment by-and-by will go by default, and we cannot complain, since our pusillanimity will be alone to blame.

SOME RESEMBLANCES OF DISEASE IN ANIMAL  
AND VEGETABLE TISSUE.

A PRESIDENTIAL ADDRESS.

BY CONRAD THEODORE GREEN, M.R.C.S.ENG.,

L.R.C.P.LOND., F.L.S.

*President of the Liverpool Branch.*

GENTLEMEN,—It is now eleven years since you last did me the honour to elect me to this chair. And now, before I begin my address, allow me to offer you a sincere apology for what I feel is the incompleteness of my treatment of this subject.

I need a couple of years more at least to work it up, and I hope to continue it in the hope that I may possibly add a little to the knowledge of tissue-change in disease.

I refer more especially to what I would term “irritation tissue,” that is, cellular tissue whose structure and mode of growth are profoundly modified by different kinds of irritation applied to it.

I have studied botany as a hobby all my life, but more especially since I began to work at the micro-fungi some ten years ago, I have been struck by the resemblances of disease as occurring in vegetative structures when compared with those we have to treat, viz., those occurring in animal tissue.

At the outset I wish to emphasize the fact that I do not seek to prove identity, but only a suggestive resemblance between diseases attacking these two sorts of living tissue.

I am afraid in many cases you will consider these resemblances highly superficial, but in others the likeness is great.

COMPARISON OF NORMAL STRUCTURE AND FUNCTION.

When we remember that organic tissue, whether animal or vegetative, is built up of cells which subdivide and multiply, it will not surprise us that these tissues, whether



healthy or diseased, often resemble each other in structure and function.

In both kinds of tissue there is the cell filled with protoplasm, without which there is no life. In both there are intercellular spaces filled with fluids containing the elements of nutrition. In both there is an enclosing epidermis, often containing pigment, which serves to protect the tissues within and through which open pores or stomata which provide for the transpiration of gases and water.

In the interior are the skeletal tissues, which afford support to the softer ones, bones in the animal and fibro-vascular bundles in the plant.

Between these two systems are groups of softer cells, highly organized and differentiated to perform various functions.

#### *The Circulation.*

In the animal the lymph channels may be compared with the intercellular spaces in the plant, and the blood-vessels of the former to the nutrient canals that permeate the fibro-vascular bundles of the latter.

Plants, like animals, bleed when cut; they may also bleed when not cut, suggesting a seasonal state of hæmophilia. This occurs chiefly in the spring, when the root pressure is great. It may be measured with a manometer. The sap of the vine raises a column of mercury 804 mm. and that of the nettle 354 mm.

This bleeding ceases when transpiration is well established, as it is when the leaves are fully developed. When a young stem of the rapidly growing hop is broken the sap runs out freely as from a vein.

#### *Sleep.*

Sleep is necessary to both organisms.

The leaves and petals of many plants fold up at night, and in other cases the plane of the leaf is altered from that which it occupied when awake.

The leaves thus affected become more horizontal by day in order to get more sunlight, and they droop when the sun goes down.

Some flowers close at different hours during the day at times which synchronize with the departure of those insects which fertilize them, and possibly to avoid attacks by disadvantageous insects. In some cases the petals fold over the ovary when fertilized and do not open again. This resembles death more than sleep.

In animals we may note that the normal position in sleep is one of partial folding up, or flexion of the limbs and spine.

#### *The Effect of Light.*

The effect of light on both is remarkable : too little light causes the animal to be feeble and anæmic, and, in the dark recesses of the deeper Alpine valleys, leads to cretinism, to a weedy growth of body and mind. The vegetable is also profoundly affected by the stimulus of light ; it, too, becomes pale and anæmic in dark places.

The most refrangible, the red rays, chiefly affect growth ; the blue rays exert a more mechanical force, as in the production of heliotropism, negative or positive, a turning away from or to the direction of the sun. These rays retard undue growth.

Oddly enough, the remedies are much the same, *i.e.*, more light, phosphates, and iron.

#### *Growth.*

Growth in both animal and vegetable is by intussusception—the growth of the individual cell and of cells between those already existing—and is quite different from the “growth” of inorganic bodies like crystals which increase in size by apposition from without.

#### *Respiration.*

Plants, like animals, absorb oxygen from the air, oxidizing a part of their organic substance and giving off  $\text{CO}_2$ . This transpiration of gases occurs through the stomata of the leaves which lead into the intercellular spaces.

One function of the leaves is to absorb carbon, which is elaborated into starch and is stored in the various forms of tuber and root to be used as the plant needs it.

Leaves, then, appear to serve the double office of lungs and liver.

Some diseases, as erysiphe, choke the stomata and so interfere with respiration and nutrition.

### *The Cell.*

The vegetable cell contains protoplasm and often a nucleus, and this, nucleoli.

The entire protoplasm of the mother-cell divides into four or more rounded masses, then four new nuclei appear, around which the protoplasm aggregates to form the four new cells. These are then liberated from the mother-cell. The wall develops around each of the daughter-cells either during or after division.

In malignant disease cells are disorderly in their growth; they do not know when to stop growing—they do not make for the welfare of that aggregation of cells which we call the individual.

So it is with many vegetable irritation tissues, whose growth is chaotic and harmful to the plant. Some animal tumours are restricted from growing freely beyond certain limits by capsules.

Some plant tumours, as insect-galls, show a well-defined outline, beyond which they do not grow. On the other hand, the attacks of some micro-fungi show that the local external signs of the disease are not the whole of the matter, for the microscope reveals the fact that the mycelium of the fungus pervades the tissues far beyond the spots or sori where the spores are developed.

Degeneration of the centre of the diseased part may often be traced in both animal and vegetative tissues. In the case of leaves we first see a paling of the centre of a ring or sorus, as we do in psoriasis. The mycelium of the fungus absorbs and destroys the tissues where it first begins, and then spreads radially.

The diseased parts then blacken and die, and frequently holes or fissures result.

If we do not yet know the entire genesis of malignant disease, we do know that it appears to result from some

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long-continued irritation, such as altered gastric secretion in the case of the stomach, the carious teeth in epithelioma of the tongue, or a blow in determining the incidence of scirrhus of the breast.

Plant irritation tissues are frequently due to the attacks of insects when they puncture the leaves to deposit their eggs, and probably at the same time inject an irritant poison which stimulates the normal cells to a wholly abnormal growth.

In micro-fungous disease it is a little different, for the parasite attracts to itself the nutriment intended for the plant, and grows at the expense of its host.

The disease of various cruciferous plants, as turnips and cabbage, caused by *Plasmodiophora brassicæ*, is remarkable in several ways.

This fungus belongs to the myxomycetes, which differ from other divisions in having their protoplasm free and not being contained by a cell wall. Moreover, these cells, which consist of rounded masses of plasma lying free within the cells of the host-plant, are possessed of amœboid movement.

As growth of the fungus continues, it causes the formation of giant-cells by the distension of the infected ones. This condition reminds one of the plasmodium of malaria, &c., lying within the blood-corpuscles.

This "clubroot" "anbury," "fingers and toes," attacks the roots of turnips, &c., and attracts the nutriment to itself that should go to the plant. It interferes enormously with the proper growth of the vegetable.

### ANIMAL PARASITES IN PLANTS.

Plants, like animals, have their parasites, both animal and vegetable. Certain nodules on turnips that are called "boils" are caused by the turnip weevil. Another animal parasite is called the eelworm, of which there are several species. These form small galls or tumours, sometimes called "cockles" or "purples" when they attack grain. They are also found in the leaves and stems of clover,

and other plants used in agriculture. They thrive in the living portions of plants and extract their juices by means of suckers. They may be as large as  $\frac{1}{8}$  in. in length, and are often found in colonies curled up. This forms one kind of "clover sickness," others being due to several species of micro-fungi.

*Mildew and mould*, which produce appearances similar to some of our skin diseases, are in fact skin diseases of plants. They are loosely applied terms to various genera of micro-fungi which differ much in their anatomy, such as *mucor*, *peronospora*, *erysiphe*, *sphærotheca*, &c. The last two form a white mildew covering the surface of the leaves of very many plants. These and similar genera cause injury by blocking the stomata in the leaves and so interfering with transpiration. The suckers or haustoria of some of these genera absorb the juices of their host to some extent, but their network of hyphæ forms a white matted covering on the surface of the leaf, but does not penetrate the plant tissues as is the case in *peronospora*.

The hop and rose, among other plants, are often quite destroyed by these external mildews.

Other moulds, as *peronospora*, grow their mycelium within the plant tissues, but send out aerial branches, conidiophores, through the stomata. The branches matted together produce the appearance we recognize as mould.

#### *Potato Disease.*

The potato disease in this country is not caused by the Colorado beetle, but by the mildew *Phytophthora infestans*, one of the *peronosporæ*. It causes the leaves to turn black and curl up. Its mycelium spreads through the intercellular spaces and causes rapid decomposition or gangrene wherever it goes. The tubers become soft and quickly rot.

There are several other micro-fungous diseases of the potato, as that caused by *Peziza postuma*, first observed in the West of Ireland in 1880.

This last does not cause putrefaction, but desiccation or dry gangrene.

*Bacteriosis.*

Bacteria cause putrefaction in several plants, notably the onion and tomato.

The *Bacterium allii* is chromogenic, producing a green colour in the infected onion.

One has read of a leper being as white as snow. The micro-fungus *cystopus* produces snow white patches on the stems and leaves of many plants, as the cruciferæ, goatsbeard, and the sea spurrey, which I have found on Hilbre Island.

The bladder-plum or witches plum, caused by *Exoascus pruni*—one of the ascomycetes—is a curiosity in plant diseases. This fungus attacks the young fruit just as it is beginning to swell. The plum goes on growing, but becomes tough and leathery, having a hollow where the stone ought to be. It is of an irregular, more or less flattened shape and has no juice. It is of a dirty greenish brown colour.

The hyphæ or threads of this fungus penetrate among the cells of the fruit and gradually absorb all the nourishment that should feed it.

Indeed, this neoplasm seems to attract to itself an extra amount of food, and therefore produces an extra large tumour, but with a concurrent shrivelling of the normal tissue.

By destroying the bladder-plum you do not destroy the disease that caused it, any more than you can extirpate a cancer by cutting it out and leaving behind the neighbouring glands and lymphatics. The hyphæ of the fungus remain in the twigs and young branches, therefore it is necessary to prune back to the old wood.

Ergot is such an important drug, esteemed highly by those who insist on using the freshly prepared extract, though believed by others of wide experience to be inert, probably because some old alcoholic extract is employed, that I must offer a few remarks upon its life-history.

Ergot is an epidemic parasitic disease, whose spread

is much facilitated by over-crowding. It occurs most freely in cereals and grasses that are grown in crowded colonies and in the same districts every year.

It sporulates in June and July, rather earlier than such epidemic diseases of parasitic origin as enteritis in children, which also is favoured by heat and over-crowding.

Ergot is the name given to the compacted mycelium of *Claviceps purpurea*, which forms in a horn-like manner in the flowers of many of the gramineæ. The upper glutinous part of *Claviceps purpurea*, which is the first sign of the disease in the flower of the grain, is the oidium stage; it is termed sphacelia or gangrene.

Some micro-fungi infect a plant through the flower or leaf, many through the root, working upwards, as seen in the smut of oats, &c.; others in both ways, as ergot. The spores falling on the ground are washed in by rain, and so obtain access to the roots. Other spores are blown about and reach the flower of the rye or other grain.

#### HEREDITARY DISEASE.

There is marked analogy between the animal and vegetable kingdoms, when we consider that most debatable question whether disease is transmissible from parent to offspring.

There has long been a controversy, with able mycologists on either side, as to whether the rust on wheat does or does not owe its origin to the cluster-cups on the barberry. It was argued by the former that if the barberry were exterminated, the rust, *Puccinia rubigo-vera*, would disappear too. The barberry has been nearly exterminated from growing in a wild state, and yet the rust on wheat is not at all lessened.

Mr. W. G. Smith considers the answer to this puzzle is that the mycelium of the rust is perennial, so that infected dead straws and living grains of wheat falling to the ground and remaining there in a "resting" state through the winter would germinate in the following spring.

Many years ago the Rev. Berkeley wrote: "The mycelium of cereal fungi is known to exist from the earliest period in corn"; and further, "a diseased stock can be

scarcely expected to produce a perfectly healthy offspring" ; and " it is certain that the germs of cryptogamic plants may be present in tissues, and yet remain more or less inert."

Is not this similar to the accepted view that we harbour many disease germs which can only multiply to our detriment when our opsonic index falls too low? Have plants also an opsonic index? Much has been learnt since the day of this acute observer, and it is now known not only that the mycelium of many fungi is perennial, but that microscopical examination of apparently healthy seeds has revealed a mycelium inside the integument which surrounds the embryo, and within the coat of the seed.

Dr. M. C. Cooke took seeds from a celery plant infected with *Puccinia apii*, and sowed them in a row adjoining to one of seeds obtained from healthy celery.

The healthy plants remained healthy all the season, but of those plants which came up from the diseased seed, every one became diseased.

I could extend examples and references to the same effect, but have only quoted enough to show that plant diseases may be inherited as some animal diseases are, and that the disease germ or entity goes right back to the ovum or embryo.

In carcinoma and tubercle, nowadays we prefer to say that it is only the tendency to reproduction in the offspring that exists, and not that the disease itself is transmitted from parent to offspring as it is in syphilis.

But perhaps after all there is some greatly attenuated germ hitherto undiscovered, or as undemonstrable as Weissmann's " germ-plasm," that is transmitted through the ovum.

Syphilis in the fourth generation becomes tubercle, we are told. Is not this somewhat after the manner of the alternation of generations, which is well proved to occur in the life-history of many fungi, as in the genus *Puccinia*, to mention only one example where the cluster-cups or æcidiospores of *Puccinia poæ* on the coltsfoot continue their existence first as uredo and then as teleutospores on the meadowgrass *poa* later on in the year?

Dr. Francis Darwin's Presidential Address to the British



Association in Dublin this year is remarkable for his attempt to show that the similarity of animal and vegetable is greater than has hitherto been imagined or accepted.

If I were asked what I thought was the main difference between the two, I should say that animals have a nervous system, but vegetables have none. But Dr. F. Darwin adduces instances which, if accepted, go to show that plants have a kind of elementary nervous system.

He gives examples showing that plants can form habits of doing things in the same sequence from long continuance of the same stimuli, and he then goes on to say: "On the other hand, many will object that even the simplest form of association implies a nervous system. With regard to this objection, it must be remembered that plants have two at least of the qualities characteristic of animals, viz., extreme sensitiveness to certain agencies and the power of transmitting stimuli from one part to another of the plant body. It is true that there is no central nervous system, nothing but a complex system of nuclei; but these have some of the qualities of nerve-cells, while inter-communicating protoplasmic threads may play the part of nerves. Spencer bases the power of association on the fact that every discharge conveyed by a nerve leaves it in a state for conveying a subsequent like discharge with less resistance. Is it not possible that the same thing may be as true of plants as it apparently is of infusoria? . . . There is likely to be another objection to my assumption that a simple form of associated action occurs in plants, viz., that association implies consciousness. It is impossible to prove whether or not plants are conscious, but it is consistent with the doctrine of continuity that in all living things there is something psychic, and if we accept this point of view we must believe that in plants there exists a faint copy of 'what we know as consciousness in ourselves.'"

Since the day of Charles Darwin it has been generally accepted that acquired characters cannot be transmitted to offspring.

Perusal of his son's able address shows that he believes there is ground for thinking that this theory requires modification to-day.

I must confess that my own few studies incline me to the view held by such able heretics as Dr. Francis Darwin, that acquired characters may be transmissible from parent to offspring in both animal and plant.

## WORKS CONSULTED.

- “Botany Morphology.” By W. R. McNab.  
 “Germ-Plasm.” By Auguste Weismann.  
 “Microscopic Fungi.” By Dr. M. C. Cooke.  
 “Diseases of Plants.” By H. Marshall Ward.  
 “Diseases of Field and Garden Crops.” By Worthington G. Smith.  
 “Diseases of Crops and their Remedies.” By Dr. A. B. Griffiths.  
 “Presidential Address to British Association, Dublin, 1908.” By Dr. F. Darwin.

IRRITATION TISSUE: *i.e.*, GROWTHS SET UP BY VARIOUS IRRITATIONS.

ANIMAL.	VEGETABLE.
<i>Tumours.</i>	
Carcinoma, sarcoma of the long bones	{ Eryophies on hawthorn; cintractia on toad flax. Large insect-galls on oak, rose and ash. Galls on stems of hawkweed and bramble. <i>Urocystis viola</i> ; club-root on Cruciferae.
Hyperplasia of normal tissue ...	
Callosities due to pressure ...	{ Callus: overgrowth of bark to repair wounds and fractures of trees. From branches rubbing against each other. Thickened sori on leaves and stems caused by growth of mycelium.
<i>Distortion of Skeletal Tissues.</i>	
Osteomalacia: the bones bend and thicken	Puccinia of stems of nettle and mint, &c.
Acromegaly: bones enlarged at the ends	{ Nodosities on roots of Crucifers due to plasmodiophora. <i>Exoascus pruni</i> on plums.

## DISEASES DUE TO MALNUTRITION.

Anæmia and Chlorosis ...	{ Complete and general, as when plants are grown in the dark or deep shade. Partial, in patches or whole leaves from malnutrition, resulting in insufficient chlorophyll being formed. Local chlorosis due to invasion of mycelium of micro-fungi in leaves, as by Pucciniæ, Uromyces, &c. General chlorosis of whole plant, as in <i>Puccinia suaveolens</i> on thistle, and <i>Cintractia cingens</i> on yellow toad flax, <i>Linaria vulgaris</i> . Chlorosis of stems and leaves from imperfect nutrition, and not from micro-fungi.
Parasitic worms ...	{ Nematoid, or “eelworms” infesting leaves of clover and other crops.

## SKIN DISEASES.

Leucoderma, leucoplakia, albinism		White patches on leaves due to malnutrition, causing insufficient formation of chlorophyll.
Melanosis...	...	Black patches on sycamore, caused by <i>Rhytisma acerina</i> .
Purpura ...	...	Red spots on dock leaves due to insect punctures.
		Red colorations on leaves of strawberry, willow herb, &c., not due to autumn changes.
Jaundice ...	...	Yellow discolorations of leaves, due to malnutrition.
Leprosy ...	...	White thickened patches on stems and leaves of rose, hop, and grasses, due to sphaerotheca; <i>Cystopus candidus</i> on Cruciferae, epichloe on grasses.
		"Club-root" on Crucifers, due to plasmodiophora.
Gangrene	Moist	Bacteriosis of tomatoes and onions; the tubers in potato disease.
	Dry	Leaves in potato disease, due to <i>Phytophthora infestans</i> . <i>Peronospora</i> causes putrefaction in many plants. <i>Sphaerotheca castagnei</i> , by means of its haustoria, drains the juices of the hop, causing the leaves to dry up, but does not invade the tissues of the plant.
Psoriasis ...	...	Fungous infiltration of skin of banana.
Lichen, pityriasis	...	Growth of sori of <i>Coleosporium</i> , &c., on leaves; lichenes on trees
Eczema	Moist	Exudation from broken epidermis as in Coniferae, araucaria
	Dry	Bullae formed over sori of micro-fungi before the epidermis ruptures, as in <i>Protomyces</i> , <i>Uromyces</i> , <i>Puccinia</i>
Eczema rimosum	...	As in the long cracks in grasses, caused by growth of <i>Puccinia</i> , <i>Tilletia</i> .
Ringworm	...	Lichenes on bark, mycelium of micro-fungi, which grows from the centre, causing roundish discoloured patches on leaves.
Acne, miliaria or blackheads	...	Sori of various sizes and colours on leaves, showing where the spores are formed from mycelium within the plant tissues.
Variola, favus	...	Cluster-cups or aecidiospores (yellow) as <i>Puccinia poae</i> on coltsfoot.
Rupia	...	Thickened epidermis, consisting of corky overgrowth, as on birch and elm.
Warts	...	Numerous kinds of small galls (insects) on salix, acer and alnus.
Ulcers	Discrete	Sori of micro-fungi, when the epidermis ruptures, as in the Uredineae.
	Serpiginous	The tracks caused by mining insects within the leaves of honeysuckle, &c.
Boils		Nodular growths on roots of Leguminiferae, caused by nitrifying bacteria.
		Nodules on turnips caused by the turnip weevil.

NASAL OBSTRUCTION IN CHILDREN.<sup>1</sup>

BY JOHN ROBERSON DAY, M.D.LOND.

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

SOME time ago I had the pleasure of bringing to your notice a *rare* disease—scleroderma. This evening I have chosen for my subject a very *common* disease; but common diseases, from the very fact of their commonness, have a special claim on our attention, and although much has been, and is still being, written on nasal obstruction, we have by no means heard the last word.

All the works I have consulted on the subject deal with the surgical treatment, and very little, if anything, is said about the medicinal treatment.

The condition is so widespread, and its consequences so far-reaching, that it is of the first importance to recognize it early and apply the appropriate treatment for its removal.

The more intelligent of the public are becoming alive to this fact and frequently seek advice, but, as a rule, not until matters are well advanced.

But this is by no means always the case. Quite recently in a doctor's family I found two of the younger members with well-marked adenoids and the characteristic voice and facies. The old proverb of the cobbler's children being the worst shod still holds good.

I think it would be no exaggeration to say that over 50 per cent. of the children of to-day suffer from nasal or naso-pharyngeal obstruction to a greater or lesser extent.

S. A. W. Hawley (*Pediatrics*, April, 1905), who examined school-children, found 47 per cent. had adenoids or hypertrophied tonsils, or both. In another school 57 per cent. had adenoids or hypertrophied tonsils, or both; and in another school 52 per cent. had adenoids or hypertrophied tonsils, or both.

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, November 5, 1908.

We are often asked the question, Why do we hear so much about adenoids to-day? I think this question is best answered by asking another: Why do we hear so much about appendicitis to-day? The reply in both cases is, We know more than we did.

It is no new disease we are dealing with; the peculiar intonation of the voice in nasal obstruction was observed by William Makepeace Thackeray so long ago as 1854, when he wrote "The Newcomes." We read that Mr. Moss, of Gandish's Studio, laughed at Mr. Clive Newcome: "Paid five pounds to see that woman! I could have took you *beide* the *seeds* and showed you her for *dothing*."

At this period of history nothing was done for such children, who were allowed to grow up with the condition persisting, the results of which are familiar to us all.

Meyer, of Copenhagen, first called attention to the importance of the pharyngeal tonsil—Luschka's tonsil—which may be regarded as a peripheral lymphatic gland. It is this pharyngeal tonsil which hypertrophies and then constitutes the condition known as adenoids.

Frequently, on looking into such a throat, the pharynx is seen to be studded with lymphoid nodules the size of a mustard-seed or larger. These bodies coexist with adenoids and have the same microscopic structure.

In the naso-pharynx of all children there is a certain amount of adenoid tissue normally present. Enlarged faucial tonsils are frequently present also.

Mayo Collier says: "If by day or by night nasal respiration must be supplemented by oral respiration, then there is nasal or naso-pharyngeal obstruction."

The *causes* of this hypertrophy are not very clear. Many cases are hereditary. In the case of the doctor's children I mentioned, the mother had suffered from adenoids, and evidently had not been treated, because she preserved the peculiar voice.

Poor and neglected children are the chief sufferers, though by no means exclusively so. Moisture favours it, and bad hygienic conditions generally; neglected colds are a most fertile source.

Massie states adenoids are very rare in Italy, where the climate is mild and dry. The acute infectious diseases are favouring causes. Dr. Knyvett Gordon (*Pediatrics*, April, 1906) says: "Post-nasal adenoids grow more rapidly after an attack of scarlet fever or measles, and cause deafness through Eustachian obstruction. They occur in the earliest days of life, and have been removed from a child aged 10 days. They are commonest between 4 years and 12 years, especially between 7 and 10, and are rare after 17.

Mr. James Cantlie says; "Adenoid, nasal and pharyngeal growths have become a factor in disease during the last decade or two. They came in synchronously with artificial foods, feeding-bottles, comforters, early dental decay, and mis-shapen jaws; and I believe some common cause is at the root of all these evils." But what this common cause is he does not say.

During puberty they tend to disappear, when there is a great increase of the naso-pharyngeal space and the air-cells communicating with it.

The consequences of untreated cases of naso-pharyngeal obstruction are so well known and obvious that I need only name them: the vacant expression with open mouth and hanging jaw, the peculiar voice, which is in itself pathognomonic; the constant nasal discharge, anterior and posterior; the deafness and headache, besides the deformities of the upper jaw and palate and the misplaced teeth.

Mr. Arbuthnot Lane (*Guy's Hospital Gazette*, March, 1907), says: "One of the most important factors in determining the form of the bones of the face is passage of air through the naso-pharynx in respiration. Its importance is shown by cases in which it is in abeyance. The amount of air that passes can be almost gauged by the appearance of the individual. In a well-marked case the malar bones do not project normally, and below the eye is a deep hollow continued on to the side of the nose." The mouth is open, the upper lip raised so as to slightly uncover the upper incisor teeth. This is the condition in a position of rest, but when the patient smiles the whole of the upper alveolar

border and gums of the incisors are seen. The teeth in such cases appear to be more liable to decay, and the breath is foul from the dryness of the mouth.

It is interesting to note here that Ziem has experimentally produced in animals deformed jaws by blocking the nares with cotton wool.

The more remote effects are seen in the contracted or pigeon-breasted chest, the frequently caught colds and the general malnutrition induced by these concomitants.

The irritation set up in neighbouring lymphatic glands may cause their enlargement, and in tubercular subjects this is especially liable to occur.

The cervical lymphatic glands may be divided into three sets :—

(1) Those along the hinder border of the sterno-mastoid, which drain the back part of the head and naso-pharynx. It is these which enlarge with adenoids.

(2) Those round the angle of the jaw, draining the tonsils and pharynx.

(3) The submaxillary and submental, which drain the tongue, lips, and jaw. This last group does not enter into our consideration.

With this rapid review of the conditions we must content ourselves.

Bearing in mind that this evening is allotted to the consideration of materia medica and therapeutics, let us turn to the all-important question of treatment.

The old school appear to ignore all treatment other than surgical, as I have already said, and this is resorted to in almost all cases. This thirst for operating received a check at the hands of Sir Felix Semon, who decried this indiscriminate operating.

The operation, as practised is not a cure for the disease. We have all probably seen cases where the disease has recurred a second and even a third time :—

*Case 1.*—Amy K., aged 7, had previously had adenoids removed at the Croydon Hospital when  $3\frac{1}{2}$  years old. She came to me July 8, 1908, with pains in the ears, the left discharging, and had been deaf for two weeks. She was a mouth-breather with the usual

granular pharyngitis. I prescribed iodium 3x and the chin strap. She came again on September 10, greatly improved, the deafness all gone, but with a persisting post-nasal catarrh with yellow mucus. I repeated iodium 3x, and on October 12 changed it for calc. c. 12, as she had headache and perspiration about the head at night.

October 22. Breathing through nose; no headaches; no deafness; no perspiration. Better in every way.

Surgeons who specialize in this department say recurrence is chiefly due to imperfect removal, but we see so many cases which come to us from other Metropolitan hospitals, where we may suppose at least they know how to operate, that the theory of imperfect removal cannot be the cause of recurrence. No! The constitutional state is not altered by the operation—the local removal of the adenoid tissue cannot change this; it is no cure for the disease, and until the constitutional and specific treatment is adopted, these growths will continue to return. You can no more expect to cure adenoids by their removal than tuberculosis by excising tubercular nodules.

Parker advises removal in the following cases:—

(1) Nasal obstruction causing: (a) broken sleep, struggling for breath; (b) anæmia and general debility, nightmare; (c) malnutrition and stunted growth; (d) headaches and poor memory; (e) snoring; (f) enuresis.

(2) Mouth-breathing, with the attendant chronic laryngitis, bronchitis, and croup.

(3) When the adenoids cause: (a) thick nasal speech; (b) inability of infants to suck; (c) frequent colds, or a chronically running nose; (d) deafness; (e) gastric disturbances from swallowing nasal discharge; (f) epistaxis; (g) anosmia.

(4) Where certain reflex symptoms are present, due to adenoids: (a) asthma; (b) hay fever; (c) stammering; (d) epilepsy.

This long list of the consequences of adenoids comprises *all* the symptoms that are met with, and therefore it amounts to saying that whenever adenoids exist they should be removed.



An American writer says the first and great indication for removing adenoids is that they cause nasal obstruction: "It is as unphysiological to breathe through the mouth as to eat and drink through the nose." This is perfectly true, but there are other ways of restoring nasal breathing besides operating, as I shall show later on.

Chronic nasal discharge, which is stated as a reason for operating, is capable of treatment by other means also.

Again, the deafness should be no reason for operating at once before our remedies have been tried.

To relieve the last group of symptoms—asthma, hay fever, epilepsy, &c.—only after medicinal treatment has had a good trial should operation be resorted to.

I find with increasing experience in the treatment of these cases that operative treatment becomes less and less necessary:—

*Case 2.*—Ivy W., aged 5, was brought to me May 25, 1908, for mouth-breathing, restlessness, irritability, otorrhœa, and constipation. Her face was malformed.

The condition was so bad that I ordered the adenoids to be removed, but through some misunderstanding this was not done. Calc. phos. 12 and syphilinum 200 were prescribed, followed by sulph. 12.

In September there was a purulent discharge from the nose, offensive in character, and for this I gave merc. v. 2x. gr. ii., three-hourly.

By September 28 there was a great improvement; nasal discharge had ceased; the earache and otorrhœa gone.

October 29. Keeping mouth closed; sleeping quietly. No earache; no discharge. Bowels act well. Rep. merc. v. 2x and syphilinum 30 weekly.

Moreover, no operation can be regarded as curative unless at the same time the constitutional condition is prescribed for and treatment continued for a considerable time:—

*Case 3.*—Fredk. D., aged 6, was sent to me by Mr. Dudley Wright, who two months previously had removed his adenoids. On June 22, 1908, I saw the patient. He was pale, flat-chested, measuring 21 in. at the xiphoid cartilage, with a catarrhal condition of the nose and throat and a cough. Ant. crud. 12 was

ordered and the chin strap. On July 6 I added weekly doses of tuberc. 30. In September he was able to breath continuously through his nose, although there was still post-nasal catarrh with yellow mucus. For this I gave iodium 3x. Breathing exercises were given more or less regularly, and by October he was breathing well and had lost his cough entirely.

The *immediate* effects of the operation are often so beneficial that parents are apt to think a cure has been effected. It is always important to bear this in mind and give the warning, otherwise the condition will relapse.

I should therefore be inclined to very greatly diminish the list of cases requiring operation and restrict them to the following :—

(1) Where there is absolute nasal obstruction which has resisted medicinal treatment continued for a reasonable time.

(2) Where there is much nasal obstruction associated with enlarged tonsils and deformity of the chest.

(3) Where there is associated with the obstruction deafness and otorrhœa.

In a learned paper in three sections published in the *Edinburgh Medical Journal* for 1897, no medical treatment whatever is advised.

Wingrave says: "With regard to *medicinal* treatment, this is unfortunately often viewed by parents as a substitute for operative measures and should therefore be approached with caution; as far as adenoids themselves are concerned, it has not afforded any very satisfactory or reliable results."

This is the kind of teaching which has led to such frequent operating. Patients often come to me having been told nothing but an operation would do any good.

*Case 4.*—Marie B., aged 7, brought to me by her mother because she had been told the child had adenoids and required an operation to cure her.

This was February 15, 1908.

I found no nasal obstruction, and nothing amiss except a granular pharyngitis. She complained of occasional tenderness in her ears and a pain on blowing her nose, for which I prescribed calc. phos. 12, promising a cure without operation.

She continued to come to see me till May 13, when she was quite well.

Having, therefore, decided to employ medicinal means, there are certain points which call for consideration. The constitutional state, or diathesis, is all-important. This may be well marked at first, or only reveal itself during the course of treatment.

The tubercular diathesis is the most frequent of all, affecting all classes of society. It is here we find *tuberculinum* of such signal service in the 30 or 200 dilution, given, as a rule, at weekly intervals.

Congenital syphilis is a widely prevalent disease, and in the form of snuffles, so often seen in infants, leads to mouth-breathing and favours the growth of adenoids. Snuffles should thus be promptly treated with some preparation of mercurius. I usually prefer the merc. vivus. 2x ; at the same time the nosode *sypphilinum* (200 or 30) in weekly doses, as we give tuberculinum, has a marked effect. Here, again, recent investigations confirm our clinical experience, as they have done in the case of the tubercle bacillus.

The spirochætæ, which are pathognomonic of syphilis, simply swarm in these children. About 300 or more papers upon the subject have been collected, analysed, and summarized by W. Fischer in the *Berlin Klin. Woch.* for 1907, and one of the most remarkable things about the organism seems to be the way in which it abounds in the tissues of congenitally syphilitic infants. It has been found in almost all the viscera of such children, as well as in the bronchi, the bile-ducts, and even the urine. The infantile organs may appear perfectly healthy to the naked eye, and yet teem with the spirochætæ when examined microscopically. As a test for congenital syphilis this seems to be the most valuable and certain that we have. Case 5 illustrates this:—

*Case 5.*—Albert W., aged 10 weeks, came September 17, 1908, with absolute nasal obstruction. Purulent discharge from the nose and inability to suck. When sucking he had to stop to take breath and would cough and vomit. He had snuffled at birth, but was otherwise healthy. I prescribed merc. v. 2x, gr. i. two hourly.

In a week's time he could breathe through his nose, and I now ordered a chin strap; and as the bowels were relaxed, merc. v. 3x, which was continued till October 9, when he was breathing well through his nose, though still snuffing. I now ordered merc. cor. 3x and syphilinum 200 weekly.

The dangers of streptococcal infection in cases of snuffles are very real, and Paul Gaston has pointed out that bronchopneumonia, diarrhoea and vomiting, and marasmus are often caused by streptococci and their toxins.

Rhachitis, another widely prevalent disease, is often present with its characteristic indications—sweating about the head during sleep, kicking off the bedclothes, delayed dentition, &c. *Calcarea* 12 has a simply marvellous effect with these children. Besides the pathogenesis of calcarea, which so closely corresponds to the symptoms found in rickets, there are special nasal symptoms—ulcerated and scabby nostrils, epistaxis, obstruction of the nose by yellowish foetid pus, coryza excessive and fluent. *Silica*, which appears to act in a complementary way, filling up what calcarea has left out in the treatment of rickets, has also special nose symptoms—epistaxis, anosmia, fluent coryza, acrid and corrosive mucus in the nose. How we are reminded of the adenoid condition by these symptoms, and the picture is made more complete when we get the boring and throbbing in the ears, shootings in the ears from within outwards, and otorrhoea.

These local symptoms, together with the general constitutional symptoms, make *silica* a particularly valuable remedy in these conditions, and clinical experience fully confirms this; hence a course of silica 12 or 30 follows calcarea well.

Rickets and congenital syphilis may coexist, as is often the case, when the symptoms which are in the ascendancy call for the most clearly indicated remedy.

*Iodium* is frequently called for; it has in its provings deafness from Eustachian catarrh, inflamed tonsils, roaring in the ears, stoppage of the nose, fluent coryza, yellow mucus from the nose, increased watery saliva, burning in the fauces, swelling and elongation of the uvula. There is also dry

cough; child grasps the throat with the hand; agitated, restless sleep, with vivid and anxious dreams; nocturnal sweat.

These symptoms, which are so frequently met with in post-nasal growths, I have seen yield to iodium 3x. On looking into the throat there is a glistening semi-translucent state of the mucous membranes, a granular pharyngitis, the mouth is watery, secreting too much saliva, and abundant mucus.

These last symptoms also suggest *antim. crud.*, a remedy specially suited to infants and children. Besides suiting the local condition, it is also a scrofulous medicine.

In the pathogenesis we find otorrhœa and deafness, roaring in the ears, excoriation of the nostrils and corners of the nose, stoppage of the nose, accumulation of thick yellow mucus in the nostrils. It is a medicine of great value in such conditions, the special indication being the white, coated tongue and watery mouth :—

*Case 6.*—Kenneth D., aged 8½, a persistent mouth-breather with characteristic speech. When 3 years old had an abscess in the ear. His sister is tubercular. The cervical glands are hypertrophied and pharynx granular.

March 28, 1908. I prescribed calc. phos. 12, hydrastis spray and the chin strap.

June 13. Still post-nasal catarrh and gummy saliva, which pointed to antim. crud. 12. This greatly benefited.

On July 17 I prescribed iodium 3x, and repeated the hydrastis spray.

September 3. I saw him last, when he was breathing naturally, keeping his mouth closed, even at night, and no longer needed the chin strap.

*Pulsatilla* is most useful in those cases of Eustachian catarrh of recent origin following an attack of measles. It has many ear, nose and throat symptoms, and has a profound action on the mucous membranes :—

*Case 7.*—Edith M., aged 5, came November 28, 1907, with follicular tonsillitis, snoring, mouth-breathing, and a cough; she also had earache and was deaf, all these being frequent concomitants. I prescribed pulsat. 3x, and subsequently calc. c. 12.

In July, 1908, she had a course of iodine 3x, followed by ant. crud. 12.

On October 12 there was marked improvement, mouth closed and no snoring. The original symptoms with which she came had completely disappeared.

*Calcarea phosphorica* is a constitutional remedy of great value. I find I prescribed it for nearly all the cases at one time or another. In the pathogenesis there are the special nose symptoms: coryza, swollen nose, with sore nostrils in scrofulous children. Blood follows when the nose is blown.

It suits the thin, flabby child, whereas calc. carb. suits the fat child.

There are besides these medicines many others which occasionally are of signal service—such as merc. sol., nitric acid, arsenicum and sulphur—and their appropriate indications will at once occur to you.

In the treatment of these cases the heartiest co-operation on the part of the mother or nurse is necessary. It is useless to prescribe unless every detail in treatment can be attended to, and this brings me to a consideration of the local and mechanical measures, which are of the utmost importance.

Parents require to be taught that the *nose* is meant to breathe through and the mouth should always be kept closed.

When an infant is asleep the mouth should always be closed. If this is not the case, there is probably some nasal obstruction. The trouble usually starts with a nasal catarrh. The mucous membranes of the nasal passages are exceedingly sensitive to catarrh, and coryza is one of the commonest affections of childhood. For this reason it is thought nothing of, and consequently neglected. Parents should be warned of this, and the harmful consequences of neglecting a simple cold in the head pointed out. If a catarrh has started the patient should be kept in a well-ventilated room of a uniform temperature of 65° F., and acon. 3 given in the early stage, followed by arsen. 3 for the fluent coryza.

Should the nasal passages become blocked, anointing the nose externally with glycerine or some simple ointment, and then fomenting with hot water, will do much to relieve the

obstruction. The child should then be taught to blow the nose, one nostril being closed, so that the full force is expended on the one open nostril.

A *warm* spray of hydrastis is very helpful for this purpose (10 drops to ʒi.). When the nasal passages have in this way been cleared so that nasal respiration is possible, the chin strap should be applied. This is a simple elastic support, which serves to close the mouth; it is a perfectly safe appliance and is always worn at night, and, in bad cases of persistent mouth-breathing, in the daytime as well, till the pernicious habit has been broken.<sup>1</sup>

Too much importance cannot be placed upon this necessity for insisting on closing the mouth and breathing through the nose. This is the true preventive treatment for adenoids.

I know a school where the first exercise is what is termed "handkerchief drill." The children are made to stand in line and blow their noses, each nostril receiving separate attention as I have indicated. It is most effectual; each child tries to make the loudest noise and with the best results. This operation should always precede the breathing exercises, which form part of the treatment in all cases. All children are benefited by breathing exercises, and some have to be taught how to breathe through the nose—a method that seems never to have been adopted. This deep breathing should, if possible, be practised in the open air, and the sea air is especially beneficial in these cases. The salt in the air has a very good effect on the mucous membranes, checking catarrh, besides improving the appetite. These matters may appear to some of you as unnecessary details, but, believe me, it is only by attention to such details that successful treatment will be assured.

Since writing the above, a medical friend, not knowing the subject I had already selected for this evening's paper, was drawing my attention to the need there was for stating what homœopathy can do in the treatment of adenoids; this has been my object, and I trust, in the discussion which is

<sup>1</sup> The chin strap can be obtained from Meyer and Meltzer, 71, Great Portland Street, W.

remedy—and phosphoric acid was another very important sycotic remedy. *Calcareo phosphorica* very well seconded *Thuja* in many cases. He quite agreed with Dr. Day that many of the cases were syphilitic, and in such cases *Syphilinum* was an excellent remedy, also a *Syco-syphilinum*, which he thought was the real nature of Burnett's "glinicum." It was one of Burnett's nosodes which he considered to be a gonorrhœal remedy, but he (Dr. Clarke) thought from not only Burnett's, but his own uses of it, that it was really a *Syco-syphilinum* that it contained both the syphilitic and the gonorrhœal taint, and well met many such cases, as also did *Medorrhinum*.

Dr. WYNNE THOMAS enquired whether Dr. Day had noticed that adenoids were more prevalent among bottle-fed children than children brought up on the breast. He had never yet seen a teat connected with a bottle which in any way resembled the normal nipple of the mother. Teats and comforters seemed to be much too long, *i.e.*, the bulbous part was at least one inch or more inside the mouth. That pressed up the soft palate and the back of the hard palate into that part of the nasal cavity where the obstruction occurred, and it seemed to him that the use of comforters and teats of that description might be a contributory cause to the trouble which afterwards ensued. He thought there was room for a teat to be invented which would be more of the nature of the mother's nipple, which should only go a short way inside the mouth.

Dr. ALEXANDER (Southsea) stated that he had come to the meeting because he was specially interested in the subject of the paper. He noticed that in the outline of the paper reference was made to the use of local applications. He had for a good many years been searching for some such treatment, and several very valuable suggestions had been made during the evening which would be most useful in supplementing the ordinary medicinal treatment. As Drs. Jagielski and Clarke had remarked, *Thuja* was a very excellent remedy. Personally, he strongly recommended the use of sea-water. Living, as he did, at the seaside, he was a very great exponent of the benefits of sea-bathing, and he usually enforced as much as possible the great advantage of using inhalations of sea-water for the treatment of the disease. He at once pleaded guilty to being an exponent of operative methods for the treatment of the trouble. His plan had usually been in every case that came under his notice to commence with medicinal treatment, treating the patient from the point of view of the diathesis, and also the more special local symptoms. The prin-



cial drug he had prescribed was *calcareo phosphorica*. Curative effects were sometimes obtained from that treatment, but there were a great many cases where medicine completely failed. In such cases he always operated, especially where deafness was a prominent symptom. When he first began to operate, he had obtained recurrences, but latterly, from improved methods and increasing experience, he might say he never had a recurrence. He always began with constitutional treatment, and after operation he invariably continued the medicinal treatment. No doubt that was a very great factor in the non-recurrence of the disease, but it was necessary to emphasise the completeness with which the operation was performed. At first he used the ring instrument, but he now invariably employed the forceps, and with that instrument it was possible to completely clear out the adenoid growths. He was very glad to have had his attention again directed to the chin strap. He had himself used it, but after the demonstration just witnessed he thought most present would invariably fall back upon it in future as an additional aid to other methods of treatment.

Dr. EADIE thought that operative interference had been rather discredited in the paper; but in his student days at the London Hospital he had been particularly struck with the remarkable effect obtained from nothing but operative treatment in such cases. Of all operations he had ever seen, he thought this was the one from which the greatest benefit was obtained after the obstruction was removed. The child's condition immediately improved without the use of any medicine at all. Recurrence might, he thought, be prevented by proper and judicious treatment; and with improved methods fewer cases were obtained. Especially with the poorer class of patients, he thought it was not a bit of good going in for the exercises which had been demonstrated. The best thing was to clear out the nasal obstruction right away, so that patients could get into the lungs the fresh air they wanted, and then to treat them medicinally afterwards.

Dr. REED HILL referred to the fact that in one of the medical papers a little while ago a statement was made that a practitioner had a certain number of patients suffering from adenoids and enlarged tonsils in a particular street. So many of them slept with the windows closed and so many with the windows open. Those that slept with the windows closed did not have adenoids, and those that slept with the windows open had adenoids. Was that cause and effect? He did not see any answer to that question in the medical journal! With regard to the question of recurrence,

it seemed to him that if the operation was performed in the autumn recurrence was more frequent than if it was done in the spring or early summer, and it would be interesting to know whether that had been sufficiently taken into account in considering the number of recurrences that happened. A patient of his, a lady about 28, had enlarged tonsils and adenoids to a smaller extent. For several winters she had suffered from sore throat—so much so that one autumn he proposed she should seek further advice with reference to the removal of the tonsils and adenoids. The surgeon advised that the operation should not be done in the autumn, but should be left to the spring. Unfortunately for his (Dr. Hill's) credit he did not put the patient on any medicines, but simply sent her away to three or four different places during the winter. In the spring and ever since no operation had been required!

Dr. VINCENT GREEN noticed that Dr. Day had entitled his paper "Naso-pharyngeal Obstruction," but he had made no reference to the commonest form of nasal obstruction—namely, obstruction in the nasal cavity. A great many such cases were seen in the out-patient department of the hospital; hardly a Saturday passed without a patient being sent for removal of adenoids, where on examination it was found there were no adenoids at all, the trouble being due to enlarged turbinates within the nose. He read a paper before the Society some three or four years ago in which he tried to show that recurrence was not due to improper removal, but neglect in after-treatment. Adenoid or lymphoid tissue was normally present in the mucosa of the pharyngeal vault, and in a healthy child would increase if irritated. A young child was very fond of crawling about on the floor, banging its hands on the dusty carpet; consequently, the mucus which tended to collect in the vault owing to back eddying of the respiratory current soon became loaded with germs. As a result of this irritation the adenoid tissue began to proliferate, and in due course would fill up the naso-pharynx by its hypertrophy. Only the redundant adenoid tissue was removed, so that if the child was allowed to go on breathing through the mouth and to crawl about on the dusty carpet, so surely would the adenoids recur unless the child had reached the age of puberty, when the adenoid tissue was no longer needed in the economy. So that the recurrence of adenoids was due to the after-treatment of the case being neglected, and not to the imperfect removal as suggested to-night. That at any rate was his experience, which extended over 3,000 operations. The question had been raised when should adenoids

be removed by operation and when not. That all depended upon whether the child could breathe through the nose or not. If the child could breathe through the nose, the practitioner was justified in trying remedies, and there homœopathy scored very considerably. But if the child could not breathe through the nose, then he did not think one was justified in risking loss of hearing, the improper development of the nasal cavities, and general deterioration of the patient in order to try and get rid of the trouble by medicinal means when operation was so safe, certain, and prompt. He differed very much from Dr. Day's suggestion that the chin strap was a remedy for adenoids. It was only of use after the adenoids had been removed to prevent them recurring, *i.e.*, to assist the child overcoming a bad habit. It was for that he had devised the chin strap some five years ago. To put a chin strap on a child who had adenoids was as if the mother had said, "Doctor, my child cannot breathe through the nose," and the doctor replied, "Very well, make him wear this chin strap; that will prevent him breathing through his mouth." His colleague in the Physical Exercise Department, Dr. Deane, was very strong on that point, contending that it was absolutely harmful for a child who could not breathe freely through the nose to be put through physical exercises, the mouth being shut to make the child breathe through the nose. One of the exercises given in the course of the demonstration was, he thought, very harmful, where the child's hands were placed at the back so as to expand the chest, the child being told to expire a breath. The child's chest was then in a position of expansion, and if the chest was kept in that position and the child was made to expire a breath something had to fill up the cavity. Probably the right auricle would dilate. With regard to the question of remedies, he was very interested in Drs. Jagielski and Clarke's suggestions with regard to thuja. Personally he had never tried it. He had obtained his best results with iodine. He had lately been using a nosode. From an apparently healthy child with an excellent family history he removed a piece of adenoid tissue, and had a trituration made of it up to 3. He had only given it in one case, with seemingly excellent results. He was now trying it in others. In the treatment of fluid coryza there was nothing more effective than a pinch of common salt as a snuff. In ordinary coryzas he had found nothing to equal kali-iod and arsenicum. With regard to the diathesis, if there was one thing more than another that had struck him in the cases, it was the healthy children that were troubled with adenoids. That fitted in with his theory that

adenoids were the result of the healthy reaction of normal adenoid tissue to external irritants—that was to say, the lymphoid tissue of the thin, scrawny syphilitic type of child had not the power to react to the irritant in the naso-pharynx. Dr. Day was, he knew, a great believer in the tuberculous origin of adenoids. He totally disagreed with him in that contention—so many healthy children in his private practice had had adenoids who he was perfectly certain had no personal or family history of tubercle, and, as a general rule, in the out-patient department of a hospital it was the exception rather than the rule to find a child with adenoids who also had enlarged glands or other symptoms of scrofula, which, if Dr. Day's theory was the correct one, should be the rule rather than the very rare exception.

Dr. ROBERSON DAY, in reply, thanked the members and also Mr. Goethe, who had given an interesting demonstration. Some of the remedies suggested he had never used. He had used thuja in high potency—the 30th—but never in the mother tincture, which he would certainly try. The medorrhinum and other nosodes he had not yet used, but he would certainly bear them in mind. He thought the general question of nasal obstruction could be summed up as follows: If the nose were disused as an organ for respiration it ceased to develop. Therefore, owing to the mouth-breathing habit being acquired and practised, the nose and the nasal passages remained infantile in form. The jaw developed, but the roof of the palate remained high; and in the pictures he had placed on the table the serious deformities could be seen which resulted from persistent mouth-breathing. He had used sea-water in the form of a spray, and he believed that children living at the seaside were very much less liable to adenoids. The salt in the air seemed to be so beneficial to the mucous membrane that if children were sent to the seaside they had less catarrh. Dr. Green claimed to have invented the chin strap, but perhaps it was an independent discovery on his (Dr. Day's) part also. The chin strap was most beneficial in the case of persistent mouth-breathers. If they were made to use it constantly for a week or two, it did much towards helping the treatment. Of course, where there was no aperture through the nose, he did not mean to say the child could be left without operation for any length of time; and a similar remark applied to the breathing exercises that had been mentioned. When there was a narrow passage through the nose, it ought to be enlarged by exercises, and the mouth should be closed. Dr. Green suggested that mainly healthy children suffered from adenoids; this was not his

experience and at the hospital. In private practice, of course, healthy children were liable to suffer also, but he was sure adenoids abounded among the poor owing to bad hygienic conditions and neglected nasal catarrhs, where the damp climate and causes of that kind were at work.

## MEDICAL EDUCATION : A COMPROMISE.<sup>1</sup>

BY CHARLES W. HAYWARD, M.D., C.M., D.P.H., M.R.C.S., L.R.C.P.  
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THE question of "education" being so much in evidence at the present time and the hope of some satisfactory and honourable "compromise" cherished by all true friends of real educational progress, are strong reasons for the desire that the rational carrying out of such a commendable cause shall not be wrecked by any *odium theologicum*, a condition of mind which almost nullifies its own "religious" origin.

It is because the writer of this paper fears that in any future developments in medical education an undesirable obstacle may be raised in the shape of *odium medicum*, that he desires to consider the question this evening.

And, firstly, let us clearly understand our position. What is homœopathy? And what is a homœopath? Homœopathy is nothing more and nothing less than a law or, as opponents would say, a theory of drug action; and a homœopath is one who believes in and adopts this law or theory.

All the difficulties under which we as a sect suffer, and most of the *odium medicum* from which some of us, with our friends the enemy, suffer, are due to a shallow and unreasoning view of the true position. Homœopathy, as such, does not in the least affect the many other branches of the healing art. The truth of the principle of homœopathy has rightly no more to do with surgery than the truth of transubstantiation has to do with the multiplication table. Whether the doctrine of homœopathy be right or wrong, it has no more control over drainage and other sanitary precautions

<sup>1</sup> Presented to the Liverpool Branch, November 12, 1908.

for the public health than a theological doctrine has over the *pons asinorum* or other problem of Euclid.

Regarded from the view of a complete medical education, homœopathy ranks as a therapeutic speciality, which develops its own proper and limited sphere to the highest position yet attainable; but in itself it is not a medical education or equipment. The term "homœopath" when applied to a medical man does not describe him accurately, except in the case of a pure physician, who never goes outside the one limited department of drug-prescribing. To describe a general practitioner as a "homœopath" may be right so far as it goes, but it is no more truly correct than it would be to describe an engineer as a "hammerer." Both terms are the truth, but they are not the whole truth—they belong to that most dangerous class of statements known as "partial truths," which in many cases are more prolific of evil than actual lies. And it is this false description, and the silly, unreasoning acceptance of it without question, that are responsible for most of the professional disabilities under which we as homœopaths suffer.

I fear it is a fact that the false opinion of what the description "homœopath" really signified was due in great measure to the unwise method in which the doctrine was promulgated. I am willing to put the most charitable construction upon the facts, and to allow that it was over-zealous enthusiasm—perhaps goaded by some measure of inappreciation or persecution—which caused the earliest homœopathic medical men to take up an attitude which quite justified the opposition, though it should not have stifled the reason, of the remainder of the profession. They appeared to claim that homœopathy was the first and only truth, and gave ground for the assumption that other knowledge outside this law was unnecessary in medical practice. In so far as they did this, the opposition and ostracism of the profession were not only justified, but meritorious. Of course, as unfortunately happens in all human societies, when once opposition and hatred were wakened, untruth and exaggeration took the places of truth and enquiry. This caused an opinion to become widespread that "homœopaths" practised nothing

else than drug-prescribing in a peculiar manner, and that they knew nothing outside this one department. Although this silly and spiteful mistake has now been banished from the mind of the profession, I think it may still be found to linger amongst some of the lesser informed public. I myself have met it when, on being sent for to a case in the country, I found that the friends of the patient were of opinion that "homœopathic doctors" were not qualified like those of the other branch of the profession.

This wrong estimate of our capabilities has acted against us very materially, and it has taken 100 years for its final refutation. I believe that originally there was some ground, some untenable claim asserted, which invited the gross and spiteful exaggeration of the profession, and that although unfair exaggeration was altogether due to opponents, they did not invent the central idea upon which they founded their superstructure.

If at the first, through undue enthusiasm, any medical man claimed the practical omnipotence of homœopathy, then the rest of the profession were perfectly justified in saying that as a "general practitioner" he was not qualified. And if there are to-day any medical men who are so obsessed with homœopathy as to deny the necessity or advantage of surgery and all other extra-therapeutic aids, then I maintain that such men are not qualified to carry on general practice. They are positive dangers to the public, and some means should be devised to prevent them undertaking to treat cases outside their speciality. I would seek and value their opinion as to the selection of a drug in any case, but I would strenuously oppose the trusting of my own case, or that of any of my family or patients to their care, until I had obtained details sufficient to assure me that no benefit could be obtained in that case from any of the other developments of science as applied to the art of healing the sick. I would as soon think of trusting a case of pneumonia to a qualified dentist as I would of trusting such a fanatical homœopath with a case of hernia, calculus, or abscess.

In my opinion, the ideal medical man is one who has kept right abreast of all the latest developments of

all the sciences which can be of assistance in either curing or ameliorating the condition of the sick, and who knows, and has watched, the action of drugs upon the human subject, both—and I especially call your attention to this word “both”—in what are described as “physiological doses” and their direct action, and in infra-physiological doses and their curative action when selected upon the law, *similia similibus curentur*.

The practice of medicine has now grown to such vast proportions, and collected such valuable aids from so many different sciences, that I doubt if it be possible for any one man to keep up with it all round. The man in the best position is the one latest from the great universities, where everything of value can be collected for examination; but in a short time science so advances, and no man in practice can possibly keep up with every ramification. He must in greater or lesser degree specialize and select some branch to keep up with. If he be a “general practitioner,” if he be one of that fortunate minority who can be honest with themselves, he will recognize from time to time that, if he desires to preserve his own self-respect, he must acknowledge that cases do arise in which he would not be acting fairly to the patient if he did not seek the advice of some specialist who had developed one branch of knowledge further than he had been able to do. The safest doctor is one who honestly recognizes his own limitations and who candidly accepts their restrictions. Maintaining, as I do, that homœopathy is only a speciality, I do not consider that a homœopathic medical school is any more complete or desirable than a present-day medical school. The former would be incomplete unless the material action of drugs is taught theoretically and watched clinically. The latter is incomplete in that the more valuable action of drugs when selected on the rule of similars and given in non-physiological doses, is neglected.

I do not believe in the multiplication of schools, and I hope that until strenuous attempts at compromise on the lines advocated above have been made, and have failed, I shall never see the establishment of a homœopathic medical



school in England. We have nothing that we can teach better than the present large schools have excepting the theory and clinical application of the law of similars as applied to drug action. As a restricted body we have not the large funds necessary to fully equip and maintain a medical school in all departments, and we should better serve our generation if we applied every penny of what funds we raise to the teaching of the homœopathic action of drugs alone. It would be pure waste of money and effort to enter into competition with the universities in all those subjects in which we do not differ at all from them. I am of opinion that much better value for the money expended is obtained in all forms of education by having as few schools as the distribution of the population will permit, having these schools thoroughly equipped, including facilities which it would be impossible to duplicate indefinitely in many establishments. The staff and classes in these schools should be so proportioned that individual attention is possible. In this way maintenance charges would be reduced to the lowest possible proportion of the total expenditure, a greater sense of educational fellowship would be developed, and further advances rendered easier.

I think that all our efforts should be directed at the present time to seeking to come to an honourable understanding with the universities and large medical schools. I would far rather see an arrangement by which one or more wards in one of the present teaching hospitals could be utilized for the treatment of cases by homœopathic prescribing, under the direction of a competent homœopathic medical man, than I would see the establishment of a fully equipped small medical school managed entirely by our branch of the profession, or the establishment of any number of homœopathic hospitals up and down the country. I think that we should utilize the funds which are subscribed for the advancement of homœopathy in maintaining a ward or wards in one of the large teaching hospitals, and providing therein clinical material under the supervision of some of our own body. Of course, many of you will consider this idea worthless, and perhaps even silly; but I believe that if we could

go to the present medical schools and offer out of our funds subscriptions which would relieve them of the cost of part of their hospitals, one or more of them might accept the offer ; and even if they would not do so at present, public opinion would need little more enlightenment and direction towards this end to compel them to compromise with us. Such a development is far more likely of attainment than the establishment of a complete school, and would be of far more benefit to homœopathy itself, and to the advancement of its beneficent influence amongst the general profession.

All our efforts should be directed towards this end. The offers should be made and renewed, whilst at the same time we should so train and direct the pressure of public opinion that it will at the earliest possible time enforce the acceptance of the offer. Then only, will medical education be complete and our position justified.

Here is the true direction in which the British Homœopathic Association can be of real service. With the funds at their disposal, let them make a public and carefully considered offer to one or more of the recognized schools to take over some of their wards. It will, no doubt, be refused at first. Then with this fair offer as an object-lesson, let them agitate public opinion. Many of our own body are also subscribers to allopathic hospitals, and it should not be impossible to influence them and other reasonable members of the public to withdraw their support from these allopathic hospitals unless they acceded to such a fair, and to them, costless offer.

What should be our policy in the meantime ? We must maintain our own hospitals in the greatest state of efficiency possible. I much regret the waste of funds which this entails.

Homœopathic hospitals should really be devoted entirely to such cases as the homœopathic drug action can benefit. They ought to be hospitals for this speciality, and could the compromise be carried out, then every penny of the funds subscribed for homœopathy could be expended towards increasing its usefulness. Two difficulties prohibit this under present conditions. The more important condition is that few cases can be entirely circumscribed by any

speciality—even homœopathy—and therefore it is necessary—but only for so long as we must continue to have separate hospitals—to provide facilities for the extra-homœopathic treatment which may be required. The other condition is that, as at present any medical man who believes in the law of similars in therapeutics is prevented from developing his experience of other specialities in ordinary hospitals, it is only fair that the public, which benefits by his adhesion to the speciality which benefits them and ostracizes him, should, even at an unavoidably uneconomical expenditure, provide him with some of the facilities which the rest of the profession enjoy in the other hospitals, and thus allow him to develop his knowledge and add contributions to the general stock of medical advance in all departments.

While maintaining our present hospitals, and doing the best possible work in them, we ought only to regard them as temporary necessities, and never cease to help forward any tendency to compromise with the rest of the profession, so that not only may waste of funds be limited, but that the general profession may obtain the benefit of being able to watch the greater success of medication when carried out according to the law of similars in wards of the general hospitals. Also that the members of the homœopathic body might reap the advantage of enjoying the facilities provided in these larger hospitals, and the fact of becoming eligible for any other post upon their staffs outside the homœopathic speciality, according to their choice of such other special study, whether surgical, electrical, or other branch.

In the account of the October meeting of the British Homœopathic Society I read: “Professor Packard is of opinion that a complete fusion of the two schools is sure to take place, and that at no distant date.” This is the most cheering news I have heard; and although they have fully equipped schools in America—homœopathic colleges enjoying the same advantages, providing the same extra-homœopathic facilities as other colleges, and as complete in every way for the general training of students, I shall have greater confidence in the graduates from a combined school, after the fusion has taken place, than I at present have in a graduate of any homœopathic college.

I do not consider that a man is fully and honestly equipped for the best service of suffering humanity, even should he know every symptom of every drug on the homœopathic plan, unless he also possesses—and uses—knowledge, and the fullest possible knowledge, of the tonic, sedative, stimulative and other actions of drugs when given in larger doses and not on the homœopathic rule. The man who does not know, or will not use, as occasion may invite, laxatives, tonics, sedatives and other means of relief to his patient at the earliest possible moment, is not honestly carrying out his contract with that patient, as either through ignorance or wilfulness, he is keeping that patient in a condition of danger or pain because he will not use means which appear to clash with his adopted view. It is no denial of the truth of homœopathy to use drugs for their non-homœopathic effects. Occasions may arise when a physiological dose would afford the quicker relief, and in such cases it is our duty at once to use such means.

I am aware that my advocacy of compromise is likely to receive rough treatment at the hands of many of our body. Some will consider it Utopian, and dismiss it with the remark that it might be good, but it is impossible. To these I reply that the impossible of to-day is the commonplace of to-morrow, and what Dr. Packard is assured will occur in America at an early date, should not be impossible in the near future, even in old-fashioned England.

In others—and I think mainly the older members of our body—my suggestion may wake their old sense of wrong and injustice, and they will ask for “no compromise” unless the enemy humbly supplicate for it. I ask these if it is politic to allow a sentimental remembrance of past wrong at the hands of the last, not the present, generation of medical men, to block the way to such a desirable consummation. As well expect the Established Church to come in sackcloth and ashes to the Nonconformists. Their ancient injustices to this body were more bitter, and less religious, than the *odium medicum*. The best substitute for ancient strife is present co-operation. And a third class, composed of those who have done strenuous and good work in our

hospitals, but who have adopted a "forward" and "pushful" attitude, will howl at my suggestion, hurling at it epithets of "cowardice" or "surrender." I shall not in the least be perturbed by their denunciations. I would simply point out to them that whenever it may be possible to accomplish any advance by honourable and peaceful means, thus saving the waste of money necessitated by hostilities, and quietening the brutal passions of strife, the man who refuses to follow the peaceful path and who, with a ludicrous assumption of valour, "mounts the ramparts" waving a flag and braying, is not acting as a statesman nor as a hero, but foolishly.

If the same or better objects can be attained by peaceful means, then the bottom is knocked out of the argument for aggressiveness, and violence becomes merely an advertisement of more or less ill-founded claims for personal glory.

We as homœopaths have only one principle to guard. So long as we are at perfect liberty to prescribe drugs upon the law or rule, *similia similibus curentur*, without any consequent deprivation of honours or rights, we maintain our principles unstained. That is the utmost that any honourable man needs or desires.

I maintain that our principle would be of greater benefit to mankind if, by compromise, we could work with the rest of the profession.

At present we have our one talent of money, which we cannot utilize to the best advantage. We have our leaven which should mix with and leaven the whole medical profession. This beneficent action is at present rendered impossible by confining it to our own measures of dough, with the result that the "medical bread" served out by the general profession is still rather sodden. Our aim should be so to fashion our conduct that this leaven may have the largest possible scope for its work. If by compromise we could transfer it bodily and openly, instead of secretly and fragmentarily, into general medicine, this would be a far higher and nobler aim than to maintain our isolation and thus limit its opportunities. For the providing of the fully equipped, all-round medical man, for the more rapid

advancement of the science of medicine, for the complete recognition of our enlightened method, for greater scope for our ambition in other branches of medicine, and for the public good, I desire to urge, and I wish for, "compromise."

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## CHRONIC DISEASES OF THE HIP-JOINT.<sup>1</sup>

BY PERCY WILDE, M.D.

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THE surgical text-books describe a chronic disease of the hip-joint met with in advanced life and which is variously called "rheumatoid arthritis," "osteo-arthritis," "arthritis deformans," "nonarticular arthritis," and "morbus coxa senilis."

The multiplicity of names indicates something of the uncertainty which prevails as to the nature of the complaint.

Chronic diseases of the hip come very frequently under my observation, but the word "arthritis" does not always apply to them, because this word indicates an inflammation of the joint, and in a large proportion of these cases there is no inflammatory process from start to finish. There *is* a chronic disease of the hip-joint to which the name "rheumatoid arthritis" or "osteo-arthritis" can be properly applied.

If we examine a large number of patients who have the disease in other joints—the fingers, wrists, elbows, shoulders, knees, or ankles—we shall at last find a case where the hip is involved.

The hip is not very frequently affected in cases of rheumatoid arthritis, and when this happens it is always one of the last joints to suffer. When, therefore, we meet with a patient who has disease of the hip which has existed for many years, and the patient has no other diseased joint

<sup>1</sup> Presented to the Section of General Medicine and Pathology, December 3, 1908.

in the whole body, I think we should hesitate before calling it "rheumatoid arthritis."

When we examine a patient with true rheumatoid arthritis of the hip, there is evidence of a subacute inflammatory disturbance. The range of movement is limited by acute pain; in order to avoid this pain the muscles involuntarily contract, partly to restrict movement and also to draw the head of the femur closer to the acetabulum. In the more acute cases considerable swelling of the affected hip occurs at quite an early stage, not due to the joint itself but to tonic contraction of the muscles which surround it. The sciatic nerve becomes irritable and there is a tendency to flexion of the knee. In rare cases fluid forms in the joint, and then the limb becomes abducted as well as flexed, and the foot is everted. This position enables the capsular ligament to contain more fluid with less pressure. The pain of rheumatoid arthritis is always distinctly referred to the hip from its first onset, and no difficulty occurs as to diagnosis. When the patient is kept at rest acute inflammatory symptoms are usually avoided.

There is a form of chronic hip disease which is much more common than rheumatoid arthritis of the hip, which I propose to consider under the name of "atrophic disease of the hip-joint." It has peculiarities which distinguish it from every other form of joint disease.

In the first place, it is *invariably* a primary disease of the hip. Not only is this the case, but patients with this disease practically *never* suffer from joint disease in any other part of the body.

The earliest symptoms do not appear to have been described, and patients are very vague as to the time when the disease commenced.

There is a preliminary period when there is merely a sense of weakness in the affected limb, and this disappears after walking for a little while.

Later on pain is felt at night or while the patient is resting; the pain is not referred to the hip, but to the back and outside of the thigh. This pain is much worse if the patient has had an unusual amount of exercise during the

day, but the patient does not always connect the two events, as the pain comes on some hours afterwards.

Next the patient begins to feel some amount of pain, stiffness or incapacity on commencing to walk; the actual symptoms differ in various cases, but it is almost invariably better after some exercise.

During this period there is no diminution in the range of movement in the joint, and in many cases it is impossible to elicit crepitation at this stage.

The symptoms very slowly increase, and perhaps the patient on making an unaccustomed movement may feel a sharp twinge of pain in the hip-joint. This is usually ascribed to rheumatism and attracts no attention. After a long time, it may be two or three years from the first onset, a decided lameness exhibits itself in the patient's walk, and walking is obviously accompanied by a dull pain in the hip and muscles at the back of the thigh and a sense of weakness in the limb.

The pain is far less acute in the hip than when there is simple rheumatism in the tendons of the muscles.

Owing to the very slow progress of the disease, it is possible to meet with cases where the disease has existed for five or six years and yet the patient's power of walking is not greatly impaired.

There is a characteristic symptom which I have found very helpful in diagnosis, as it occurs at quite an early stage of the disease. As the patient rises from his chair and commences to walk, there is a momentary pause before the first step is taken. I have noticed the symptom at a time when it was impossible to elicit crepitation in the joint.

There is another early symptom which may not always be present, which occurs with great frequency. The patient is able to flex, extend, abduct or adduct the limb, and is able to walk for a considerable distance, but when he wants to put the affected limb over the sound one—an attitude assumed when drawing on a sock or stocking—he finds more or less difficulty in doing it. The difficulty is greatest when the patient is in the sitting posture, and may be so slight that it is only detected by careful experiment.



The progress of the disease is very slow, and the acuteness of the symptoms depends very much upon the mechanical conditions to which the patient is exposed. Lameness becomes a prominent symptom, but the disease is usually diagnosed as rheumatism or sciatica. After the failure of the usual remedies, the patient tries massage, electricity, or various forms of baths, but the results are not satisfactory, because all this time the weight of the body is allowed to rest upon a joint which has lost its power of resistance. The patient is usually urged to walk as much as possible, "to prevent the joint from becoming stiff." All patients appear to have these indiscreet friends, and the fact that walking is accomplished with more ease after the first few minutes appears to justify this advice.

I have found medical practitioners to whom I have described the nature of the disease, and insisted upon a period of rest; exhibit anxiety about possible ankylosis. Practically we have no fear of this in a case of atrophic disease of the hip; for even at an advanced stage, when deformity of the hip, shortening of the limb, and eversion of the foot have occurred, the range of movement in the limb is not greatly impaired. It is this fact which makes the early diagnosis of atrophic disease of the hip, or, rather, the recognition that the hip is diseased at all, very difficult. Not only can the hip be moved freely in every direction, but in the early stages crepitation is not present, and subsequently only elicited with difficulty by moving the joint whilst the muscles are contracted. I have never seen a case of atrophic disease of the hip where pain was reflected to the inner side of the knee by the obturator nerve, such as occurs in tubercular disease of the hip. I saw one case where the pain was reflected to the knee-joint by the internal cutaneous branch of the anterior crural, because the pain was felt upon *both* sides of the knee. The patient had been treated at two hospitals for disease of the knee-joint without benefit. On asking him to go to a couch for me to examine him, I observed that although the right knee was affected, he carried his walking-stick in his left hand. I at once pronounced this a case of hip-joint disease, because I have

noticed that patients with hip-joint disease will sometimes prefer to carry the stick in the opposite hand ; a patient with disease of the knee-joint never does so. I mention this because we need every possible aid to diagnosis in this disease.

#### PATHOLOGY.

I think a clearer knowledge of the pathology of this disease can be reached from a study of its symptoms than by a *post-mortem* examination at any particular period of its progress.

We have a distinct atrophy of the tissues and the bones, constituting the acetabulum and the head of the femur. I see no way of explaining this condition, except by the suggestion that there is a lesion in the nerve responsible for the nutrition of the structures involved.

There is no inflammation or morbid process to help us to any other interpretation. Two cases occur to me where it was possible to study with the naked eye the direct effect of local lesions of nerves upon the phenomena of nutrition. A major of horse artillery showed me a patch, about the size of the palm of the hand, on the outer part of the thigh, just above the knee-joint. The skin and subcutaneous tissue were shrivelled up and quite insensitive to the touch. The patch corresponded to the distribution of the external cutaneous nerve. The nerve was healthy at its origin from the lumbar plexus ; there was, therefore, some local lesion to its trunk. It occurred to me that the constant thumping of the hilt of the sword against the outside of the thigh whilst riding might be a possible cause of the injury. The patient at once accepted the suggestion, and told me that sometimes after hard riding over rough ground (he was in command of a mountain battery) the side of the thigh was positively bruised. In this case we have an almost diagrammatic example of cause and effect : a mechanical injury of a nerve-trunk causing atrophy and insensibility at its area of distribution.

Another case was a young lady, in robust health, except that all the muscles and tissues of one hand were absolutely

atrophied. The symptoms resembled progressive muscular atrophy, and blisters to the spine and energetic medicinal treatment had been employed.

I found the brachial plexus quite healthy, which proved the absence of central disease, and the mechanical lesion was easily found in the forearm, where there was a deeply seated elongated swelling, very resilient to the touch. The swelling was evidently due to a collection of synovial fluid in the sheaths of the tendon. This could best be accounted for by carrying heavy weights, and a young lady living in the country would hardly be likely to strain herself so severely in this way unless she kept poultry and carried pails of water some distance for feeding purposes. This proved to be the exact fact. In this case, continued pressure on the nerve trunks had caused an atrophy of the hand in a perfectly healthy patient. In neither of these cases should we expect to find a similar condition in any other part of the body.

I may remind you that the hip-joint receives nerves directly from the sacral plexus, a branch from the sciatic and a small filament from the anterior crural; also it is supplied by the obturator nerve and its accessory. The symptoms met with in atrophic arthritis naturally direct attention to this last-named nerve.

The obturator nerve is given off by the second, third and fourth lumbar nerves and descends in the inner fibres of the psoas muscle until it reaches the brim of the pelvis. It then leaves the inner border of the psoas, and crossing the sacro-iliac articulation traverses the outer wall of the pelvis, just above the obturator artery, and passes into the thigh through the obturator foramen. You will remember that, as it does so, it gives off a branch which supplies the capsular ligament of the hip, and another which supplies the ligamentum teres, and probably the head of the femur and the acetabulum.

The obturator nerve supplies the obturator externus muscle, the adductor brevis, the adductor longus and magnus, and also the gracilis muscle.

This nerve might be called the adductor nerve of the limb, because upon it the chief power in adducting the

limb depends, but it is the act of supra-adduction, when we wish to cross one limb over the other with some external rotation of the thigh, as in putting on a sock, that it is essential that the adductor nerve should possess its full physiological activity.

It is chiefly because this disability occurs so commonly in cases of atrophic arthritis, and because we know that the tissues in the hip-joint which are primarily affected by the disease are also supplied by this nerve that we can hardly avoid the conclusion that an injury to this nerve is the direct cause of the disease.

This injury must take place inside the pelvis. We know that there are ways in which this nerve has been injured within the pelvis: thus pressure of the head of an infant during childbirth, or the pressure of forceps, has caused a temporary paralysis: a hernia pressing upon the obturator foramen is another cause.

The sigmoid flexure of the intestine lies over the course of the obturator nerve, and it occurs to me that the constant pressure of the bowel when loaded with fæces, which may be almost a chronic condition in some cases, is a very possible cause, and one which would produce just that imperfect functional activity without paresis, and without pain, which would cause the symptoms we meet with in atrophic disease of the hip. Once we accept this hypothesis, all the obscurity of the symptoms of the disease disappear.<sup>1</sup>

We shall no longer expect pain in the hip as one of the earliest symptoms. Possibly at this stage there is some anæsthesia. We can understand the unsteadiness on commencing to walk from want of co-ordinating power in the adductor muscles. If the anterior crural nerve was affected the leg would give way from weakness at the knee; this does not happen in atrophic disease of the hip—the patient

<sup>1</sup> Since this paper was read, a case has come under my notice, in which atrophic disease of the hip immediately followed a perityphlic abscess which discharged partly through the rectum and partly through an abscess in the gluteal region. This happened ten months ago. Crepitation in the hip is well marked, but power to super-adduct the affected limb is the only movement which is difficult. This case strongly supports my view that pressure on the obturator nerve is a direct cause of the disease.

can walk because neither the anterior crural nor the sciatic nerve, which are concerned in the act of progression, are injured. As the adductor muscles have their nerve supply supplemented by these nerves, we can understand why the patient can draw the legs together and yet fail to cross them in the sitting posture, when the peculiar functions of the obturator nerve are required.

We shall realize why, in atrophic disease of the hip, reflex pains are not conducted by the obturator nerve and felt on the inside of the knee, as happens in tubercular disease of the hip. The reflex pains are felt in the sciatic and the external cutaneous nerves, whose functions remain unimpaired.

The whole weight of the upper part of the body being balanced upon the heads of the thigh-bones, and the functional activity of the tissue entering into the composition of the hip-joint being impaired, we can readily understand the gradual atrophy and breaking down which take place when this severe work is imposed upon it while it is in a condition of functional incompetence.

The subsequent deformities are merely the results of chronic irritation in a diseased joint and require no explanation.

In every case of chronic joint disease there are three factors to consider: (1) The original disease; (2) the effect produced upon the disease by the constitutional state of the patient; (3) the mechanical conditions to which the joint has been exposed.

Atrophic disease of the hip affects persons in middle life and after; some of them have the gouty diathesis, and in such case urates, following a regular law, tend to deposit themselves in tissues where the circulation is most feeble or the vitality is lowest. It follows, therefore, under such conditions that a deposition of urates frequently takes place in the hip affected by atrophic disease. In such cases we have an amount of crepitation out of all proportion to the extent of the destructive change in the joint, and elicited with far greater ease than in an uncomplicated case.

This constitutes an aggravation of the original disease,  
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and is sometimes the first manifestation which directs attention to the hip-joint.

But it is a curious fact that I have never yet seen this condition develop into a case of subacute gout of the hip, which is so common in the shoulder-joint when urates have been deposited there. The urates appear to act as a simple mechanical irritant until they are removed by baths and other treatment.

#### CHARCOT'S DISEASE.

There is a disease described by Professor Charcot which more nearly approaches atrophic disease of the hip and its pathology than any other affection. This disease is found in association with locomotor ataxia. There is an absolute destruction of the joint due to central paralysis of the nerves supplying it. In spite of the absolute disorganization of the tissue of the joint, pain is not a marked symptom, except at the commencement, and there is no tendency to ankylosis even at an advanced stage. In this disease we have an absolute paralysis of the trophic function, while in atrophic disease of the joint we have only an impairment of functional activity. In the first case we have rapid destruction, in the second the destructive changes are so slow and insidious that ten to fifteen years may elapse before sufficient tissue has been lost to cause a true shortening of the limb and, I may add, before the nature of the disease is diagnosed.

#### HYPERTROPHIC DISEASE OF THE HIP.

There is another disease of the hip which I do not think has been described and which I have met with only infrequently.

It consists of a general hypertrophy of all the structures which enter into the joint, so that ankylosis is one of its earliest symptoms.

The pain is not acute, but rather a dull aching, which comes on at night and during rest, especially after prolonged exertion. The patient complains of a difficulty in bending forward to tie the shoe, and on examination a decided

swelling is found over the anterior surface of the joint, which is acutely tender to the touch.

In one case this disease appeared secondarily in the acromio-clavicular articulation, which being superficial enabled me to watch it. But the only fact observable was that the outer third of the clavicle became suddenly enlarged to about twice its normal size, and the joint was entirely obliterated. There were pain and tenderness during the process, but these ceased when ankylosis became complete.

This is also true in relation to the hip. In one case both hip-joints were simultaneously affected, and the pain after exertion was considerable and excited spasm of the muscles of the hip. As soon as ankylosis took place the pain entirely ceased and the patient is now able to get about fairly well with the use of a stick, and has become so clever in using the limb that she can actually ascend stairs, and always holds herself perfectly erect. I always think of this case when my medical friends evince so much anxiety concerning a possible ankylosis of a single hip-joint.

#### PHYSICAL DIAGNOSIS.

The diagnosis of atrophic disease of the hip at an early stage presents some difficulties. It is not until we have excluded every other possible cause for the symptoms that we are justified in reaching a conclusion which obliges us to put severe restriction upon the use of the joint for a considerable period.

The process of diagnosis by elimination may appear tedious, although it is excellent practice. The time actually occupied depends entirely upon the way we set about it.

If we commence after the manner described in the text-books, and strip the patient and examine the physical appearance of the joint, we shall learn nothing of this or any other form of hip disease in its *earliest* stages. The disease must have made some progress before there are any of the deformities we are taught to look for.

That some information may be obtained by looking at a joint is unquestionable, but that an accurate diagnosis of

joint disease is to be obtained by simple inspection is an error to guard against. Personally, I *never* commence the physical examination of a patient suffering from a painful affection of the hip or thigh by uncovering the affected part.

I observe a simple routine in all cases which does not occupy four minutes, and which usually enables me to localize the site of mischief and make any further examination which may be necessary.

It is so simple that it would appear almost unnecessary to describe it, but I do so because I see cases with very great frequency where I think it would help to a more exact diagnosis.

The patient lies upon a couch in the semi-reclining position, the clothes not being disturbed.

In examining the right limb I place my left hand firmly upon the knee-joint and grasp the heel with my right hand.

I then flex the knee upon the abdomen as far as possible, and while in this position I make one or more movements of circumduction of the hip, and then, the limb still being flexed, I ask the patient to kick out as hard as possible, while I offer resistance with my right hand grasping the heel.

During this simple exercise I have tested the range of movement of the knee and the hip-joint; I have gained some information concerning the condition of the principal muscles, and have also some knowledge of the physical powers of the patient.

If we find the movement of the joints perfectly free, but the power to extend the limb under resistance very feeble, the question of spinal disease, debility, or myxœdema would at once occur.

If the act of flexing the knee-joint caused very acute pain, *synovitis* would suggest itself, and we should expect to find heat and swelling in the joint; a soft yielding resistance, without pain, would suggest chronic effusion; a creaking friction, rheumatoid arthritis; a soft, coarse crepitation, the same disease at a later stage; a finer, dry crepitation, uratic



deposits in the joint; and when more superficial, uratic deposits, extra-articular or beneath the patella. All this comes to us during the few seconds whilst the knee is being flexed and extended, the hand over the joint receiving the impression. No radiograph will give such accurate information as to the condition of a joint as the hand placed upon it during its resisted movement. If during the exercise we find *very acute* pain in the muscle, rheumatism of the muscular fibre is evident, but such cases are less common than is supposed; the form of "muscular rheumatism" which we see most frequently is a rheumatism of the sheath of the muscle, and here, while the movement is painful, it becomes less so as the movement is continued. There is another allied disorder which is *not* affected by movement or muscular contraction, and which is due to deposit of urates in the fibrous tissues surrounding the muscles. Pain is usually felt at night or when the patient is resting. The pain does not correspond to the distribution of a nerve, but there is usually some, but not great, tenderness upon deep pressure over the area affected, which is also the case in rheumatism of the muscle or its sheath. This form of gout is usually diagnosed as "neuritis."

In respect to the deposit of urates in the tissues I think we shall find invariably:—

(1) Urates are only deposited in those tissues when the circulation is inactive.

(2) That when pain occurs as the result of such deposits it comes on under those conditions when the normal circulation in the tissue is diminished.

It is usual to speak of rheumatic pains "increased by the warmth of the bed." It is a little difficult to accept this explanation, because in such cases the application of heat invariably gives relief.

I think we can find a possible explanation in the fact that when the body is at rest the muscles relax, and there is a passive flow of blood to them, and this will diminish the supply in the surrounding tissues. This would explain those cases where pain in a joint or muscle comes on directly the patient lies down to rest, and the pain is relieved when the

patient gets up and walks about. It is the contraction of the muscle which appears to influence the result.

In the arm we have another source of pain and acute tenderness over the muscles; the insertion of the deltoid and the back of the forearm are favourite sites. These cases used to be diagnosed as "deltoid neuralgia"; they are now invariably called "neuritis." They are really due to subacute gout in the shoulder-joint, the pain being chiefly reflected by the circumflex nerve.

We do not appear to have a corresponding condition in the hip-joint; at least, I have never seen such a case, although the presence of urates in the hip-joint is of frequent occurrence. There is another disorder, of which the movement I have described does not give us exact information. When rheumatism or gout attacks the lateral ligaments of joints, the deep fascia, the fibrous tissue surrounding the large nerve trunks, and the tendons of muscles, pain is not produced by the normal movements of the limb, although there may be some stiffness, but if we can stretch the tissue by any movement pain is at once manifested.

We make use of this fact in the second movement of the preliminary examination. In this movement, when examining the right lower limb, I grasp the patient's hip with my left hand, the fingers are placed above the great trochanter, and the thumb pressed well into Scarpa's triangle. I place my right hand just above the heel and direct the patient to keep the knee stiff. I then flex the extended limb upon the abdomen.

The foot is thus moved in the arc of a circle. If when the first third of this arc is completed acute pain is felt in the back of the thigh, the patient has rheumatism of the sheath of the sciatic nerve or of the fascia above it. In the latter case the pain is more superficial and more diffused. In this movement the tissues are stretched. The same movement of the thigh with the knee flexed will not produce pain. If at the end of the second third of the arc of the circle there is an obstruction, it is due to some swelling or inflammation on the anterior surface of the hip-joint. If this occurs near the termination of the movement, it is due to mischief posterior to the joint.

In a recent case marked crepitation was elicited at this point, due to deposits of urates behind the joint, the point of deposit being determined by the relation of the limb to the body. The case cleared up very rapidly under treatment. It might easily have been mistaken for disease of the hip-joint. When the limb is fully flexed upon the body, the patient is directed to bring it back to the couch with all the force possible, while resistance is offered by the right hand, which is grasping the leg above the heel. This movement brings the head of the femur in close apposition to the acetabulum, and is one of the most favourable conditions for eliciting crepitation. Another movement which elicits crepitation is extreme abduction, the limb being then adducted with resistance. I next, at a point about 3 in. above the internal condyle of the femur, give deep friction over the internal cutaneous nerve. I do the same at a point on the outside of the thigh, midway between the great trochanter and the external condyle of the femur, where the external cutaneous nerve is most superficial. The number of cases I meet with, when pain or loss of power in the thigh is due to traumatic injury of the lumbar plexus, has caused me to make this an essential part of the preliminary examination.

When we feel tenderness at either of these points, we shall usually find a tender part in the back which can be found by taking a line from the crest of the ilium to the spine, bisecting it, and giving deep friction at a point 1 in. beneath it, *i.e.*, over the lumbar plexus.

This frequent cause of trouble in the hip and thigh is not described in the text-books. The subject is too large to enable me to deal with it properly to-night, but I may say that injury to the lumbar plexus, on one side only, is usually due to a violent twist of the body in the effort to *avoid* a fall. When it occurs on both sides, it is usually due to an effort to lift a heavy weight while the back is bent.

The injury rarely makes itself felt at the time of accident ; the symptoms occur some time later, and the patient has frequently forgotten the event. While pain is sometimes felt in the back, it is more frequently felt in the external or internal cutaneous nerves. In some cases there is no pain at

all, but loss of function in the nerve. Thus, the anterior crural nerve supplies all those muscles which govern the first act of progression when we commence to walk. If we have a patient whose knee suddenly gave way with him for no accountable reason, we may be safe in saying that there has been a traumatic injury of the lumbar plexus (perhaps very many years ago), and the anterior crural nerve is affected. In one case this symptom came on in an old lady the day after a fall, attended by no visible injury. I was asked to see her by her brother, a surgeon-general, who had been sent for from London. Unfortunately I had only a few minutes to catch a train for a distant consultation, but I gave him a diagram of the back, on which I marked the site of injury. Directly he touched her on this spot, the pain was so acute that she nearly jumped out of bed. The surgeon-general was even then absolutely mystified as to how I could discover the injury without seeing the patient.

A case occurs to me which appears worth quoting, because it not only shows the value of the simple method of preliminary investigation I have described, but also how little is known of traumatic injury of the lumbar plexus as a cause of pain in the hip and thigh.

A lady, living in a distant Colony, upwards of 70 years of age, was seized with very severe pains in the back and hips. After a time she was sent to England for diagnosis and treatment. She consulted a surgeon of great eminence and experience, who made a most careful examination, which occupied him nearly an hour. At the end he confessed himself unable to state the cause of the pain, and suggested a consultation with a specialist on nervous diseases of great experience. Together they examined her for quite an hour, and at the end decided that she had arthritis of both hip-joints, and was quite incurable.

This patient was sent to me by Dr. Annie Clark, of Birmingham. I examined her precisely in the manner I have just demonstrated and within five minutes was able to tell her that both hip-joints were perfectly healthy, that she had sprained the lumbar plexus on both sides by trying to lift a heavy weight, and that her condition was perfectly

curable. She at once remembered that, her husband being ill, she had leaned across a wide bed in the effort to lift him. She felt the strain severely, but the acute pain came on some days later and she did not connect the two events.

I did not actually examine the back until the next day, when I was instructing the nurse to give deep friction over the affected nerve, which I find the best method of treatment. I may say that the patient made a complete recovery and returned to the Colony.

Traumatic injury of the sacral plexus usually occurs from a fall in the sitting posture. This accounts for many cases described as sciatica. In these cases there is tenderness over the sacrum corresponding to the points of exit of the sacral nerve, and also tenderness over the sciatic nerve, but there is no pain produced by flexing the extended limb upon the abdomen as in rheumatism of the sheath of the nerve. In pure neuralgia of the sciatic nerve there is usually some tenderness over the nerve, but none over the sacrum, and no pain on flexion of the extended limb. In this way we can resolve cases of "sciatica" into their respective classes, and have indications for treatment which the mere diagnosis of "sciatica" does not afford us.

It is as well not to forget the possibility of sacro-iliac disease as a cause of the symptoms. In the class of cases we are considering, if the joint is affected it will rarely be tubercular, and the well-known symptom of the patient bending to the opposite side in order to relieve pressure is not very prominent. There is pain on pressure directly over the sacro-iliac joint, and pain may be radiated both by the sciatic and external cutaneous nerves. This joint may be affected by subacute rheumatism and gout, but I have never in these cases been able to elicit pain by pressing the ilia of the pelvis together, as in tubercular disease.

As this joint is supplied from the obturator nerve it sometimes happens that it is subject to irritation in cases of atrophic disease of the hip, but such irritation occurs in cases where the hip is not affected. Long-continued irritation of the sacro-iliac joint may set up spasm of the muscles surrounding the hip on the affected side. I have not seen

this fact mentioned, but I would suggest that when the hip is "enlarged" without evidence of any disease of the hip, an examination of the sacro-iliac joint should be made.

When the obturator nerve is injured *outside* the pelvis, chiefly by excessive riding, spasm of the adductor muscle is set up, which prevents the patient from stretching the limbs apart, and there is limitation in the movement of the hip. This usually occurs in both legs simultaneously.<sup>1</sup>

We must not forget also the possibility of reflex pain from cancer of the rectum or lumbar vertebræ, or from any cause of mechanical pressure on the spine or pelvis.

The differential diagnosis of such cases would carry me beyond the limits of this paper, but I think I may take it as a general rule that the reflex pains from such disorders are not attended by tenderness in the nerve trunks which convey them; on the other hand, the reflex pains of gout are accompanied by pain at the point of distribution of the nerves which conduct them. I do not put this forward as a final conclusion, but in the hope that further investigations will be made in reference to this point, which is of some importance.

It is not until we have exhausted every other possible source of the symptoms that we should diagnose a case as one of atrophic disease of the hip-joint.

#### TREATMENT.

No treatment can meet with success in a case of atrophic disease of the hip, unless the mechanical problem of weight is efficiently dealt with. I am satisfied that moderate movement of the hip-joint is not prejudicial, and most often beneficial, but that the weight of the body pressing upon the head of the femur is the immediate cause of the atrophy and subsequent deformity. I have seen cases

<sup>1</sup> Since reading this paper I have seen a case of 15 years' standing which had been always diagnosed as "rheumatoid arthritis" of the hip. Both hip-joints were healthy, but there was spasm of the adductor muscles on both sides, causing limitation of movement in the hips, but the patient could walk fairly well. It came on after excessive riding and fatigue during an attempt at farming in Australia.

make a complete recovery when the disease was diagnosed at an early stage and the proper mechanical conditions could be observed. But here we are faced with a difficulty. The patient may be engaged in active business or professional life. He may be able to get about with very little difficulty and without much pain. He expects to be cured of his "rheumatism" or "sciatica" after a few weeks' baths. To condemn him to a life of absolute inactivity, and tell him that this must continue for at least two years, is a decision in which the patient will not always readily acquiesce.

There are circumstances in which we cannot do the best thing, and must be satisfied with the next best. I have designed a number of appliances which have for their object the relief of the hip-joint from the weight of the body, but while they are helpful in acute cases, combined with rest, I am not satisfied as to their efficiency when the patient is allowed to walk. To relieve the hip from weight it appears essential to throw the weight of the body directly to the ground. Appliances which will accomplish this are too cumbersome to be practicable, and none of them accomplish it so efficiently as the ordinary crutch. But in the class of case I am alluding to, the patient who can walk several miles with the aid of a walking-stick, the crutch is rejected because it is both unsightly and cumbersome. As no patient objects to a stick, it occurred to me to attach a support to the shoulder-joint, which could be worn beneath the coat, and to connect this support with an ordinary walking-stick in such a way that it could be disconnected when the patient required to sit down.

My first experiment convinced me of the immense advantage of this arrangement. Instead of the patient having to lift and advance a heavy crutch at each step, the crutch, being attached to the shoulder, advanced with him as he walked, and did not require the use of the hand to keep it in position. I also discovered how much of the weight of the body was conveyed through the arm in the use of the ordinary crutch. My appliance, padded even more softly

than the ordinary crutch, felt hard under the axilla, because the bulk of the weight of the body was borne at this point and not by the arm. I got over the difficulty by using a pneumatic padding precisely on the lines of a bicycle tyre. The details took some time to work out, but I was finally able to patent a crutch which is half the weight of an ordinary one and which, in use, appears only as a walking-stick.<sup>1</sup> This appliance, which will be useful in many cases of infirmity, arose out of the effort to deal with the mechanical problem which results from the early diagnosis of atrophic disease of the hip.

In every case I advocate a preliminary period of absolute rest of the joint for four to six weeks. During this time the following measures are useful :—

(a) The use of baths, which raise the body temperature and prevent or remove the deposit of urates in the joint. A douche at 105° F. to the hip for five minutes is distinctly beneficial after the bath.

(b) The application of the galvanic current, the positive electrode being placed over Scarpa's triangle, and the negative over the lumbar plexus on the affected side. This I give on alternate days with the faradic or alternating current applied to the inner side of the thigh over the adductor muscles, the other electrode being applied over the lumbar plexus.

At the end of a fortnight, gentle resisted movements are given to all the muscles of the hip, especial attention being directed to one involving the act of supra-adduction, in which the affected limb crosses the sound one.

It was only after continued observation that I convinced myself that these movements were desirable, and I am quite sure that harm would be done if they were exaggerated or too long continued.

(c) It is absolutely important that the bowels should be kept open; a constipated habit is common in such cases. A pill containing sulphate of iron and aloin, of each  $\frac{1}{2}$  gr., is usually sufficient.

(d) In respect to specific remedies, I believe that calcarea

<sup>1</sup> This crutch is supplied by Lenay and Co., Terrace Walk, Bath.



carbonica and pulsatilla are the most efficient; the value of the first remedy in preventing the deposit of urates in joints and removing them, will only be realized when it is given over long periods.

I am afraid I have wearied you with much detail, and I will not detain you with reports of cases treated.

My clinical records prove that this disease, when recognized in the early stage, is quite curable, that the deformities associated with it can never occur when the mechanical conditions receive proper attention. That the best results will always be attained in those who are in a position to avail themselves of the mechanical conditions necessary to recovery; but even when the best thing is impossible, and we have to be satisfied with the "next best," it is always possible to relieve the patient of much pain, suffering, and deformity.

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Dr. JAGIELSKI was of opinion that the disease under consideration was difficult to treat except as a specialty. With regard to treatment, he was of opinion that electric light and heat were very valuable, especially the torpedo light, which Dowsing had introduced, and he (Dr. Jagielski) asked if Dr. Wilde had made use of it. He, personally, always had it at hand, because he had found it very useful, not only in hip disease, but in other diseases connected with the lumbar parts, and the knee and ankle joints. With regard to medicinal treatment, in addition to the two drugs mentioned in the paper—calc. carb. and pulsatilla—he had found *stellaria media* a remedy of much value if it was taken upon constitutional lines. Given in conjunction with the heat bath or the Dowsing torpedo light it gave most excellent results. He congratulated Dr. Wilde on having dared to tackle a subject containing such great anatomical difficulties.

Dr. DYCE BROWN mentioned a case of atrophic disease of the hip similar to one mentioned by Dr. Wilde. The patient was an old lady of over 70. The pain had commenced with an attack of sciatica some years ago, and the sciatica had gradually altered into a pain localized in the groin. There was no enlargement, or thickening, or swelling to be felt, and no disease of the hip-joint could be found. When the lady was sitting or lying down she was at perfect ease, remained perfectly passive when examined, and could bear the leg being bent up as far as possible and

straightened out without feeling pain. Any natural movements of the leg, however, caused great pain. All he could surmise was that there was a large amount of nerve involvement, causing contraction of the muscles round the joint. The patient was of a gouty habit, but had never shown any unmistakable gouty signs in any joint. He had often said that if the lady had a thorough external eruption she would very likely get better, but, curiously enough, this year she had an extremely acute attack of eczema, and it made no difference whatever. Everything had been tried which might be of use, not only homœopathic medicines in different dilutions, but all forms of external applications, light and heat baths and electricity, but without any result. The only thing which brought relief was heat. The case exactly corresponded to Dr. Wilde's graphic and minute description of atrophic disease of the hip-joint, but nothing wrong was to be found with the hip-joint proper, the muscles of the part and the nerves being alone involved. The only thing referable to the joint was that on voluntary movement the patient could hear a crack in the joint. He himself had heard it once or twice, but not more. He could make out no creaking whatever in the usual movements, and there was no sign of effusion in the joint. If the joint was pulled up to the abdomen quickly there was pain, but if pulled up slowly there was none.

Mr. KNOX SHAW asked Dr. Wilde if he had made any observations with regard to whether there was a shortening of the femur in his hip cases. These cases, it seemed to him, were very much on a line with a disease amongst young people, which was recognised surgically where pain was experienced in movements without any obvious disease of the joint, but where there was an atrophic condition of the neck of the femur, leading to incurvation and shortening of the neck. The condition was known as coxa vara. Such cases were very difficult to treat from the surgical point of view, and he wondered whether, in the cases referred to, there might not be a similar condition prevailing.

Dr. SEARSON congratulated Dr. Wilde on the lucidity of his paper. He would emphasize kali carb. as a drug worth remembering, and he commended it to Dr. Wilde's attention in cases of back pain. He had seen in the hospital that afternoon a woman advanced in pregnancy six months. She had had a very bad time, with aggravated back pain, and he had given a C.M. unit dose of kali carb. with striking result, and that evening she had come and said that the pain, which was so severe that it kept her awake for three nights, was completely gone. He had given that

particular drug not only because of the back pain in parturition, but because she spoke of the pain as occurring in the early morning, about 3 a.m. The subject of joint trouble was a most fascinating one, and lately in the hospital several interesting cases of joint trouble had been seen which had left him with the impression that a final and satisfactory classification of joint diseases had not yet been reached. He mentioned the case of a child, aged 7, in Barton Ward, under Dr. Day, who had what might be regarded as a typical condition of rheumatoid arthritis; the finger and knee-joints showed fusiform swellings, and there was marked atrophy of muscles, especially the muscles associated with the scapula. In Vaughan Morgan ward was a case of a young girl, aged 15, who had a very peculiar joint trouble. She had fixation of the knee-joints, with marked swelling and considerable pain. There was a dislocation of the end of the femur forwards and the head of the tibia backwards in each knee. The patient had been treated some months previously with an extension apparatus, but it was afterwards removed, it being found that on account of the so-called trophic changes the skin could not bear the modest pressure associated with apparatus. That was a case which he considered very difficult to put under any of the known classifications; it could hardly be regarded as purely rheumatic, because in rheumatism as a rule one did not look for trophic changes, nor could it be regarded as a typical rheumatoid, gout, or Charcot, although it seemed more nearly allied to the latter. Another case, which he saw about six months ago, was that of a woman who had a very pronounced swelling in the right shoulder; the joint was found to contain a good deal of fluid of a serous character. It was examined carefully, and nothing distinctive was ascertained. The joint was much disorganized. The rapid growth of the swelling at first, and its irregular shape, suggested the possibility of it being a sarcoma. The patient was admitted into the hospital. The joint was aspirated, but quickly refilled, and the patient is still under observation. That case also was not, in his opinion, to be classified under any of the known heads. There was another case of a patient suffering from locomotor ataxy, kindly exhibited by Dr. Goldsbrough, who had a remarkable painless enlargement of the right tarsal bones. Was that to be regarded as a Charcot joint or not? He hoped Dr. Wilde in his next paper would deal with the further classification of general joint troubles. With regard to treatment, he had taken a modest part in that matter, and he felt that *the* treatment was primarily treatment by baths, combined with electricity and physical treat-

ment. The special bath which seemed to him to give the best result was that on the lines recommended by Dr. Wilde—namely, a bath of heat, vapour, and light combined. With regard to the form of electrical treatment, his own experience was that no fixed rule applied in every case. Some patients were benefited by galvanism, some by Faradism, or the two combined, and others by high frequency current. The latter method had been in use now for many years. When it was first introduced he believed its reputation suffered very much, owing to the too haphazard way in which cases were sent to it, and he thought those responsible for the treatment were unwise to have accepted cases for high frequency current which the current had no chance of helping. Now, however, he thought a discrimination could be made in the class of cases for which the high frequency current was suitable, and its application in suitable cases was very useful. With regard to cataphoresis and the so-called ionic medication, he thought the latter was a method from which good results could be expected in the future.

Mr. EADIE said with regard to the crutch which Dr. Wilde had handed round, he thought it was very bad, because it could not be pressed against the side of the chest, which, and not the axilla, was where the crutch should lie. He had recently seen a number of cases of crutch paralysis, due to the patients not being properly instructed how to use a crutch. They had used the crutch right in the axilla, with the result that crutch paralysis occurred, and in the last case he saw, paralysis of the musculospiral nerve, lasting eight months, followed. A gentleman had been plucked at the last final fellowship examination on account of not knowing how a crutch should be used. The collar on Dr. Wilde's crutch, it seemed to him, was bound to keep the crutch in the axilla; it did not allow the crutch to go by the side of the chest. With regard to the word "trophic," it seemed to him that that word, like charity, covered a multitude of sins or conditions. He criticized what was said with regard to "trophic" function of nerves in causing alteration of the bone especially, because he had seen in quite a number of cases, although the nerves to the parts were severed, no changes had taken place. It was quite a common operation in horses—for instance, in lameness in the foot—to cut the nerves just below what was called the knee-joint, which corresponded to the wrist in the human subject, and he had never seen any change in the bones of the foot. The condition was sometimes obtained of so-called "trophic" change—in the conjunctiva, for instance, which was really sensory and not

due to implication of supposititious "trophic" fibres. It was known that many of the alterations in the joints were associated with certain nerve disorders, such as Charcot's joint, and such a state of things was difficult to account for, but he did not think the so-called "trophic theory" was a very satisfactory one. He had seen a modification of Thomas's knee splint used in certain cases; it went round the thigh, caught the pelvis above the hip-joint, and then extended right down to the ground, the foot thus being kept about 2 in. from the ground. By such a method the patient did not use the hip-joint at all, the whole weight being thrown on to the pelvis. He had seen one or two cases in which the hip-joint had been excised, the advantage of that being that ankylosis was obtained afterwards. In operative treatment one could fix the joint in the position one wished. If the patient were allowed to let his joint ankylose of itself, the chances were that it would be in a faulty position.

The PRESIDENT remarked that if he understood Dr. Wilde aright he attributed some forms of atrophic diseases of the hip to pressure of the sigmoid flexure of the colon on the obturator nerve, due to the presence of fæces there. That was a suggestion which required very careful thought, and he asked that, if it were a primary cause, would not atrophic disease of the hip be more frequently found in women than was the case, considering the immense proportion of women who suffered from chronic constipation? He commended a book which he had picked up some time ago, which had been written between fifty and sixty years ago, to anyone who was interested in the particular subject under discussion, because it contained extraordinary illuminating facts which bore on the subject of delayed pain after injury. The book was by Dr. Inman, who had been Physician to the Liverpool Northern Hospital, and was entitled "Inman's Myalgia." Inman was a man with an unusual power of intuition. Probably, in the light of more recent knowledge, many of his deductions would not be accepted at the present time, but fifty or sixty years ago, considering the knowledge at his disposal, they were truly remarkable. With regard to spinal neuritis associated with atrophic disease of the hip, Dr. Wilde had told them that the pain was elicited in the lumbar region. He would like to know whether it was not the case that such pain was also very frequently associated with disease in other joints, more particularly in the knee. He had noticed it several times, and was amazed at the fact that when the thumb was rubbed along the spinal roots downwards towards the lumbar region, in diseases of the knee—more

particularly in rheumatoid arthritis—it was found that those particular nerve roots were extraordinarily tender, although patients had never complained of any pain in the spine.

Dr. McCULLOCH remarked that the conditions of tissue hyperplasia round the nerves and round the hip-joints, from their chronic nature and from their peculiar remoteness from the centre of circulation, undoubtedly led to great difficulties in the way of amenability to treatment. He had been using the electrolytic treatment, which had been referred to as the ionic treatment, by using sodium chloride in water and applying the active electrode, the positive, to the region affected, and the negative, or indifferent electrode, to the arm or to the leg of that side. He had also been using the X-rays locally to the points where there were neoplastic formations, and he had succeeded in getting a certain amount of resolution of those tissues, as it was known that they were of low organization and very rapidly and easily resolved under the molecular action of X-rays or electricity, or of iodine or the iodides. He referred to the case of a patient, a gardener named Wright, who came to him as suffering from sciatica. He strongly suspected that the condition was not one of sciatica, and he had been trying on the patient fibrolysin injected into the gluteal region, which had had a good effect. But the basis of treatment in each of the methods was the same—namely, to get resolution of the rudimentary tissue forming the neoplasm. He noticed in the radiograph which Dr. Byres Moir had sent round that there were certainly bone changes to the extent of dense bone where there should not be dense bone; that was, the shadow was thrown where normally there ought *not* to be so dense a shadow—round the head of the femur, external to the acetabulum.

Dr. WILDE, in reply, thanked the members for the reception of the paper. The treatment of disease could not advance until practitioners knew what they were talking about. It was the same at the beginning of all sciences; advance was only possible when an exact nomenclature had been arrived at. With reference to the word “trophic,” he had not used it because he liked it, but because there was no other word by which he could express himself better. Even now he spoke about “arthritis of the hip-joint,” although there was no inflammation, because he knew if he used the word “atrophic” disease he would not be understood. The word “rheumatoid arthritis” was used to express a number of different conditions with no connection between them. He had seen that morning a case of arthritis deformans where there had

not been any inflammation of the joint from start to finish. He thanked Dr. Jagielski for his remarks. He himself had always used baths with the view of raising the body temperature, and he wished to do that with as little heat as possible. He was no advocate of using high temperature; he wanted the maximum amount of heat of the body for the lowest amount of temperature of the bath, and therefore he always used vapour, and of late years electric light with vapour. He found that a temperature of 105° F. was as high as he ever required to go. Dr. Dyce Brown's case was a very interesting one. He thought that rest for the joint was the main thing to prescribe. He regarded the hand pressed over the joint during resisted movement as giving much more information than any radiograph. Where inflammatory conditions prevailed, he thought the Röntgen ray was very apt to mislead. He had a case recently where a lady was seized with severe pain in the knee-joint, accompanied by laceration of the veins. A radiograph had been taken, and her medical advisers came to the conclusion that it was a case of fracture of the patella, followed by complete ankylosis of the knee. The patient was subsequently sent to him. He examined her before the radiograph arrived, and made out that the injury was due to a chip of uratic deposit, dislodged from beneath the patella, which had been drawn up into the thigh and had lacerated the veins; it was not a case of fracture at all, although when he saw the radiograph he could have quite believed that it was. The patient made a good recovery. He thought too much attention should not be paid to a radiograph, unless it was taken in conjunction with the method of putting the hand over the joint during resisted movements. With regard to the question of crutches, his experience was that nothing which one could do or say would make a patient alter the way he used a crutch; he would always use it in the way he found most comfortable. His own crutch gave greater latitude of position than the ordinary crutch, the hand could be turned in any direction, and the pneumatic padding relieved all fear of crutch palsy. The use of Thomas's caliper splint in hip disease was out of the question; it took the weight off the knee-joint only. With regard to the President's remarks, if a patient was found with a tenderness over the lumbar plexus, one would be usually right in assuming that a previous injury had something to do with it. It seemed to him that no nerve specialist ever examined the nerve trunk to see whether it was injured. In the case of the patient with the bad hand he had mentioned, the first thing he did was to put his fingers on the brachial plexus above the clavicle, and

on finding the nerves were quite healthy he did not trouble about the spine. With reference to Mr. Knox Shaw's remarks about the shortening of the femur, it is very rare a case was seen which was so far gone that there was actual shortening of the hip. He met with cases occasionally, but then the patients were almost always flail-jointed and the foot was everted. In some cases where there had been a great deal of walking about there was a certain elevation of the hip, but not always; but there was undoubtedly a shortening of the limb in those cases.



## MINUTES OF THE SOCIETY MEETINGS.

THE FIRST MEETING of the Session 1908-9 was held at the London Homœopathic Hospital on Thursday, October 1, 1908, at 8 o'clock, Dr. Cash Reed (President) in the chair. There were also present the following Fellows and members: Dr. Blackley, Dr. Dyce Brown, Dr. Burford, Dr. Clarke, Dr. George Clifton, Dr. Cooper, Dr. Spencer Cox, Dr. Cronin, Dr. Roberson Day, Dr. Eadie, Dr. Epps, Dr. Fairlie, Dr. Gilbert, Dr. Goldsbrough, Dr. Vincent Green, Dr. Granville Hey, Dr. Grantham Hill, Dr. Jagielski, Dr. Mason, Dr. Byres Moir, Dr. E. A. Neatby, Dr. Norman, Dr. Pincott, Dr. Powell, Dr. Sandberg, Dr. Shackleton, Dr. Frank Shaw, Dr. Stonham, Dr. Wynne Thomas, Dr. Wheeler, Mr. Dudley Wright. Apologies for absence were sent by Dr. A. C. Clifton, Dr. Neild, Dr. Searson and Dr. Storrar.

The President delivered the inaugural address for the Session, entitled "Esto Vigilans." This address appears *in extenso* on p. 1 of the current issue of the JOURNAL.

At the conclusion of the address Dr. Dyce Brown proposed, and Dr. Burford seconded, a vote of thanks to the President for his address.

At 9.15 p.m., at the invitation of the President, the meeting adjourned to supper at the Hotel Russell.

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THE SECOND MEETING of the Session was held on Thursday, November 5, 1908, at 8 o'clock, Dr. Cash Reed (President) in the chair. There were present Dr. S. P. Alexander, Dr. Dyce Brown, Dr. Burford, Dr. Cooper, Dr. Cronin, Dr. Roberson Day, Dr. Eadie, Dr. Vincent Green, Dr. Granville Hey, Dr. Grantham Hill, Dr. Reed Hill, Dr. Jagielski, Dr. Johnstone, Dr. Byres Moir, Dr. Wm. Roche, Dr. Ross, Dr. Sanders, Dr. Stonham, Dr. Thomas, and Mr. Wilkinson. Dr. Marriott, of the London Homœopathic Hospital, and Dr. Milhem Stettin were present as visitors.

## NEW MEMBER.

Henry D. McCulloch, M.B., C.M.Glas., of 27, New Cavendish Street, was elected a member of the Society.

## DEATH OF DR. T. H. HAYLE.

The sudden death of Dr. Thomas Henry Hayle, of Rochdale, a member of the Society since 1886, was announced by the President as having taken place on October 30.

The PRESIDENT remarked that it seemed almost incredible that Dr. Hayle had passed from amongst them, when they remembered that he sat in the room in which their meeting was now being held and took part in a discussion quite recently. Dr. Hayle's life was an extremely laborious one. He was a man of great ability, who worked prodigiously hard, and who was extremely conscientious. He was sure the members greatly regretted his loss.

Mr. WILKINSON endorsed what the President had said. In proportion as they knew Dr. Hayle they grasped the integrity of his purpose and the sterling goodness of his character. His death was due to his constant attention to his work. Mr. Wilkinson moved that the Society request the Secretary to communicate to the widow the deep sympathy of the members and their great respect for a valued colleague who would be missed for many years.

Dr. BYRES MOIR, in seconding the motion, said that he had known Dr. Hayle before he began practice as a qualified man. Many years ago, when Dr. Hayle was a student at Owens College, his father was taken ill. He (Dr. Byers Moir) was living in Manchester at the time, and went over to Rochdale and helped him. The father was a brilliant homœopathist in every way. The son left Owens College with the reputation of one of the best students of his year, and his bright prospects had been fully carried out in life, particularly in his work at Rochdale. He was an original thinker, and took an interest in a great many public questions. He recently took up the education question, and it was narrated of him that when inspecting some schools he was not satisfied with the air space in them; he thereupon broke all the windows on the spot. He was sure all the members would feel they had lost one of their best members, who was not only a deep thinker and a good worker, but a most conscientious man in his practice.

Dr. DYCE BROWN, in supporting the motion, referred to their late friend's personality. All who knew him liked him; he was very much esteemed personally, and he was a most interesting and charming man to talk to.

The resolution was carried unanimously.

## SECTION OF MATERIA MEDICA AND THERAPEUTICS.

Dr. J. Roberson Day read a paper entitled "Nasal Obstruction in Children, with special reference to Homœopathic Treatment," which was followed by a discussion. This paper, with the discussion, appears on pp. 30-42 of the current issue of the JOURNAL.

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The THIRD MEETING of the Session 1908-9 was held on Thursday, December 3, 1908, at 8 o'clock, Dr. Cash Reed (President) in the chair. There were present also: Dr. Speirs Alexander, Dr. Dyce Brown, Dr. Cavenagh, Dr. Clarke, Dr. Eadie, Dr. Gilbert, Dr. Granville Hey, Dr. Jagielski, Dr. McCulloch, Dr. Byres Moir, Dr. Neatby, Dr. Purdom, Dr. William Roche, Dr. Searson, Mr. Knox Shaw, Dr. Stonham, Dr. Tindall, Dr. Wheeler, Dr. Percy Wilde, Mr. Dudley Wright. Dr. Marriott, Dr. Payne, Dr. Hall, and Mr. Watts were announced as visitors.

Dr. Roberson Day and Dr. Goldsbrough sent apologies for absence.

## DEATH OF MRS. A. E. HAWKES.

A vote of condolence with Dr. Alfred E. Hawkes, of Liverpool, a past President of the Society, was passed on the announcement of the death of Mrs. Hawkes.

## NEW MEMBER.

Alfred Ernest Underwood Hawkes, M.R.C.S.Eng., L.R.C.P. Lond., L.S.A., of Liscard, Cheshire, was elected a member of the Society.

## SECTION OF GENERAL MEDICINE AND PATHOLOGY.

Under the auspices of this Section a paper was read by Dr. Percy Wilde, of Bath, entitled "Chronic Diseases of the Hip-joint." A discussion followed, which, with the paper, appears on pp. 58-77 of the current issue of the JOURNAL.

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## COST OF PRINTING THE JOURNAL.

At a MEETING OF THE COUNCIL held on October 16, 1908, it was resolved that in order to avoid costly corrections in the JOURNAL, members be requested to furnish typewritten copies of their papers for printing, to the Editor.

## SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

*Extracted from Exchange and other Journals by the Editor, in  
collaboration with J. Galley Blackley, M.B.*

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**Adonis Vernalis.** *Summary of Proving.*—A proving of Adonis vernalis has been made on two students of the University of Michigan under the following conditions: Complete note was first taken of the normal health and physical states. The diet and routine of life were supervised for several days before any drug was given. The provers were unaware of what drug was given. The provings were supervised by the director of the pathogenetic laboratory. The period occupied by the proving was forty-eight and thirty-six consecutive days by each prover respectively. The attenuations used were from the 12th to the  $\phi$  tincture. Not until considerable quantities of the pure tincture had been given did any symptoms arise which could be attributed to the drug. No cumulative effects were noticed. One prover (M.) was much more sensitive to the influence of the drug than the other (C.). C. noticed slight alteration of the excretory products, constipation, followed by relaxation of the bowels, and much flatulence. Headache developed during the late days of the proving, mostly frontal over the eyes, but also lateral. The sphygmogram showed a higher wave than normal, and higher than the other prover (M.). C. is not impressionable, and is matter of fact, active, alert, energetic. Height, 5 ft. 10 in.; weight, 10 st. 10 lb. M. is 5 ft. 6 in. in height; weight, 10 st. 5 lb., is impressionable and optimistic. In M., after the second week of the proving, ten drops of the tincture for a dose having been given, an irregularity of the pulse was noticed, also acceleration from exertion. After singing in church his heart beat against his chest like a sledge hammer, and there was slight tinnitus aurium. Later vertigo came on, < rising in the morning and on turning the head quickly. During last four weeks of proving had precordial sensation described as a consciousness of the heart, also a feeling of weight on chest with desire to take a long breath. Later

vertigo became more marked, and was noticed in lying down, also < on any change of position. Abnormal appetite developed, < 10 p.m., also obstinate constipation and much flatulence. Lack of usual thirst. Back became tired with dull ache across loins. The director of the proving reports that no alterations were found in the blood or urine. The average blood-pressure in C. was 130 mm., with M. 120 mm. C.'s average pulse was 78 ; M.'s was 83. (*University Homoeopathic Observer*, October, 1908, p. 191.)—ED.

**Adrenalin.** *Pathogenesis.*—The following is a collection of the results of provings made upon small mammals by means of intravenous and subcutaneous injection of adrenalin.

*Circulation.*—Injected into the veins of an animal, adrenalin causes slowing of the heart-beat, fall in blood-pressure, and slowing of respiration. Almost immediately afterwards the blood-pressure rises above the normal, and the heart-beats become quickened and irregular. After seven or eight minutes the blood-pressure gradually sinks, and a slowing of the heart comes on ; then the blood-pressure suddenly sinks below normal, rising again somewhat later on. From this point there is fresh acceleration of the pulse, and if the dose has not been immoderate the blood-pressure returns slowly to the normal. With poisonous doses, on the other hand, the initial high blood-pressure is followed by a very decided fall, which after a few oscillations arrives at zero. In this case the acceleration of the heart is very decided, although its energy gradually diminishes, and the heart dies in systole.

With small repeated intravenous injections a rise of blood-pressure occurs every time ; the same thing occurs, though less decidedly, after subcutaneous injection. Administered internally, the effect of the drug is still more transient, owing to oxidation, which occurs when it comes into contact with the tissues.

Josué's provings, confirmed by those of Baduel, have placed it beyond doubt that repeated injections cause atheroma and heart lesions in animals. The arterial lesions commence with change in the middle coat ; the heart lesions manifest themselves in the shape of hypertrophy of the heart-muscle, extravasation of blood in the myocardium, and small-celled infiltration.

Lastly, adrenalin is a powerful but transient vaso-constrictor, whose mechanism we will explain later on. By means of its power of selection it stimulates the muscular coats of the peripheral vessels ; this power of selection also extends to the centres of the medulla oblongata. Lastly, adrenalin increases the elasticity of the heart-muscle.

*Respiration.*—The effect upon the centres of the medulla is seen in increase of respiratory movements, soon followed by suffocation. Small doses cause increased interchange of gases, strong doses diminution of the same, with simultaneous sinking of the body temperature; death eventually occurs from suffocation following upon paralysis of the medulla.

*Local Effect.*—This is no more than a natural sequel to its effect upon the circulation. A solution of the strength of 1 in 1,000 painted upon the skin or mucous membranes causes contraction of the vessels and transient anæmia lasting from ten to fifteen minutes. Painted on the conjunctiva, this anæmia lasts from one to two hours, and is accompanied by slight contraction of the pupil. Injected under the skin the drug elicits the same local phenomena.

Of its action upon metabolism little is, as yet, definitely known.

It has been proved also beyond question that adrenalin exerts a powerful influence upon the functions of the liver, and that very pronounced glycosuria ensues as a consequence of intraperitoneal injections. It has also been found by several observers that after removal of the suprarenal bodies in animals death speedily follows from general progressive paralysis.

The three most noteworthy points in the above pathogenesis are: (1) Its power of selection upon the vasomotor system; (2) the same upon the centres of the medulla oblongata; and (3) evanescent action of the drug. Its whole physiological and therapeutical effects conform with Arndt's fundamental biological law, and its mechanism hinges upon the *phenomena of contact* so ably set forth by Dr. Hugo Schulz in his "Aims and Objects of Modern Therapeutics." We find the same mechanism in all drug effects: a small dose causes stimulation, which increases in proportion to contact, goes further, and then speedily diminishes, both on account of the large excretion of the drug and its transient effect; large doses, although preceded by slight symptoms of stimulation after the initial absorption, are soon followed by paralysis. With immoderate doses death may follow unless there be gradual return to the normal with intermittent signs of stimulation, according to the rate of excretion of the drug. (Siefert, *Allg. Hom. Zeitung*, October 22, 1908, p. 70.)—J. G. B.

**Belladonna in Suppurative Inflammations.**—Dr. Newbery confirms Dr. Wheeler's suggested free use of fomentations of belladonna in acute suppurative inflammations by reporting two cases, one of whitlow where the inflammation was very intense

and had nearly disappeared next day, and the other in inflammation of the hand following a punctured wound by a rusty nail a week previously. The latter case rapidly improved, and suppuration appeared to be promoted. (*British Homœopathic Review*, November, 1908, p. 680.)—ED.

**Cantharis.** *Acute Poisoning.*—A man, aged 58, was admitted into the Johannesburg Hospital on June 30 suffering from breathlessness, giddiness and weakness, the symptoms having manifested themselves three months previously. Temperature, normal; pulse, 80; respiration, 20. Arteries at wrist slightly thickened. Urine clear, amber colour, specific gravity 1008, acid, no sediment, free from albumen and sugar. On July 9 patient complained of pain in left side and cough; there was also present a profuse watery exudate. Physical signs were those of fibrous or plastic pleurisy. Counter-irritation by liq. epispasticus B.P. was ordered to a space the size of a shilling, but by mistake an area 7 in. by 2½ in. was covered. One hour later there was urgent desire to micturate, passage of blood-stained urine in small quantities, at intervals of about five minutes. Slight headache was noticed, the pulse rose to 120 per minute, and profuse perspiration occurred. The pain, which was intense, was referred to the distal end of the pelvis. Morphine ¼ gr. gave relief to the pain. The amount of urine passed the first twenty-four hours was 28 oz., specific gravity 1019; acid, blood and albumen were present, the latter being estimated at 7 grm. per litre. The microscopic sediment consisted largely of mucus, numerous red and white blood cells and kidney cells (large round cells with vesicular nuclei), and granular protoplasm twice to four times the diameter of a red blood corpuscle. On July 10 patient passed 57 oz. of urine, but still complained of burning pain on micturition. Urine, specific gravity 1017, strongly acid; albumen, ½ grm. per litre. The centrifugalized deposit contained mucous corpuscles, numerous leucocytes, and red blood cells, the latter in chains and clusters of from forty to sixty, columnar epithelial cells from the urethra, epithelium from the bladder, altered by the action of the urine, and a few granular tube-casts. Next day the specific gravity was 1010, fattily degenerated renal epithelial cells, and leucocytes were still visible, but the red elements of the blood were absent. The urine measured 52 oz. in twenty-four hours. Next day a few spermatozoa were noticed, otherwise the symptoms had abated. (*Lancet*, September 12, 1908, p. 800.)—ED.

**Cirrhosis of the Liver.** *Therapeutics.*—Dr. Dewee has recently treated two cases of hypertrophic cirrhosis of the liver,

occurring in confirmed alcoholics, with the happiest results. In the first case improvement commenced only when the patient was put on a course of biniodide of mercury, and in the second upon merc. dulc. Case 1 was that of a man aged 46, who, when first seen, had œdema of the legs, prepuce and scrotum, and ascites to such an extent that the liver could not be palpated. His complexion was bronzed, there was some glycosuria, albumen to the extent of 2 grm. per litre, and the quantity of urea stood at only 9 grm. per twenty-four hours. The patient had already been treated *secundum artem* and had been put upon a strictly lacto-vegetarian diet, and this was continued by Dr. Dewee. The drugs given in succession were (1) cantharis and merc. cor. in alternation. These brought down the proportion of albumen from 2·0 grm. to 0·5 grm. per litre; otherwise the patient's condition remained unchanged. (2) Apis and nux vom. in alternation. (3) Apocynum  $\phi$   $\eta$ xxx. to  $\eta$ xl. per day, alternated either with kali nit. or scilla marit. (4) Arsenicum in the 30th, 12th and 6th dilution. At the end of three weeks, as the general condition remained unchanged, the patient was ordered merc. biniod. 2x 1·0 grm. per day, taken in four doses. The effect of the drug was immediate. At the end of five days urination had increased to such an extent that on each of two succeeding nights the patient passed as much as 8 or 10 litres of urine. It was then possible to examine the liver, which was found to reach nearly to the right iliac fossa (the patient was hump-backed). The biniodide was then continued in the 3x trit., 0·5 grm. ter die, alternated occasionally with nux vom., and the lacto-vegetarian diet was persevered with. At the end of ten months the liver was soft, the ascites had not reappeared, albumen was no longer measurable, and the quantity of urea was 23·0 grm. in twenty-four hours. Shortly after this the patient had a relapse, due to his own indiscretions, and ascites reappeared as on the previous occasion. A short course of the same drugs, merc. biniod., nux and bryonia, with a return to the lacto-vegetarian diet (relaxed so far as to allow the patient 100 grm. of meat twice a week, and one or two eggs), acted as speedily as on the first occasion, and the patient was soon in better health than he had been for years.

The second case was that of an engineer who, before falling into alcoholic habits, had resided for a long time in Indo-China, where he contracted malarial fever. He had been tapped three times in Paris before coming under Dr. Dewee's observation. When first seen there was ascites, with enormous collateral



circulation, œdema of legs, scrotum and prepuce. Here also palpation of the liver was impossible owing to the amount of the ascites. Relying upon the fact that quinine in large doses has been known to produce oliguria and even anuria, Dr. Dewee ordered chin. sulph. 6, 20 cg. every two hours, with the result that 2 litres of urine were passed the same evening and 8.6 litres during the following day. The liver could then be felt extending down as far as the anterior superior spine of the ilium. In order to prevent, if possible, the natural evolution of the disease towards the atrophic and invariably fatal stage, the patient was given a course of merc. dulc. 1x trit., 20 cg. per day, with lacto-vegetarian and non-saline diet, and, of course, suppression of all alcoholic drinks. Within a few months the patient was able to resume his professional duties and travelled over a great part of Spain and Algeria without feeling any the worse. (*Journal Belge d'Homœopathie*, October, 1908, p. 169.)—J. G. B.

**Eel-serum in Subacute Nephritis.**—Picard, guided by Jousset's proving of serum from the eel, administered it to a patient with subacute nephritis following articular rheumatism, and with very gratifying results. The renal symptoms came on quite suddenly, without apparent reason, eight days after she first sought advice, and were ushered in with vomiting and puffiness of the face. During the succeeding twenty-four hours only 250 gm. of urine were passed; these were high-coloured and cloudy, threw down an abundant deposit, and contained abundance of albumen. The patient was in a condition of semi-stupor, vomiting was frequent and abundant, and micturition frequent, scanty, and painful. Cantharis and belladonna were given every hour alternately, with a strictly milk diet, absolute rest in bed being ordered. Next day (after twenty-four hours of this treatment) there was no sign of improvement. The quantity of urine and frequency of micturition remained the same. There was œdema over the malleoli and the back of the hand, and puffiness of the face. Vomiting was more frequent, and the condition of stupor more pronounced. Eel-serum (2x dilution, ten drops in divided doses during the twenty-four hours) was now administered with a watery diet, the result being that marked improvement was noticed on the following day. The quantity of urine had doubled, and as much as 150 grms. had been passed at once. Vomiting had ceased, and the œdema and stupor diminished. The remedy was continued, but this time in the 1x dilution, and the milky diet was resumed. Next day there was all-round improvement and about a litre of urine had been passed. On

the ninth day from the date of the appearance of renal symptoms the urine was once more normal, the quantity being 1 litre, and there being no trace of albumen. The remedy was continued for a few days longer (thirteen days in all), when the patient was pronounced to be well and was allowed to resume ordinary diet. (*Revue Homœop. Française*, June, 1908, p. 263.)—J. G. B.

**Electricity as an Anæsthetic.**—Dr. William Harvey King draws attention to the Leduc current as capable of producing anæsthesia in animals and the human subject. The Leduc current, so named from its introducer, Dr. Leduc, of Nantes, France, is a special form of unidirectional current of low tension, with interruptions at the rate of 100 per second, and with the duration of each impulse as 1,000th per second. The current from an incandescent circuit of 110 volts pressure is employed, and this is passed through a double shunt for the purpose of reducing the voltage. Dr. King has made some experiments on four animals and two human beings. The latter are interesting as showing that this form of electricity is capable of proving the beginning of anæsthesia, and, perhaps, when more is known of its effects it may find a place in therapeutics. The first subject of Dr. King's experiments was a literary gentleman who suffered from almost continuous attacks of congestive headache with periodical exacerbations. The current was applied during an attack. It seemed to produce pressure, palpitations and rushing currents through the head, and after a considerable time a soothing sensation which, when the application was removed, was judged to be of a general anæsthetic character.

The other person experimented on was a woman of sensitive temperament. The current produced in her a feeling of intense nervousness and subsequently a "crazy" feeling in her head. She was apparently fast falling asleep with a regular pulse but irregular respiration when the current was turned off. She then stretched herself, and felt she had been roused from a nap. (*North American Journal of Homœopathy*, October, 1908, p. 504.)—ED.

**Lachesis in Facial Neuralgia.**—Lachesis is probably not often indicated in facial neuralgia, but a case reported by Dr. Edward R. Miller is sufficiently distinctive to show that it may sometimes be the remedy. A. H. N., male, aged 72, had suffered from severe pain in the left upper jaw for eighteen months, following the extraction of a molar tooth. The pain was of a sharp, jumping, piercing character, as if a knife were thrust into the part.

< eating, drinking cold water, mornings and forenoons, exertion, taking sour things, > hot drinks, at night, after dinner. Tooth cavity very sensitive in the morning < suction and swelling, talking and laughing. Always better in the evening. Mag. phos., aconite, arsen. alb. and merc. sol. were tried without effect, treatment being continued for six weeks. Then on the last-named indications lachesis 6x (? x) was given, followed by 12x (? x) and 30x (? x), with quick relief and permanent cure in a month. (*New England Medical Gazette*, November, 1908, p. 506.)—ED.

**Nux Moschata.** *Characteristics.*— There are three leading characteristics of nux moschata which, when present in a case of disease, point to its selection in preference to other remedies. These are excessive drowsiness, especially after eating, due to a numbing influence on the nervous system rather than to vascular or circulatory changes, excessive dryness of the mouth without thirst, the tongue, lips, and throat are all dry, and pain with flatulent distension of the stomach and abdomen, especially after food. As regards the first characteristic, nux moschata may be compared with antim. tart. and opium; as regards the second, apis, pulsatilla and lachesis, and as regards the third, kali bichromium, nux vomica and anacardium. (Dr. W. O. Cheeseman, in the *Homœopathic Recorder*, 1908, p. 491.)—ED.

**Opothrapy in the Treatment of Malarial Fever.**—Dr. Castellan, of Toulon (an old naval surgeon), believing that after the febrile attacks have been cut short by quinine the chief indication is to overcome the deglobulization of the blood, and consequent anæmia, which is so marked a feature of chronic malaria, has been systematically using an opotherapeutic remedy prepared from splenic pulp. This is now put up in "ampoules" for hypodermic injection, and has been christened *Paludol*. Dr. C. now uses the remedy from the beginning, to the exclusion of quinine, and finds that a hypodermic injection given during the febrile stage will bring down the temperature 4° (C.) within a quarter of an hour; the pulse falling proportionately. "The rigors, muscular pain and anguish are removed as it were by magic." During the treatment he finds that a painful spot appears in the splenic region, and he looks upon it as a sign that the remedy is taking effect, and that active regeneration of red corpuscles is in progress. The sterilized ampoules of *Paludol* contain the equivalent of 0.003 gramme of splenic pulp in each cubic centimetre, and with adults Dr. Castellan injects one every twenty-four hours at first, and

every two or three days as soon as the fever has disappeared. In some cases he found that four injections were sufficient. (*Journal Belge d'Homœopathie*, vol. xv. p. 126.)—J. G. B.

**Plumbum.** *Saturnine Poisoning, with Meningitis, Anæmia, and Jaundice.*—M.M. Bernard and Traisier give the following account of a case of lead poisoning with marked cerebral symptoms, due at least in part to meningitis as demonstrated by an examination of the cerebrospinal fluid.

The patient was a worker in a pottery, was an alcoholic, and had had ague years previously. He was admitted into hospital on April 20, 1907, complaining of headache, giddiness, and mental obfuscation following upon an epileptiform seizure, which had occurred whilst at work the day before. When admitted he was seen to be plunged in a very pronounced condition of mental hebitude almost verging upon coma. When questioned, however, he answered correctly, though with an effort. There was no loss of memory, and he was able to give his history. Unlike his fellow-workmen, he had never had either colic or palsy, but had felt pains in the legs, and noticed a diminution of visual acuity to the left. There had been also considerable loss of appetite, flesh, and strength of late, and he had become very pale.

On examining his nervous system no disturbance of motility or sensation could be made out. The headache was continuous, but not intense; there were no trophic troubles, and neither Kernig's sign nor stiffness of the neck. The reflexes were normal. Vision was diminished to the left, and he complained of diplopia; pupillary reactions were normal.

Lumbar puncture gave a clear liquid issuing rapidly *guttatim*, containing 60 per cent. albumen (Esbach); it contained no trace of lead, even with tests sensible to 1 : 200,000. Examined microscopically, it showed about twenty lymphocytes and a few medium mononuclear cells. The arterial tension varied between 16 and 18 of Potain's sphygmomanometer, and there was no souffle in the jugulars. The skin was waxy-looking, almost greenish, mucous surfaces completely exsanguine. There were no bile pigments in the blood serum, and the latter had no hæmolytic action upon the patient's own red corpuscles. These last numbered 2,790,000; white cells, 7,000; hæmoglobin, 70 per cent. On microscopic examination of fixed films polychromatophile cells were very numerous, and there were a few nucleated cells and a few myelocytes in each slide.

There was a well-marked blue line on the gums. Urine contained no trace of albumen.

On August 25 the patient had three typical epileptic crises, following which he was in a condition of somnolence interrupted by delirium. Next day he had another crisis, and on the 27th a slight attack of jaundice, colouring skin, and conjunctivæ, though the stools were not pale.

By August 31 jaundice had almost disappeared. During the forenoon of September 1 he had five fresh epileptic crises, followed by pronounced delirium. On the days following, this latter, alternately with periods of lucidity, and there were no fresh crises. From this date improvement set in, and by the end of October he was practically well, although a second lumbar puncture showed still some lymphocytosis. (*Société Méd. des Hopitaux*, May 22, 1908.)—J. G. B.

**Silica Marina in Constipation.**—Dr. E. Cronin Lowe reports five cases of chronic constipation in patients, four of whom were accustomed to take strong aperients and suffered from backache, tendency to hæmorrhoids and other accompaniments of such a condition. The drug was given in the 3x trit., administered at night or night and morning, and the patients allowed to continue their purgatives at less frequent intervals. The effect of the silica marina was gradual but permanent, as after a few weeks the purgatives become unnecessary, and comfortable daily evacuations took place. The fifth case was that of a child, aged 3, who had very rare stools (once in seven days), hard, broken and light coloured. Various remedies had been given without effect, but silica marina 3x every night cured the case in ten weeks. (*British Homœopathic Review*, December, 1908, p. 715.)—ED.

**Strychnia Phosphorica.** *Summary of Proving.*—Eleven students of the Iowa State University Homœopathic School, under the supervision of Dr. George Royal, have made a proving of the phosphate of strychnia under the general rules of the O. O. and L. Society. The provings may be summarized as follows: The drug seems to act through the cerebrospinal nervous system. Twitching, trembling of muscles, lack of co-ordination stiff, weak, or complete loss of power, vertigo and fainting. Mentally, much silly laughter. Very irregular pulse, from 50 to 132, face flushed, skin at times cold and clammy. Subnormal temperature as low as 97°F. Markedly worse from motion. Better from rest and open air. The attenuations proved were the thirtieth, sixth, third and first; all acted. (*Homœopathic Recorder*, November, 1908, p. 515.)—ED.

**Viscum album in High Arterial Tension.**—Dr. Le Breton-Oliveau (*Thèse de Bordeaux*, 1908) was led to study the action of the extract of mistletoe in albuminuric hypertension after reading the results of Gaultier's experiments in Dieulafoy's laboratory. Gaultier found that intravenous injections corresponding to 0.25 cg. of fresh plant exercised a powerful action upon the central vaso-motor system; it augments the heart-beat, diminishes reflex action, and dilates the pupil. Dr. Le Breton-Oliveau has tried the effects of the drug in fourteen cases of hypertensive albuminuria (chiefly in pregnant women) and finds that it brings about speedy lowering of arterial pressure followed by amelioration of the albuminuria, especially if used in conjunction with a strict *régime lacté* or *régime déchloruré*. He prefers injection of repeated small doses of the drug to injections either subcutaneous or intramuscular, as the quantity used can be larger, and its action is more certain and continuous. (*L'Art Médical*, June, 1908, p. 469.)—J. G. B.

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A GENERAL REVIEW OF THE DEFENSIVE  
POWERS OF THE ORGANISM AGAINST  
MALIGNANT DISEASE; A WORKING HYPOTHESIS FOR ITS THERAPEUTIC TREATMENT; PERSONAL EXPERIENCES WITH CACODYLATE OF SODA AS A REMEDY.<sup>1</sup>

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SYNOPSIS.

I.—That the future successful treatment of malignant disease lies with the physician and not the surgeon.

II.—The general immunity-mechanism of the body against malignant disease.

III.—The local reaction (first line of defence) against malignant disease.

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, January 7, 1909.

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IV.—The local and general powers for disintegration and resorption of cancer deposit.

*A Working Plan for Early or Limited Cases.*

I.—It is necessary to heighten the depressed general immunity-mechanism.

II.—It is necessary to safeguard the local provision (first line of defence) for isolation of cancer-growth.

III.—It is necessary to increase the natural powers for disintegration and absorption.

*Personal Experience with Cacodylate of Soda as a Remedy.*

I.—The type of case where cacodylate is of the greatest service.

II.—The precise time for the institution of cacodylate treatment.

III.—The necessary duration—"the three-year limit" of systematic cacodylate prescription.

This paper is a clinical paper.

For short I have used the word "cancer" as representative of malignant disease; and I must ask you so to construe it.

The facts I have observed myself, and they can be verified by any competent observer. The views seem to me fairly deducible from the clinical work.

For the facts I beg your verification; for the views I invite the full flavour of your candid criticism.

PART I.

*I.—That the successful treatment of the future in cancer will lie with the physician and not with the surgeon.*

Considerations of cause do not impair the validity of this view, for whether cancer be of local or constitutional

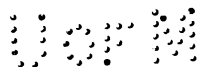




origin, whether the primary determinant be a ferment or a bacterium or a sporozoon, whether we trace its physical basis to cell-rests or to reversions to type, the whole subject-matter resolves itself into questions of soil and seed, and these are the problems of the physician.

As in the cognate case of tubercle, cancer-surgery deals with end-results only; but the fundamental problems of the case are quite other than those secondary issues whose solvent is surgery. The tracking of the remedial processes actually employed by Nature in its occasional spontaneous cures, the physiological methods of prevention—the immunity-producing agencies—active in each one of us at the present time who have not got cancer; the increasingly frequent breakdown in the victim of the subtle mechanism of protection hitherto competent—these are the real problems of the prevention and remedial management of malignant disease, and not the mere lopping off of cancerous parts, concerning which an enlightened age will one day wonder how in the name of patience we could ever have been content.

The old high and dry *non-possumus* school—now hopelessly belated—would have none of the larger outlook. Chief exponent of this self-limitation within a rigidly closed circle was Syme, who would have it that cancer was not curable, and what you cured was not cancer. Contrast with this the latter-day utterance of Sir William Church, ex-President of the Royal College of Physicians: “It appeared that the natural cessation—he would not say cure—of the growth of cancer occurred more commonly than the bulk of medical men thought. It had been common knowledge to all surgeons that different kinds of malignant disease—especially carcinomata—did die out. As a physician he had himself seen cases of that kind.” Mr. Henry Morris followed: “He was sure that it should not be taken as a routine procedure that because a person had cancer which was capable of removal, therefore it ought to be removed.” When orthodoxy thus proclaims its dissatisfaction and its hope, the new medicine may well be assumed to be already in the van.



II.—*That there is a natural preventive mechanism against the development of cancer—a physiological mechanism normally producing immunity.*

The evidence of the existence of a normal prophylaxis is entirely clinical. Laboratory work has hitherto thrown as little light upon this as upon the cognate point of the neutralizing factors against cancer that is already developed. "It will," says Professor Goldmann, "remain a subject for future research to discover what these neutralizing substances are, and, above all, where they are manufactured." Some future Ehrlich or Wright, perhaps occupying a seat before me, will reveal this. But my proposition goes a step beyond—it affirms the existence, on clinical evidence, of a prophylaxis against cancer development, normally operative in all of us.

The clinical evidence is many-sided.

(1) *The Age Factor*.—Note that the plastic period of life—the period of youth and adolescence—is by far and away the least liable, in all states of health, in all kinds of heredity, to the development of cancer. It is almost within a ring-fence as regards malignant disease. Now this is a positive, not a negative, phenomenon, and is susceptible of a positive interpretation only. Note further that, *e.g.*, in women between 35 and 55, the maintenance of immunity is depressed to a very low level—and this at a time when the *sturm und drang* of existence is greatest—while after 60 the immunity-mechanism still further declines—a product of senescence. Now, where fluctuation of bodily values occurs, the environment remaining more or less constant, the main cause of this undulation must be corporeal.

Let us state a case:—

A young lady, in the early years of her married life, was operated on by Sir James Simpson for sterility. No issue followed; but the scar remained. At about the age of 70 I saw her, and found her to have epithelioma of the cervix, in the scar that Sir James Simpson had made fifty years before. Cancer of the cervix, I may say, is rare in childless women. This scar had remained unaltered all the intervening years, until the depression of the



immunity-mechanism had fallen with age below the critical point, and malignant disease easily followed.

(2) *The Ovarian Factor*.—It is found that ablation of the active ovaries exercises a retrogressive influence—at least for a time—on cancer nodules in the breast. I show one case this evening where complete disappearance of such nodules ensued. Such a sequence can only be explained on the working hypothesis of an immunity-mechanism influenced by the activity or obsolescence of ovaries.

(3) *Immunization through Heredity*.—I examined some time ago the family histories of many cases where cancer had been the family malady for generation after generation; and I was struck with the record that after a cancer-history had run through three successive generations it usually died out in the fourth—the stock had become, in fact, more or less thoroughly immunized; and I ally this observation with the ebb and flow of the protective mechanism reaching through generations.

Picture to yourselves, as part of the normal physiological outfit of each one of us, an immunity-producing mechanism against cancer. Note that its value is greatest during the plastic years of life—*i.e.*, during childhood and adolescence. Note further that its value tends to be depressed by unfavourable heredity, by age, by the changes of obsolescence, by traumatism, by prolonged emotional stress. Note again that this immunity may fluctuate from time to time—that is, may fall and rise again, as is evidenced by the age tables. Finally note that we have no laboratory evidence of this depression, below the critical point, until the result has materialized in a new growth. The synthesis will give you a broad idea of what is transpiring in the personality of every one of us, every year of our lives.

I do not propose to dwell on the vexed question as to the extent played by local conditions in the induction of cancer. In any case, whether the preceding local state be merely one of lowered vitality, or whether some purely local immunity-mechanism has degenerated, in any case I regard the local antecedent as second in priority to the generalized constitutional antecedent; and so I pass to my next proposition.

*III.—That in cases of cancer the body reacts in a varying degree against the malignant growth; that defensive substances—antibodies—are thus developed and are diffused through the organism, and that the chief area of operation of these defensive bodies is in the locality of the new growth.*

No other conclusion can be drawn from the vast clinical evidence at our disposal. Two women each receive a blow on the breast from some one of the innumerable opportunities that civilization affords. One passes through a period of local pain and swelling; the exudation subsides, all traces vanish. The second, less fortunate, loses all obvious trace of the injury, but ere long renewed growth appears at the identical site, growth bearing the palpable characters of malignancy.

What is the difference in the issue, and therefore in the equipment of these two cases? The one had an effective generalized immunity-mechanism at work; in the other it was defaulting. The first woman passes out of our province; the second remains. Under a favourable environment, with neither anxiety nor poverty, the malignant growth thus established may remain year after year at an irreducible minimum. Again, what has happened? The local defence, functioning as antibodies, reinforces the defaulting immunity-mechanism, raising this again to active value; further growth is checked. Now happens an untoward incident: "Cancer is cancer, and therefore should be removed"; round comes somebody thirsting for gore; the quiescent growth plus its surrounding is taken away, and in a little time the cancer fiend returns with overmastering force, and medicine and surgery now stand helplessly by. Here the explanation is too obvious to dilate upon; the local generation of immunity-substances, stopped by the removal of the cancer mass, no longer acts as a protecting barrier against the local spread, no longer raises the value of the generalized immunity above critical point—nay, something has happened which actually depresses it, and wholesale disorganization ensues.

Here is an object-lesson. A lady of mature years was

sent to me nearly a decade ago by a colleague. Eighteen years previously she had had a tumour removed from the right breast, and pronounced non-malignant. Later on another tumour was removed from the left breast, and also pronounced non-malignant. But ere long a multiplicity of nodules, amazingly like cancerous nodules, developed round both operation scars; the intervening skin area was brawny; there was no doubt of the malignancy this time. She died in a further few months of abdominal carcinosis. Here the same explanation applies. A growth on the cancer border-line can create a sufficient barrier of defence so as not to jeopardize life. Growth and barrier are operatively removed; the generalized immunity-mechanism remains low; another organ succumbs. A second time are growth and first line of defence removed, and something has happened which still further depresses the immunity-mechanism, for frank and declared carcinoma now runs riot just near the primary site, and later in the abdominal cavity.

Here is another case, equally teaching. A married lady, the mother of several children, one day incidentally discovered a lump in her right breast. A surgical specialist was called in, who advised and carried out removal. Microscopically the growth proved to be carcinoma of no very virulent type. But mark the sequel.

A year later uterine symptoms attracted attention. Examination showed a fixed nodular uterus, which enlarged with almost hothouse rapidity, and in less than a twelve-month after its incipiency the patient died of acute pelvic carcinosis. The breast region remained free from any recurrences; no anatomical connection existed between the primary breast cancer and the secondary uterine one. Just the same explanation obtains as in the previous case; the non-insistent local growth and its reaction, producing protective substances, are swept away. The general immunity-mechanism is still further depressed, possibly by the stress of operation, certainly by the removal of some detent hitherto functioning. The next point of least resistance is attacked—in this case the uterus—and with a

virulence that admits of no local protective measures of any consequence.

*IV.—That there is a clear clinical distinction between the processes, local and general, which maintain our protection against cancer, and the processes which disintegrate and remove cancerous masses already deposited.*

That is, *the body-mechanism of protection against cancerous growth and the body-mechanism of its removal* are two separate processes; sometimes concurrent, sometimes acting separately and apart. Clinically, they are distinct.

Consider for a moment the significance of the following case:—

A lady of mature years, the victim of great mental anxiety, had suffered from cancer of the breast, involving the axillary glands and producing huge œdema of the arm. Under measures purely therapeutic the œdema greatly lessened, the breast nodules had nearly vanished, and the upper extremity had practically ceased to give distress. This obviously represented the stage of degradation and resorption of the cancerous neoplasm.

But is that all? What put a bound to the further extension of the proliferative process? The cancer ceased to grow. What caused also its removal in great part? The cancerous nodules disintegrated and very considerably lessened in bulk. What superadded absorption of alien tissue to arrest of alien growth? Scarcely an increase in the general immunity-mechanism, for here is the sequel.

*Not long after, while the cancerous breast was retrograding, malignant disease actively set in in the pelvis; the pelvic organs became an infiltrated mass of fast-growing carcinoma, while decadence was proceeding in the original cancerous site—and the patient succumbed.*

Now he that runs may read this happening. Profound emotional upset in the first instance, depressed and maintained at minimum value the general immunity-mechanism of the organism. Local cancer-changes occur in the breast. But the local reaction eventuating in the isolation of the cancer-mass is proceeding apace. Yet another malignant

outbreak occurs simultaneously elsewhere. Clearly, then, impotence of general protection and the potency of local reaction in this type of case are concurrent. They are not actuated by the same cause: they work independently. Here the local reaction locally neutralized the generalized immunity-depression.

Did the local protective reaction, then, bring about the process of disintegration and resorption? Scarcely so; for in unnumbered cases, where local protection maintains the cancer-mass in a ring-fence of isolation—maintains it in an innocuous and stationary condition year after year—and the malignant mass undergoes no change in bulk. It is retarded in growth; no malignant developments occur elsewhere; but the antibodies that stop cancerous growth and neutralize cancerous multiplication are not the cytolytins that stimulate cancerous degeneration and resorption. And this influence has a most important bearing on treatment; for remedial measures that maintain and amplify the ring-fence may have no accelerating influence whatever on resorption. On the other hand, substantial local defence must necessarily precede and protect resorption.

So much, then, for the facts of the situation and those that have led up to it.

How are we to rectify this condition of things, and not only eradicate the end-result, the cancer-degeneration, but put an embargo on its occurrence?

#### A WORKING PLAN FOR THE TREATMENT OF CANCER CASES IN GENERAL.

*First and most important is the heightening of the generalized immunity-mechanism, whose depression has allowed cancer degeneration to occur at the point of least resistance.*

This is the key of the whole situation. Every remedial measure, surgical or medical alike, is bootless if it does *not* achieve this, and fruitful if it does. To heighten these specific defensive processes of the economy above the critical point is to arrest the further proliferation of the cancer-mass and to effectively protect the remainder of the economy.

This depression constitutes the so-called precancerous stage. How long it exists before cancer-development actually occurs we do not know. What we do know is that it fluctuates, is sometimes stationary, sometimes goes down with a run, takes time for its slow reinstatement, and sometimes is never reinstated at all. The actual presence of carcinoma is no bar to the existence of restored effective general protective mechanism, provided the mass does not increase in size. An extension in growth means the failure of the generalized protective process, an arrest in growth its sufficiency.

But it is exceedingly unlikely that any great increase above critical point of the general protective mechanism can spontaneously occur while local cancer-deposit exists; the condition is too unstable; and in all cases of malignant disease, therefore, some initial provision for the heightening of the general protective mechanism must be made if any abiding progress is to be effected.

I regard the existence of any other form of growth as an indication of a lowered general protection, but not necessarily below critical point. I regard the periods of life when cancer mortality is greatest as almost certainly corresponding to a lowered value of protective mechanism in all of us, and I regard the persistent action of well-known primary causes of cancer—chiefly emotional stress—as undoubtedly tending to lessen the general resistance of the system to cancer-development.

Unfortunately we have as yet no definite laboratory test—no positive index—by which the fluctuations of the protective mechanism may be registered. But the clinical indications, though crude, are sufficiently clear to warrant action.

The heightening of the protective-mechanism directly is at present beyond our powers. There is, however, a method of heightening the protective mechanism of the body in a circuitous way, and that is by the use of drugs. The protective powers I specially wish to bring before your notice are those of organic preparations of arsenic known as the cacodylates.



II.—*It is necessary to Safeguard the Local Provision (First Line of Defence) for Isolation of Cancer-growth.*

But the *dénouement* has occurred: Malignant disease has developed, generalized protection has failed in one point; what is to be done?

Besides seeing to it that the general protective mechanism is heightened, it is of the greatest importance that the local defensive measures are made effective. I would propound that a ring-fence of antibodies—varying much in potency—is part of the periphery of every malignant growth. And this conclusion has been arrived at not by laboratory but by clinical work. Professor Goldmann, of Freiberg, came over to England last year to read a paper on this and similar points before the Royal Society of Medicine. Here are some of his conclusions: “We find in a growing tumour—that is, a cancerous tumour—an extensive new formation of vessels. This is most apparent at the zone of proliferation, which in infiltrating tumours is at the periphery. In any case, I regard this vascular new formation as a standard by which we may test the body’s power of reacting against malignant tumours. Again, all these facts prove that the body commands powers of combating cancer and healing it. Intensified circulation itself is the effect of those healing powers.”

“The efficacy of this intensified circulation is naturally dependent on the presence of defensive factors in the blood. It will remain a subject for future research to discover what these defensive substances are, and, above all, where they are manufactured. It seems to me that our present clinical and pathological knowledge already enables us to infer that the body’s first line of defence is established on the boundary of the invading growth.”

Laboratory work has not yet identified and isolated such defensive agents, mainly because laboratory work has not long been occupied with the problem. Nor has laboratory work shown us why the peripheral defence so often is totally inadequate to meet local necessities. My own view is that this is mainly due to the persistence of the depression in the generalized immunity-mechanism.

How to heighten the local first line of defence? Certainly various drugs tend to increase and fortify this, and also such local influences as the use of radium, Röntgen and other rays.

III.—*It is necessary to Increase the Natural Powers for Disintegration and Absorption.*

Let us state now a third case, where a malignant growth, having developed, has become stationary, and no other developments are occurring elsewhere. To translate this into the terms of our working hypothesis, the general immunity-mechanism has risen above critical point : the local defensive measures have proved effective. Still there is something to seek ; it is the disappearance of the growth itself. So long as it is there we can never be sure that the local defence may not at any time default, and proliferation again set in. The next crux is the disintegration and resorption of the growth itself.

Now, is this possible? Are we dealing with the legitimate object of sane men, or only disporting ourselves in the Paradise of Fools? Listen again to the *ipsissima verba* of Professor Goldmann : “The body commands powers of combating cancer and healing it. An overwhelming amount of evidence has been brought to light on this score by Lömer. He refers to upwards of 200 cases of cancer in which the clinical diagnosis was almost invariably confirmed by histological examination, and in which recovery ensued : in some without surgical interference, in some after incomplete removal of the growth.”

I have some contributions to make to this subject ; here is the time and place for one dealing with X-rays. I attended a lady who had a slowly increasing breast-growth, ultimately becoming stationary. The husband, a man of position and intelligence, had an X-ray installation fixed up at home, and a prolonged course of X-rays was thus given. While away on holiday an acute mastitis set in in an uninvolved part of the breast ; and as this subsided it became obvious that the original growth had increased in bulk, and I removed the breast on the ground of renewed

extension of growth. The tumour was submitted for examination to one of the most expert special pathologists in town.

To my surprise he asked me, after a microscopic examination of a section, if the patient had been submitted to a course of X-rays? Before replying, I enquired on what grounds the question was asked. Why, said the expert, because I recognize in this section retrograde changes in the cancer-cells that I have learned to associate with the use of X-rays—retrograde changes, too, of a marked character; and I further obtained in conversation the opinion that had it not been for the unfortunate attack of mastitis the growth might reasonably have been expected to be absorbed in whole or in great part.

I may also say that this patient had been for a long time under the influence of cacodylate of soda also.

Now Lōmer's 200 cases of the verified absorption of cancer-masses prove incontestably that there are natural powers potent for the eradication of malignant growths under given conditions. And what is the adjustment of a remedy to a case but an endeavour to induce the given conditions?

*The Legitimate and Necessary Rôle of Surgery as a Remedial Measure in Cases of Cancer.*

But what is the exact part that surgery can play in this tripod of heightening the general immunity-mechanism, of increasing local defence, and promoting eradication of the degenerate mass?

In a scientific apportionment of remedial measures the position of surgery is definite and justifiable. As a magnificent exception in cancer the untutored instincts of mankind have decided for surgery; for much as human nature dreads the knife, it is paralysed with fear at the approach of malignant disease. So long as medicine halts in maintaining the general equation as regards cancer well above the critical point, so long as the local defensive measures cannot surely and certainly be perfected, an unbreakable ring-fence round cancer-invasion, so long as disintegration and absorption

—in a word, removal—cannot be certainly counted on from remedial measures, so long will the dramatic and spectacular but limited and faulty substitute of surgery be resorted to.

How does surgery fulfil the canons for the effective treatment of malignant disease? The chief, that of prevention, or the maintenance of the immunity processes above critical point, it obviously cannot meet at all. This is the physician's problem. The data of falling values in cancer-immunity, and the general causes which favour this decline, are to be derived from the clinical observations of the physician, and surgery cannot be blamed if it does not meet the case. Still, the fact so remains that surgery does not and cannot deal with a half of the great cancer problem—to wit, the maintenance of the bodily resistance against cancer, or, this having once occurred, the prevention of recurrence.

The next canon, the effective isolation of the cancer-mass by local reaction at its periphery, would appear not to be germane to surgery. There is no known surgical procedure which will increase this "*isolation by defensive reaction*" at the periphery of the growth. But Professor Goldman is very definite about the undoing which surgical measures *may* effect in even a well-isolated and neutralized growth. Here are his statements :—

"It seems to me that our present clinical and pathological knowledge already enable us to infer that the body's first line of defence is established on the boundary of the invading growth. From this point of view we understand cases like the following, which I believe have come within the notice of every surgeon. Patients suffering from cancer of slow growth and long duration are advised to have it removed instantaneously. The operation is successfully performed, and the healing process is normal. Yet the patient returns within a short time suffering from a recurrence which has grown rapidly, and has assumed features of an alarming nature. It appears to me that in such case the surgeon's knife has done harm. In removing the growth he has destroyed that barrier of defence which the body has care-

fully raised up during the long period of the tumour's existence."

But now, concerning the third canon—the disintegration and resorption of the cancer-deposit—does not surgery offer a more desirable substitute—the thorough-going removal of the whole danger-zone, without waiting upon the slow, uncertain and oftentimes defaulting natural removal? Now, I thoroughly endorse the opinion quoted earlier as coming from Mr. Henry Morris as to the undesirability of operating on all operable forms of carcinoma. Yet I emphatically endorse the view that *in operable cases*, where the cancerous growth is increasing—that is, where local defence has proved insufficient—the cancer-mass is better removed by surgery—should, in fact, be removed without delay rather than wait for a disintegration and absorption, which is always slow, and may never be brought about.

And this I hold to be the true function of surgical aid: to bring about by art what Nature has been unable to effect—the immediate elimination of the cancer-mass from the organism. Granted that this surgical procedure is merely dealing with results, leaving the original causes in undisturbed possession still to repeat their malignant progeny; granted that this surgical removal offers absolutely no protection against later recurrence, *in situ* or elsewhere; granted that surgical procedure is in its conduct incomplete, in that all the radiations from the malignant centre cannot be got at; that the local barrier of defence, such as it is, is swept away, and that a new weak point, an area of scar tissue, is left as a permanent addition to the places of least resistance; yet in spite of these valid criticisms, the benefit gained by surgical procedure, in proper time and place, linked up with the other essential factors in cancer-treatment, flanked by a heightened immunity-mechanism and by awakened power of local defence—I say that the benefit gained in available cases is so necessary a benefit as to make surgery a part and parcel of remedial cancer-treatment in many cases. There are banished the anæmia and sapræmia which further depress the immunity-mechanism; it is not necessary to obliterate

every enlarged gland and choked lymphatic, for the defensive powers of the body, local and general, can often be raised to neutralize these. There is then in less perfect measure a start over again, with the dire results of past physical riot swept from the field, leaving the problem to be worked out anew. The crux—after surgery, the problem of final elimination, the problem of prevention of all happening over again is still in every case clamouring to be worked out—and that, as I said at starting, is a physician's problem.

This naturally brings us to the question of the relation of surgery to the fourth canon—the prevention of recurrence *in situ* or elsewhere. I will put the issue in a nutshell. *The most perfect surgical procedure possible, worked out under the most favourable circumstances, enriches the defensive powers of the body with no new force to obviate the whole clinical sequence being developed over again in the same or another locality.*

A malignant degeneration is not an occurrence that comes once in a lifetime, leaving in its train immunity against another attack. The cured cases by Nature or the physician are hitherto too few for statistical evidence. But my own clinical experience leads me to believe that at least three years must pass after all traces of malignant disease have vanished ere the patient can be considered cancer-free. And all surgical statistics go to show that one attack, tided safely over by surgical measures, is almost inevitably linked up with a later, even after a dozen years of quiescence.

On the walls of the obstetric department of a great Continental hospital there were inscribed the mortality-statistics of childbirth before and after the introduction of antiseptics. To this was appended the moral: "It is inimical to conduct childbirth without the protection of antiseptic treatment."

Now I should like inscribed over the door of every operating-room where cancer operations are performed, and I should like every operating surgeon to take as the motto in his surgical insignia :—

IT IS CRIMINAL TO CONDUCT SURGICAL OPERATIONS FOR THE REMOVAL OF MALIGNANT DISEASE, WITHOUT BEING PER-

SONALLY RESPONSIBLE FOR THE IMMEDIATE INSTITUTION OF THE NECESSARY THERAPEUTIC MEASURES FOR HEIGHTENING THE BODILY DEFENCE.

That is the psychological moment, that is the most promising juncture attainable; when surgically freed from a cancer-mass, the patient's protective forces can now be economized to neutralize the inconspicuous peripheral remnant, and slowly heightened for future protection.

This all-important occasion will never occur again. And I put the onus on the surgeon's shoulders, in that, after the brilliant issues of his auxiliary procedure, the patient regards his words as almost inspired. The physician, with less dramatic methods, plays second violin. But the physician has the real key of the situation henceforth in his hands.

## PART II.

### PERSONAL EXPERIENCES WITH CACODYLATE OF SODA.

My first introduction to the practical use of cacodylate was in 1902, when it was used in my out-patient department at the hospital in a case of post-operative recurrence of carcinoma of the breast. I gave consent to its use as a forlorn hope; but my eyes were quickly opened to its value, as the local condition, in point of swelling and pain, underwent considerable improvement under our observation and this treatment. What was the upshot I do not recall; the patient passed out of my purview; but I do recall the definite inspiration it gave to me as to the possibilities of remedial measures in malignant disease. Nor was this inspiration allowed to play itself out.

Not long after I saw a patient with a fast-growing swelling on the abdominal side of Poupart's ligament on the left. The growth was red, soft, indifferently fluctuating; it was conceivable that it might be the outlet of a pelvic abscess. The patient was prepared for operation, and this commenced; but the first touch of the knife made it evident we were dealing with a proliferating infiltrating mass, and not a suppurative one. Excision was impossible; a small piece was removed for microscopic examination. The naked-eye diagnosis of sarcoma seemed sufficiently legitimate to justify my informing the husband that I feared his wife had but

six months to live. The incision rapidly closed; the microscopist's verdict came that the histology was that of sarcoma, and as a purely forlorn hope I ordered the patient to take cacodylate of soda in  $\frac{1}{4}$  gr. doses thrice daily, not daring to expect that any good result would accrue. Now for the sequel: Three years afterwards the patient was alive and well; she had gained over two stones in weight; she had steadily continued with the cacodylate for pretty nearly the whole of this time, with occasional breaks; and when I last saw her every vestige of the original growth had disappeared, and the only residue to tell the story was the scar of the incision that the operating knife had made.

The next case given in detail is quite as striking. It is that of a single lady who came to me in 1902 with the fact of a cancerous swelling in her left breast, and the history of a blow some time before. It did not at the time look a promising case, and I advised the removal of the hard mass without delay. At operation things seemed more unpromising still; the deeper tissues were simply studded with an enormous number of independent minute lymphatic swellings, which I took to be cancerous foci. The mass was histologically examined, and pronounced to be cancer. I feared early recurrence; and not knowing as much then of cacodylate as I do now, I gave for three months thyroïdin in substantial doses and a brief course of X-rays—all in an experimental and perfectly useless way, for in nine months' time (February, 1903) recurrent nodules appeared in the locality of the scar. These I excised later, they being of slow growth, some twenty-one months after the original operation. No record occurs of any cacodylate having been administered, and much invaluable time was thus lost. Cacodylate was now given after the recurrence-excision, but too late as a prophylactic, and further nodules were excised in six months. Then thyroïdin 1x for a few months, and nodules again removed, till fresh ones appeared almost before the patient was about again. Her body weight had now dropped by a stone in six months, and matters seemed on these lines pretty hopeless, so as a last resort I advised the patient to have the ovaries removed; this was accordingly done in December, 1904, and a course of cacodylate recommenced and continued for fourteen consecutive months. The effect of the operation was almost immediate, certainly dramatic. The growing multiple nodules began to lessen, no more occurred, and in a few months they had entirely disappeared. During two years repeated short courses of X-rays were given as a protective measure, concurrently with the cacodylate.



During 1907 precautions were relaxed—a grave error—yet as the patient had regained the weight she had lost—some 14 lb.—and seemed now in the heyday of health and vigour, we left well alone. Suddenly, like a bolt from the blue, recurrence again took place late in 1907, several nodules appearing near the scar. Cacodylate, supplemented by X-rays, were again commenced, and the patient is still taking the drug with regularity. All the nodules have again disappeared; weight is maintained; she looks and feels well.

*What are the Cacodylates ?*

They are organic compounds of arsenic in which the arsenic is so firmly attached to a carbon atom as to pass out of the body still linked up as a cacodyl molecule. These compounds therefore belong to the range of organic chemistry; in this combination the arsenic does not exert in ordinary doses its toxic effects, and material doses may be introduced into the body without acute arsenical symptoms; 1 to 3 gr. was the dose frequently used for forty-five days by Sir T. Fraser. I aim at the long-continued action of the drug—the saturation of the organism therewith—and, as with other drugs, it is demonstrable that long-continued small dosage produces a very definite therapeutic effect, quite different from the overdosage with the production of acute symptoms of the earlier experimenters. I know no work beside my own in which cacodylate has been administered over such long periods, and in which results such as mine have been obtained.

After four months' continuous use of  $\frac{1}{4}$  gr. cacodylate thrice daily, expert analysis has not been able to detect the slightest trace of arsenic in the urine.

*Conclusions as to the Value and Use of Sodium Cocodylate in Malignant Disease.*

(1) *Of its value* there can be no doubt. I am enabled to present to you a series of cases this evening—all having been the victims of malignant disease—all now demonstrably free. The time limit has not been long enough in several to rule out all probability of recurrence, but all have entered the stage where recurrence usually materializes, and none show it here and now.

(2) *The dose and duration of treatment.* A dictum of my friend Dr. Ord has explained much to me in the otherwise puzzling action of cacodylate. "In those pathological results," says Dr. Ord, "which only accrue after very long exposure to the action of a drug, *e.g.*, epithelioma in arsenic poisoning, similar curative results only appear after the long continuance of the drug—a form of saturation. I soon found in my cases that the giving of this cacodylate for periods of three weeks, or six weeks, or even three months, was of no avail whatever; one might as well have taken it one's self. But when the drug really begins to tell is after six months' steady use, and the improvement may be watched developing as the drug is continued, for I have known it taken for twenty-one months without break. But my approved plan is to prescribe the drug for a period of six months, then wait a fortnight; then for successive periods of three months with a fortnight between, until three years have been passed. Its anti-malignant action is slow, and this at once finds out the cases where it is pre-eminently serviceable. Chief are those where cancer-deposits have just been cleared away by surgery. This is of all others the moment of importance for its use. Next in those cases where local defence—or, as heart physicans would say, compensation—has been fully effected. The immunity-mechanism is already rising. After—and a long way after—is the disintegrating action of cacodylate on cancer-deposits. That it does do this my cases show, but my opinion is that it does this only circuitously by heightening the body resistance, that, therefore, it should take a long time to effect this, which is exactly what one finds in practice.

(3) *Unsuitable Cases.*—I have uniformly found unsuitable cases to be where the cancer-mass is growing rapidly—*i.e.*, where local and general defence are in grave default. Here the cacodylate does what homœopathically it might be expected it would do—it adds to the distress of the patient. I do not give cacodylate where malignant masses are rapidly increasing in size, or where recurrence takes place immediately and considerably after operation. Any recurrence of consequence within three months in my judgment rules out

the use of cacodylate. The explanation is obvious—local defence is *nil*, body immunity-mechanism is paralysed; there is no power of reaction in the tissues; the drug comes as an added stress.

The dose I commonly employ is  $\frac{1}{4}$  gr. thrice daily after solid food. The taste is very saline, metallic, and at my request Messrs. Keene and Ashwell have prepared some tablets with this dosage, using chocolate as a basis. These are not unpleasant to swallow, and I am pleased with their action.

#### DIFFICULTIES IN ADMINISTRATION.

Not infrequently the cacodylate, and especially if given on an empty stomach, creates sickness, or pain, or diarrhœa. But all these difficulties are invariably surmounted by the use of a little *nous*. This was well exhibited by one of my patients last year, who said: "At first a sense of anxiety and faintness occurred; I lessened the dose and got all right; then I resumed the original quantity, and since have felt remarkably well with it." Just such a difficulty occurred with a sensitive patient quite recently, but the dropping of the dose to one tablet a day for a few days, then increasing two, and, finally, three daily, has entirely overcome the initial trouble. Toleration is rapidly established in proper cases. I have known the administration stopped after the first dose because of sickness on an empty stomach. This is not *nous*; this is folly.

In about half the cases the breath soon possesses an onion or phosphorus-like odour—not in all. Sometimes it is compared to onions, sometimes lucifer-matches; and I have known one case in which a child refused to kiss his mother on the ground that she smelt of matches. Probably some form of mouth-wash would meet the difficulty, but these are trifles light as air compared with the serious issues at stake, for life or death are the alternatives to follow.

#### DURATION OF PROTECTION.

A three-year course being completed, I have not accumulated data enough to speak as to the duration of

protection; but this I do know, that anything short of a three-year course may still leave the patient in the cancer zone, or liable to easy relapse. The records of cancer cases also show that the greatest liability to relapse is within three years after operation.

#### PRACTICAL CONCLUSIONS.

Now I do not vaunt cacodylates as a panacea for malignant disease. It is not like iodide or mercury in syphilis, or even tuberculin in tuberculosis; there are forms and stages in and of malignant disease where its use is profitable and others where it is not. Nor do I hold that this is the only word of science as to curative remedial agents. I have no doubt there are many more; I have had most experience with this. In heightening the general protective mechanism its action is precisely like that of the nosodes now used in large and in small doses for the same end. In increasing the local protection it is parallel to those locally acting drugs like scrophularia and ornithogalum, of which Dr. Cooper has recently given so excellent an account.

But for myself, until practice becomes more exact, I prefer to leave no stone unturned that will help in the elimination of this dire and disastrous disease. Supplement cacodylate by ovarian removal, and then again by X-rays; and still we hardly achieve the issue—the eradication of the cancer-taint—for which we are striving. Yet there is a general anticipation, in this and other countries that success is almost within measurable distance of our unceasing activities.

But I scarcely expect it will come *via* the laboratory only.

Now in this work I have acted on the increasingly obvious truism that the cancer-problem is not in its nature an insoluble problem. I have acted on the sound Huxleyan adage that to explain what we do not know we must proceed in terms of what we do know, and I have therefore employed as a working hypothesis in cancer conceptions of immunity-mechanism and protection which are valid for other chronic

degenerations. I hope to have given you and myself some stimulus to clear thinking in this great cancer question : we are all interested in it, for each one of us has at this time a lowered protective mechanism compared with that at five and twenty.

Mr. President and Gentlemen,—One of the great Parliamentary orators of the Victorian era astonished the House of Commons on a State occasion by saying “ the Angel of Death had been abroad in the land ; one could almost hear the beating of his wings.” Gentlemen, this is literally and exactly true of the present-day scourge of malignant disease : its holocaust year by year mounts in ever-increasing numbers, and to you, as custodians of the health and physical prospects of humanity, I make no apology for this long exercitation this evening.

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Dr. CLARKE, in opening the discussion, was sure all present would agree that a very notable evening had been spent in listening to Dr. Burford's epoch-making paper. He could not remember a time when the members had had put before them such a philosophical, and at the same time practical, view of one of the most important subjects. He was not sure that he understood the author's distinction between the power which protected an individual from cancer in youth and the power which ate up cancer in later life. The author in his paper had brought into the whole subject a note of optimism that did not belong to it before. The results Dr. Burford had obtained from the use of cacodylate of soda in cases which had a surgical element in them, and which were in a condition of trauma as well as of carcinosis, were of extreme value and importance. Dr. Burford quite correctly said that cacodylate was not the only drug which was beneficial in such cases, but it was of very great value to have a remedy which had a wide scope and could be used without the necessity of particularly careful differentiation, or when particular indications were not too apparent. Dr. Burford had brought out a point of extreme importance in mentioning the necessity of treating cases medically which were going to be put under surgical treatment. When Dr. Burford next read a paper before the Society he hoped he would be able to substitute the word “ criminal ” for the word “ deadly ” in the rule he had laid down for their guidance. But the whole question of cancer required taking in hand and solidly

working out from the physician's point of view, whether by the use of nosodes or by remedies which would only be found by close working with the repertories.

Dr. DYCE BROWN thought Dr. Burford's interesting and practical paper had brought out many instructive points which would be of great value to the Society. One of the most important was the view that it was necessary to begin medicinal treatment for cancer immediately after operation, and that the treatment should be continued for some years. The results brought forward, showing the effects of cacodylate of soda in the prevention of the recurrence of cancer, were most important. Particulars of some of the cases must, however, always be taken *cum grano salis*, because after an operation for cancer sometimes the growth did not recur. Dr. Burford might remember the case of a lady, aged about 70, who unmistakably developed carcinoma of the vulva, which was removed by Dr. Burford, who also advised that cacodylate of soda should be given and continued for a long time. The drug was used, but, unfortunately, after a comparatively short time there were signs of recurrence of the disease. The mucous membrane near where the operation had been made was broken open; a discharge was taking place, and there was a great deal of pain. He gave the patient hydrastis internally, and also locally as an application to the part, which healed up, and the patient became perfectly well. Although four or five years had elapsed since the operation she was now absolutely well.

Dr. M. Le H. COOPER said his experience in treating carcinoma *immediately* after operation was necessarily limited, in that the cases which came to him were mainly those of patients who refused operation, or were suffering from recurrence of the disease following operation. His experience in the use of cacodylate of soda was also limited; he had, however, found that by treating patients not subjected to operation with other indicated remedies it was possible to keep them alive for many years. Cases of breast carcinoma, which had been treated by his late father many years ago, were still alive and he found they maintained their general health in a remarkable way, even although it might not have been always possible to get rid of the original growth. He had no doubt in his own mind as to the increased danger to life accruing from operation pure and simple when no attempt was made to combat the constitutional state, and he found it extremely rare for cases of carcinoma of the breast to develop secondary growths when the primary growth was not removed and the patients were treated with constitutional homœopathic remedies,

unless excessive weakening of the resisting forces was brought about by extraneous causes, such as, for example, the occurrence of an acute fever, &c., &c. Under such circumstances he had known secondary nodules develop in one case after the lapse of seven years, but otherwise it seemed possible to entirely prevent their recurrence. He had recently succeeded in curing a lady with threatened recurrence after removal of the breast by the exhibition of carnosin. The patient came from Malta, where several men of note had diagnosed her case as hopeless and sent her home to England to die. Under treatment the tenderness in the axilla, arm, and side of the chest decreased in a remarkable way, and the pain entirely ceased. The swelling of the arm also decreased and the limb resumed its normal appearance, though she had previously been unable to raise it even to do her hair. He could testify to the fact that Dr. Burford's cases did not always require cacodylate of soda, for he had treated a lady previously operated on by Dr. Burford some five or six years ago for carcinoma uteri, and who was subsequently diagnosed to have a secondary growth in the liver. Thanks to homœopathy and various remedies given according as the indications arose, she was alive and in very fair health to-day, in spite of the fact that she had suffered from several attacks of influenza, and one very severe attack of appendicitis from which she made an excellent recovery without operation. No cacodylate was employed in her case. He had good reason to believe that the nosodes would figure largely in the treatment of cases after operation in the future as their value became better appreciated.

Dr. JOHNSTONE said that of late years medical men had become accustomed to the idea that it was not the actual diseased tissue with which they had to deal for the purpose of obtaining a cure, but with the healthy tissues of the body. The endeavour was to find some means of heightening their resistance. The drug Dr. Burford has chosen for that purpose was well known to have a very definite effect upon the nutrition of the body cells generally. All present were acquainted with the phenomena of how the vitality and the power of resistance of the Styrian peasants was increased; they also knew that arsenic seemed to have some specific action upon epithelial tissues. If arsenic was given to a horse its coat became glossy and healthy in appearance, and therefore the drug must have some specific effect upon the skin and growth of the hair. In all probability it was due to the fact that the epithelial cell was in a great measure improved in condition by the use of

arsenic. Dr. Burford thought that the use of cacodylate of soda had some specific relation to the epithelial cells and to their surroundings, probably influencing their metabolism, their trophic nerves, and the cutaneous blood-supply. So that the excellent results shown in his cases were not unexpected and are quite in agreement with what we know of arsenic. It was very frequently said that surgical measures made carcinoma worse. A satisfactory answer to that criticism was found in the cases brought forward by Dr. Burford, where, in spite of persistent surgical interference, they had been treated without recurrence for three, four or five years. Speaking from experience of the Ebury Ward and of the Out-Patient Department at the Hospital, he knew that the cases were not selected, and represented the average type of case met in daily practice. Dr. Burford had been pursuing his treatment for the last five or six years in suitable cases, so that the facts given were a fair test of the drug. He thought thanks were due to Dr. Burford for having initiated the idea of the persistent use of cacodylate of soda, and for the optimistic outlook that was before them in the treatment of cancer.

Dr. E. A. NEATBY said that like Dr. Clarke he was not quite sure that he followed Dr. Burford in his differentiation of the immunizations or resisting forces being different for the general condition and the local condition. He gathered that Dr. Burford thought there was a different resisting body or substance dealing with the cancerous tendency and the developed local condition.

Dr. BURFORD said that that was so.

Dr. NEATBY thought that one or two facts that he should mention later on supported that view, although it had not been expressed in his hearing in such a clear and definite way before. He desired to ask the author a few questions. The first question was, was there as yet any indication as to when in a given case such a local barrier, or first line of defence, as Goldman expressed it, existed or not? Dr. Burford had acknowledged that in some cases there was obviously no first line of defence, and he (Dr. Neatby) concluded that in those cases he would proceed to operation, whereas in the longer standing, the more senile of fibrous cases, he would hold his hand. He would like to know Dr. Burford's practice or opinion in regard to how long it was desirable to wait in a case where one wished to ascertain whether there was such a first line of defence established or not. In seeing a patient for the first time the history might not be sufficiently clear to enable one to come to a conclusion, but it was important not to wait too long. He further wished to ask if there was any proof in two cases to



which Dr. Burford referred, in which an ovarian growth followed an operation for mammary cancer at a fairly short interval, as to whether the growth was not present at the time of operation. If the facts were indisputable it was a strong argument in favour of the view which had been put forward. Then Dr. Burford had regretted that there was nothing in the nature of a scientific indication as to whether the resisting power of the body was high or low to cancer before the definite development, and perhaps even during the progress of cancer. He (Dr. Neatby) was not quite sure that was correct, because although he did not maintain that the *Micrococcus neoformans* was the definite cause of cancer, he thought there was sufficient evidence to prove it had some relation to it. He saw about twenty cases in Brussels where the fluctation between the patients' general condition and the opsonic index to neoformans tallied very closely indeed. He had himself had many hundreds of such observations made during the last two years, and had found there was a very close relationship between the patient's general condition and even the local condition and the opsonic index, the opsonic index rising very materially with the improved general condition of the patient. He could not say he had ever seen the vaccine treatment remove any growing mass, but in several cases a recurrence which he had prophesied did not take place when the neoformans vaccine was steadily given, somewhat in the way the author had given cacodylate of soda, though at intervals of about a fortnight. Three or four days ago he received an interesting letter from a medical man, not a homœopath, who was sufficiently liberal-minded some time ago to ask him to operate in a case of obscure pelvic trouble, where it was doubtful whether the case was cancer or some inflammatory condition. On operating last May he came to the conclusion on exploring that the case was cancer, and so general was the infiltration it was impossible to remove it. Two months later he saw the patient again, and entirely agreed with the local practitioner's conclusion that the patient was very much worse, and that there could be no doubt as to the nature of the disease. He suggested that neoformans vaccine should be given at intervals of about a fortnight; and two or three days ago he had received a letter saying there was a very remarkable and surprising improve- in the patient's condition. So that it was interesting to notice that there were other agents besides cacodylate which influenced the resisting power. It was interesting also to notice, in regard to Dr. Johnstone's remarks, that arsenic would improve the nutrition or raise the immunizing power, that it could be proved by

laboratory experiment that it perceptibly influenced the opsonic index or the agglutinative power. That had, he thought, been proved to be the case by Professor Wright.

There had always seemed to him to be a little clashing in two opinions, one of which was quoted by Dr. Burford, as to the rôle that was occupied by the increased number of blood-vessels at the periphery of a malignant growth. Goldman supposed that the object of such increased vascularization was to bring a larger supply of highly immunized blood to the growth so as to check its spread. On the other hand, Sampson Handley wrote a paper showing that spontaneous cure took place at the centre of a growth and that it was at the periphery that the growth spread. Those two views hardly seemed consistent, and the question was which was the correct one—whether the blood-vessels were present in order to bring an increased quantity of immunizing blood, or whether they were the result of the irritating growth which spread out at the periphery. It would hardly be likely to spread at the periphery if that was the place where the most resistance was afforded to it.

Dr. GOLDSBROUGH inquired whether the statements made by Dr. Burford relative to the incidence of cancer were based on a calculation which applied to males as well as to females.

Dr. BURFORD replied that the figures applied to the human race, and not to females alone.

Dr. GOLDSBROUGH thought the most important point the author had brought forward was the necessity of saturating the system, not in the physical sense, but in the pathogenetic sense, with cacodylate. Sufficient attention had not, he thought, been given to that point in the treatment of chronic cases in general. In epilepsy and chronic nervous diseases, for example, it was frequently necessary to continue treatment with homœopathic remedies for a year or two before any effect was noticed. Another important point to remember was that it was necessary to differentiate in giving particular drugs in malignant disease as in other diseases. They must not run away with the idea that cacodylate of soda was the only remedy for cancer, although it might be a more important one than some others. He had used cacodylate systematically in two cases. In a case of cancer of the breast, operated on by Mr. Knox Shaw, the drug was not given immediately after the operation, because the patient was lost sight of until she came back exceedingly ill. On making an examination, he (Dr. Goldsbrough) did not at first find anything locally wrong with her; but as Dr. Burford had at the time been

referring to the use of cacodylate, she was put on that drug, as it was thought a recurrence was about to ensue, and in the course of about a month she developed a recurrence at the base of the lung. In that case the cacodylate had no effect whatever. Dr. Goldsbrough pursued the treatment as long as he could keep the patient under it, but she eventually succumbed. In another case, that of an old lady, aged 82, with a large cancer in the breast, he impressed on her the fact that if an operation were performed it would give her a chance of living longer if medicinal treatment was continued afterwards. She refused to have the operation performed, so was given cacodylate of soda, with the result that the growth began to ulcerate, and appeared to follow a much less malignant course than it usually did in such cases. He was quite convinced that the medicine had an effect on the processes that were going on. Three parts of the growth ulcerated away, without any apparent effect on the constitution. The patient kept up her strength very well, until she developed a small secondary growth in the bones of the skull, which produced other symptoms, to which she succumbed at the age of 85.

Mr. CLIFTON HARRIS said he remembered an inoperable case of malignant disease of the breast, with marked enlargement of the glands, which was treated by his wife some years ago with cacodylate, with the result that the whole of the malignant disease disappeared. He believed his wife had successfully treated several similar cases with cacodylate of soda, but he had not the details of them with him. As a matter of routine, he always gave cacodylate to that class of case.

Dr. ROBERSON DAY inquired whether arsenic had ever been given or suggested as a means of preventing the carcinomatous condition occurring. As it improved the well-being of those who took it, such as the Styrian peasants, had it never been suggested as a prophylactic? Further, was it known whether the Styrian peasants, whose condition improved with its use, were more liable to cancer, or whether they were immune to it? If that was the case, it would be a valuable remedy to give when patients got into the danger zone, and as so many people seemed to die from cancer it might prevent this termination of life.

Dr. F. WATKINS mentioned that under the microscopes on the table were six slides of sections from various parts of the uterus, removed by Dr. Burford by surgical operation, and which showed that all the cases were of carcinoma; and in none of those cases, Dr. Burford tells us, had there been any recurrence. He had been impressed with the difficulty of deciding in cases where

patients had undergone an operation for removal of cancer, and where a cancerous tumour had subsequently appeared, whether it was a secondary growth from the original source or a fresh infection. He thought, as a general rule, that where there was an anatomical connection between the two sites, it must be looked upon as a secondary deposit. A case in point was that which Dr. Burford mentioned early in his paper of a woman with cancer of the breast, a section of which was sent to the Clinical Research Association, which verified the fact that it was cancer, although they did not know of what kind. Subsequently a large cancer occurred in the abdomen. It had been shown that there was a direct communication between the lymph spaces of the breast and the abdominal cavity. He therefore suggested it was really a secondary deposit from the original growth, and not a fresh infection. A number of cases had been collected of cancer of the ovary where, owing to their size and their rapid growth, it had been thought that that was the origin of the disease, but, on more careful examination, the disease had been shown to have commenced as carcinoma of the breast.

Dr. STONHAM (in the chair) thought Dr. Burford's paper had been followed by a most instructive and useful discussion. He was interested in the cases mentioned, particularly the first one recorded, because it came under his own observation both before and after the development of the malignant growth in the left groin above Poupart's ligament. He saw it first in the condition of a very troublesome sinus to the right of the umbilicus, which was left after an operation for removal of the broad ligament. He experienced a great deal of trouble in getting the sinus to heal up, but it subsequently did so. A year or two afterwards malignant disease commenced round about Poupart's ligament. He saw the patient at various times, and the odour of the breath and the condition of the skin were most perceptible. The cacodylate of soda was pushed so far once that a dermatitis was set up on the skin of the abdomen, and the use of the drug had to be suspended until the condition had passed off. As an illustration of the first statement with regard to the different stages of immunity an individual might be in, he remembered the case of a lady who came to him with a tumour in the left breast. He was not sure whether it was cancerous or not, so he gave her the benefit of the doubt and treated her with hydrastis. In a few months the tumour entirely disappeared under that treatment. A year or so afterwards a tumour appeared in the same breast, but not in quite the same place, and he again thought he would succeed in getting rid of

it by giving hydrastis. He gave the drug without effect, the tumour went on increasing, and it was eventually removed by Mr. Knox Shaw. That case proved that on the first occasion the patient was in the depressed stage, but had not got into the cancerous zone, whereas she had done so a year or two later. No one had referred in the discussion to the possible action of the lymphatic glands in providing the immunizing antibodies against cancer. He believed Dr. McCulloch had had successful experience in stimulating the lymphatic glands by means of X-rays, and thereby producing antibodies which had had a retarding influence on cancerous growths. The lymphatic glands should not be left out of the list of defensive organs of the body against cancer. That raised the question whether it was wise in all cases of cancer of the breast to remove the glands in the axilla, and whether it would not be better to allow them to remain as a defence against cancer. He did not think the case Dr. Dyce Brown mentioned at all militated against the cases mentioned by Dr. Burford. The case recurred early, and therefore was not a case which Dr. Burford considered suitable for cacodylate of soda. The fact that the case ultimately got quite well under hydrastis spoke a great deal for that drug, but said nothing against cacodylate in suitable cases.

Dr. BURFORD, in reply, after thanking those who had joined in the discussion for their words of commendation on his latest effort with regard to carcinoma, said he very much appreciated the Chairman's remarks in regard to the criticism of Dr. Dyce Brown as to the inutility of using cacodylate of soda in the case mentioned. He was not sure that Dr. Dyce Brown's view that hydrastis was the cause of the cure could be received as final. Dr. Watkins raised an all-important point as to whether the instances of carcinoma of the breast, in which removal was followed by no local recurrence, but by an occurrence of the disease, apparently for the first time, at a distance, were not really recurrences at the end of an anatomical circuit, or whether they might not be considered practically entirely new manifestations of the disease. He could call to mind three cases of that comparatively uncommon condition. Dr. Watkins ended by saying that in some of the distantly recurring cases it was possible that they were due to previously existing cancer of the breast. He was present last year at the death-bed of a single lady whom he had known for the last thirty years. About two years ago, owing to her severe sufferings from dysmenorrhœa, her friends asked him to take the case in hand, and he advised removal of the appendages. In order to make assurance doubly sure he took

the opinion of a colleague, who was flatly against operation, and in accordance with his opinion medicinal treatment was continued. Twelve months later he was called to see the patient sixty miles away in the country ; and although a year previously no organic lesion of the pelvic organs existed, nor some years previously when she was examined under an anæsthetic, signs were now discovered of a rapidly increasing growth in the pelvic region, involving the uterus, and it was too late to operate; nothing could be done. Mr. Bland Sutton, whom he met in consultation, thought that such cases of ovarian cancer were usually secondary, and that disease would be found elsewhere of which the carcinoma of the ovaries was a transplantation, although he (Dr. Burford) was absolutely certain there had been no latent carcinoma in any other organ during the twenty-five years he had known the patient. Therefore, in answer to Dr. Watkins, he wished to say it was quite possible to have fast-growing carcinoma of the ovary without the previous involvement of any distant reproductive organ, or any other abdominal organ. Dr. Watkins had raised the point whether, in cases of carcinoma of the breast where the breast was removed and no local recurrence had taken place, and yet in the course of a few months rapid-growing carcinoma in the pelvis had intervened, that condition was secondary in point of time or in point of origin. He remembered a patient coming into the Ebury Ward suffering, *inter alia*, from piles, which were removed by Dr. Johnstone, a pelvic examination being made at the time. Some months afterwards a tumour of the breast developed, which was removed by a London surgeon, and the patient got quite well. Subsequently she came to him (Dr. Burford) again for examination, and he found there were great masses of diffused pelvic carcinoma, although the patient had absolutely no carcinoma of the pelvis or abdomen twelve months before when an examination was made, when the piles were removed. The difficulty that occurred to him in regard to Mr. Bland Sutton's hypothesis that if the breast was the primary element in the disease with obvious carcinoma, which was removed, and the uterus at the other end then developed carcinoma, how was it that in the transplantation of germs from one to the other there was not some cancerous development between the two extremes? He could not hold Mr. Bland Sutton's contention that cancer-cells of the breast permeated the lymphatics and sank by gravitation to the lowest part of the abdomen. He held the view that such cases, when carefully observed, proved that sometimes, under certain circumstances, carcinoma of some organ in the body, secondary to carcinoma in some other organ of

the body, might be viewed in the light of a perfectly independent invasion, and bear no anatomical connection with what had occurred before. In reply to Dr. Neatby's most interesting questions, he believed there was a very definite differentiation of immunizing influence to be made if the clinical history was taken of every case of carcinoma and carefully studied. The immunizing forces of the body which isolated a small cancerous mass that had sprung into existence and which remained *in statu quo* were sufficient to restrain further growth of the mass, to prevent any development of carcinoma in any other part of the body, but they were not sufficient to secure its disappearance. In that type of case and under those circumstances there must be two distinct forms of immunizing influence to bring into play—first, isolation, and second, elimination. It was quite possible for the one to occur without the other. In the first case he quoted he noticed that during the time that absorption was going on in the breast in another part of the body growth was running riot. He knew of no physiological or pathological actual proof that there was an isolating barrier. The clinical results had to be taken, and an inference drawn from them that there must be a barrier of some kind. He could give no data to help one in coming to a definite conclusion with regard to the question Dr. Neatby asked as to how long it was necessary to wait before operating in doubtful cases. That was a question which nothing but experience and observation could solve. Nor were there any data to prove how one could differentiate such cases from other cases in which removal of the breast was an actually precipitating measure. Long-continued treatment, as Dr. Goldsbrough had said, was one of the most important points to be borne in mind. He wished to bring out in his paper that the reason some people had not had success with cacodylate of soda and other remedies was because the treatment had been conducted on too heavy a scale, and had not lasted sufficiently long. The use of cacodylate was suspended after six weeks in Sir Thomas Fraser's cases, because the patients could not take it any longer owing to the large dose which had been given. If, however, the dose had been diminished and the time had been extended, he thought the results he personally had obtained would have been repeated. The statement had been made that many cases got well by operation alone, and cacodylate of soda had not been given. That had occurred in the experience of all of them. But he remembered a case of a patient in the Ebury Ward with cancer of the breast which was operated upon by one of his surgical colleagues. A large incision

was made and the breast and contiguous tissues removed, and the case was marked as cured. Nearly two years afterwards, from enquiries he had made, he found that secondary nodules had recurred, and were removed by another surgeon, who subsequently repeated the procedure, and the patient was in a bad way. Cases of that description inspired him to establish the working motto which he had brought before the notice of his colleagues.

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## A CLINICAL PAPER ON INFANTILE WASTING.<sup>1</sup>

BY EDMUND HUGHES, M.R.C.S.ENG., L.R.C.P.LOND.

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MR. CHAIRMAN AND GENTLEMEN,—This is a very large subject. Perhaps all diseases in infancy cause wasting. The word wasting means to us getting thin, and implies loss of weight. I am merely going to take a few kinds of wasting which are very common in practice. Probably when I have said something about each of these, there will be more than enough for one evening's consideration; and I shall hope, by presenting the subject clinically, to be of some service to you in the course of daily work.

The kinds of infantile wasting I am going chiefly to deal with are the severer forms. The infant swiftly or slowly becomes emaciated, and the thinness is the striking feature of its case. I will limit myself still further by taking the case of a baby, aged 3 months, and we will suppose that it is not at once clear why it has wasted to this great extent.

Confronted with such a case, several possible causes occur to the mind. One is syphilis, another gastro-enteritis, a third general tuberculosis, and the last—but not by any means the least likely—an obscure cause which we may style *x*. *X* is a useful symbol, for it is always helpful to the mind to confess its ignorance. I shall, I hope, have more to say later on about this obscure cause-*x*. Before we decide that *x* may be the cause, there must be undertaken a clear clinical process to exclude the other possible causes. I cannot help

<sup>1</sup> Presented to the Liverpool Branch, January 14, 1909.



thinking that some make this clinical process a kind of mechanical process, as may a student when taking notes of a case under obligation, or, like the detectives in an American tale, who exhausted every device suggested by a stereotyped method, and overlooked the obvious. But a clinical process should be directed by a reasoning mind, bent on making its discoveries in the most rapid and most efficient way. I should say that this is the way to diagnose, while the way to make original discoveries is to note even the pettiest details, like prisoners seeking for a mode of escape; and one finds many notable examples of that method in such books as the clinical memoirs of Richard Bright.

We examine the infant's abdomen first. The reason for that is to anticipate the crying which is likely to occur during the examination. The abdomen of a crying baby is hopelessly hard, and even when a baby is at all restive its abdomen has a deceptive feel. The infant is brought near the fire, if fires are needed, placed on its mother's lap half reclining, its head and trunk being well supported. The abdomen is gently uncovered. The examiner sits behind, and to the right side of the mother, so as to be hidden. The infant is shown something to divert its attention. The right hand, thoroughly warmed, is brought round and the fingers placed with the utmost gentleness on the abdomen outside the borders of the rectus muscle, and the spleen and liver felt for. If this simple technique is observed, the abdominal examination is often at once successful; but if crying occurs a little chloroform is required, and the abdomen is then left to the last.

Needless to say, babies of three months hardly ever have tumours or lumps in their abdomens. A few lumbar or inguinal glands are made out, perhaps. Often we are able to feel the inguinal and lumbar glands enlarged on both sides, and then it is almost certain that if we proceed further and examine other groups of lymphatic glands about the body, they will be found a little enlarged as well. The meaning of that is not quite so obvious as some seem to think, but it is of no great practical importance either to the child or to his medical adviser to know it. Someone took the trouble lately to note the percentage of children of the

dirty classes who had enlarged glands about their bodies. I forget the precise figure he got, but it was somewhere about 80 or 90 per cent., and perhaps half a dozen other writers have recorded a similar result. At this age the chief point is nearly always the size of the spleen and liver, and we may expect enlargement of these organs to be due to a syphilitic change in them. Thus, if they are found somewhat enlarged, one or both—sometimes one is more enlarged than the other—that is very important evidence in favour of syphilis. But it is not enough by itself to settle the diagnosis.

The whole body is next uncovered, and the general appearance noted. When the clothes are all removed we are able to note the shape of the body, the attitude of the body, the degree of muscular power shown, and the condition of the skin. I have often wondered what may be the importance of a prominent abdomen. Sometimes one infers that it is due to distension of the stomach and intestines with gas, and sometimes it is due to an enlarged liver and spleen, more rarely to abdominal tuberculosis. It seems to me that in general a prominent abdomen is a bad sign. The presence of visible surface veins is often overlooked. Hitherto I have been unable to find in the literature any study of these veins. I have seen them when the liver was enlarged, and then they are doubtless due to portal obstruction. I have also seen them very clearly in simple "colic."

The bones must be examined. Possibly some of you may fear that I am dealing with trivialities. But the osseous system of young babies affords an excellent example of the actual difficulties confronting the clinical observer of infancy. For you know that changes frequently found in the bones are put down by one school of opinion to syphilis, while if we took our baby over to France we should be told that it might or might not have syphilis, but it was certainly affected with rickets. It may be that both schools are blinded by a preconception, but no doubt the opposition is partly due to the clinical difficulty. And here I will only say that the fontanelle, its borders, the edges of the sutures, and both parietal and occipital bones should be examined—the last

two for craniotabes, the fingers for dactylitis, and the epiphyses for enlargement and inflammation.

Attitude usually tells little beyond the amount of muscular power. A baby of this age, which lies relaxed when awake, and which cannot in the least degree raise its head on its neck, is necessarily extremely ill. I think one usually sees this complete relaxation of the muscles in the severe toxæmia of gastro-enteritis. Perhaps attitude might tell us very much more if doctors—and especially if nurses—became close observers of it and took the trouble to record their observations. So with behaviour in general. It is the language of infancy. The skin needs careful attention. Moderate or great pallor is often seen. Many syphilitic infants at this age have assumed the bronzed or yellowish tint which is familiar to us. Trousseau compared this tint with *café-au-lait*, and with the stain on the fingers seen in cigarette-smokers. But I prefer, myself, to liken it to the sunburn or tan on youthful skins which is *nearly faded off*. At times this colour is so faint that it can only be perceived by comparison with the skin of a healthy infant—and often it is not present at all. Less often syphilis causes a waxy colour, varying from a rather striking waxiness to the severe anæmia of von Jaksch's type, which is seen in later infancy. The mucosæ are then paler than normal mucosæ. All this is intelligible when we reflect that the earlier stage of syphilis is accompanied by a low standard of hæmoglobin as well as by a diminution in the red cells. The nature, and the distribution, of a *past rash* should be enquired into. Mothers are close observers of their children's skin, and, indeed, are very suspicious and anxious about the most trifling appearances on the skin. So they are a great help to us in this respect. I am in this paper dealing with the non-obvious cases, and as regards the skin these are the cases where a rash has never existed, where a rash has existed but has disappeared, or its traces are not very distinctive, and where a rash exists but needs differentiating. In a wasted baby it is extremely common to find an abnormality of the skin round the anus and on the napkin area generally. Sometimes there has been an eruption of some



kind, and the mother or nurse has been dusting it or rubbing ointments into it, and it has gone away and left no traces. I should not like to say that all syphilitic affections of the skin at this age have left distinctive traces, or even any traces at all. In our half-immunized Liverpool population I firmly believe that syphilides on infants may leave no traces, and the number of undeniably syphilitic infants which I see presenting rashes distinctive neither in their colour nor their distribution make me believe that there is no infallible test based on colour and distribution.

There is no evidence that I know of that syphilitic infants do not have non-syphilitic rashes ; but it is often quite impossible to say at once that a rash seen on them is not due to their syphilis. But sometimes it is, or ought to be, easy to say that an eruption on a wasted infant is not due to syphilis. There is a large number of cases where the diagnosis has to rest on an existing eruption, and this is the class which compels accuracy. Some excellent studies of the "napkin" rashes of infants exist. Diday's monograph on the syphilides is almost as valuable to-day as when it was written. Parrot devoted much care to the subject, and in 1905 Dr. Jacquet wrote a treatise upon it, and the results of his work have been well transcribed for us by Dr. H. G. Adamson. Speaking generally, syphilitic rashes assume sooner or later a brownish-red or coppery colour. They are apt to involve the flexures, and the palms and soles, and the face round the mouth. Non-syphilitic erythema avoids the flexures, and occurs on the convexities of the whole napkin area, including the inner sides of the thighs, and the calves and heels, which are apt to touch the napkin. It is pink red or dull red. It may occur in discrete patches, and may show erosions and even shallow ulcers in very bad cases. Feeble young infants often have pustules, occasionally crusts and bullæ of impetigo—all of post-natal origin and due to streptococci. There is a syphilitic "impetigo" which is at once distinguished in this way: Round it is a coppery-red areola, and on removing the crust an ulcer is found, instead of the red, moist surface familiar in impetigo proper.



Some years ago a fat baby aged 6 weeks was brought to me because a severe rash on its buttocks had been getting worse with white precipitate ointment which a capable doctor had prescribed for it. There were two circumstances enabling me to alter the diagnosis. This baby was not wasting—it had not even begun to waste. A rash so intense, if due to syphilis, would not have been seen on a baby which was at once fat and gaining weight. And then there was the other circumstance, that this rash had the dull yellow exudate of seborrhœa. Ointment on Lassar's formula quickly cured it. Seborrhœa has a yellow exudate, and, of course, it often occurs in other parts—the scalp, forehead and face, behind the ears, and on the umbilicus. It should be looked for on the mother's scalp. I think in this kind of case there need be no obsession about syphilis.

Then, occasionally syphilitic roseola occurs. Lately I had a case in an infant under three months certainly infected with syphilis, and for a few days the whole body was covered with a rash of this type, which went away as quickly as it came. The exudation and the mucous tubercles or papules in syphilis are whitish, and when dry the exudation is silvery. It has been said that the psoriasis-like lesion is seldom found in babies, and I cannot remember having seen a syphilide in a baby which was very like psoriasis.

Now I have no intention of placing before you a complete summary of all possible rashes before dentition, but merely to offer a few practical ideas; and I think the matter ought to be put this way, that in many cases we can make up our mind about these rashes, but in some it is impossible to do so. Even the test of treatment is not always a sufficient test, and I repeat my belief that among partly immunized populations it is not always possible or wise to allow diagnosis to rest on the colour and distribution of a rash.

There is one more help in examining this atrophied infant. Since Hess published his paper on the epitrochlear glands I have made a rule of testing these glands for enlargement. Those who have read his article will recall that he says when these glands are bilaterally enlarged to



at least the size of a pea, they are syphilitic, provided there is no other evident cause for their increased size. In one of my cases the right gland was half an inch across, and was softer than the left, which was probably rather smaller than a pea and very hard. These glands may give most important evidence.

The age-incidence of congenital syphilis is, speaking quite roughly, in inverse ratio to that of tuberculosis. Syphilis has its greatest intensity as a rule in the first month, and post-natal wasting from syphilis commonly begins in the first and second month, at times in the third, but it is quite rare to find clinical evidence of tuberculosis so early as the third month. This is easily explained when we reflect that, according to most careful research, tuberculosis is nearly always a post-natal infection; so that the chances of infection will theoretically be the greater the longer the child is exposed to them. Moreover, a large proportion of the hand-fed have been suckled during the first month or two after birth. Again, though the rule seems to be that the bacillus of Koch rapidly gets generalized over a young infant's body, yet even at this age it may conceivably remain latent, as in the bronchial or cervical glands. This view is justified by the experiments of Harbitz. The latency of this bacillus in the European body is indeed one of the most remarkable facts brought out by recent investigations. I cannot myself recall having seen a case of tuberculosis, clinically verified, at the age we are considering. My last four cases of tuberculous meningitis have all been in infants at the breast, which, according to the parent, were exclusively breast-fed. The youngest of these, in which diagnosis was confirmed by lumbar puncture, was in its fifth month and entirely breast-fed, both parents being in good health. There are certain other instances of the kind showing, like the above, that exclusive breast-feeding by a seemingly healthy mother is not a certain argument against the existence of tuberculosis in a young infant. It is interesting here to note that Heubner (Berlin) observed 844 children under three months of age without finding a single case of tuberculosis, and of 486 autopsies on infants from birth to

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end of first month (collected by Cornet) tuberculosis was not found in one. For all that, no atrophied baby of three months ought to go without examination with that object in view.

Now Calmette's reaction ought to be done, though it is likely to be negative in any case of advanced or miliary disease, and von Pirquet's reaction is generally found to fail in this class of case. So we are usually left to our clinical acumen. The main test should be a thermometer in the rectum. A normal morning temperature is negative, but a normal evening temperature (not over 100° F.) for several days is probably positive against tuberculosis. I say "probably" because I remember Soltau Fenwick wrote a decade ago that chronic infantile gastro-enteritis complicated by miliary tuberculosis may have apyrexial alternating with pyrexial periods. He also found that uncomplicated chronic gastro-enteritis might cause a remittent pyrexia reaching to 101° F. in the rectum. But *in general* we may take it that tuberculosis in a child aged 3 months would show pyrexia if tested as I have described, while chronic gastro-enteritis would not. Moreover, an evening temperature of *over* 101° F. would be quite the rule in tuberculosis. There are other tests. Smith pointed out the frequency of œdema of the feet, and I have several times noted this œdema in my own cases. Sometimes the liver and spleen are considerably enlarged. Now, supposing that only the spleen is enlarged, the abdomen is swollen, the stools are very loose and green, the temperature is raised, there are moist sounds in the lungs, and rapid loss of flesh. Then a Widal reaction should be done. If that is negative, we have, if possible, to exclude syphilis. Now at this age syphilitic spleens are not usually very large, but in tuberculosis also the spleen may only be just palpable, so that the spleen is not likely to help us. Calmette's reaction, let us say, has been tried, and has failed. An effort should be made to obtain sputum. Holt's plan of doing this is exceedingly practical. The child is inverted, and coughing is then apt to bring down sputa into the mouth. His other way is to introduce a piece of sterile muslin into the pharynx. That excites a cough, and

the sputa are caught on the muslin. The best kind of sputum is, of course, the thick, muco-purulent kind. There is an important defect in these experiments, and that is the absence of control cases. This obliges one to say that a positive result from the sputum may be confirmatory (if there are other reasons for thinking the child has tuberculous disease), but if there are no good reasons then a positive result is ambiguous.

To sum up, we have the temperature test, the eye reaction, and the sputum test, and the physical signs and family history may also help. I now pass on to other kinds of atrophy.

Some cases are obscure. We have to say, "There is *x* the matter with this child." To say a baby has been starved is often ambiguous. The term starvation ought to be restricted to cases where not enough food is being given. But it is not always used with this meaning, and if not it implies a power of diagnosis none possess. As I shall say when I speak of diet, the idea of starvation as a hindrance to recovery is a very important and helpful idea. But that is not the same as to say that starvation caused the wasting in the first place. The reason for the initial wasting is not seldom mysterious. There are some facts and many conjectures. A curious fact to my mind is that, though infants are nearly all constituted alike in their power of digesting breast milk, yet they do not all respond in the same way to the same artificial food, but show much idiosyncrasy. Lately a suggestion has been made. It is that any artificial food causes a feebler secretion of gastric juice than breast milk; that the gastric contents then passing into the duodenum are only able reflexly to excite a feebler secretion of the duodenal juices, and that the contents of the small bowel are in their turn only able to excite a feeble secretion of the succus entericus throughout the intestine. Then we know that after an acute gastro-enteritis parts of the mucosa of the digestive tract are destroyed and permanently replaced by fibrous tissue (Fenwick). We cannot expect a complete recovery in that case. There may be a special micro-organism at work. Ballantyne suggests that ante-



natal maternal toxins may pervade the foetal tissues so as to lessen the general metabolic activity throughout the body of the newly born. Then there is the heredity of the subject, which is almost totally unexplored. Drugs, such as alcohol, have been credited with influencing heredity in this direction. But I feel very incredulous about that, because the habit is so common that alcohol has been called "the people's food." We find alcohol in heredity credited with producing more than one defect in the offspring, such as idiocy (Langdon Down), and deficient mammary secretion (Von Bunge). Indeed, if we cared to make out the argument, it could easily be credited with many more. So could caffeine, tobacco, and opium. Perhaps infant wasting is sometimes due to the union of certain germ-characters, a parallelism being found in those hereditary nerve-atrophies and dystrophies which Gowers has called the abiotrophies; the obscure type of wasting alluded to by G. F. Still may conceivably form a hereditary variety. Some cases, again, are clearly made worse by bad "hygiene." A good atmospheric environment helps them to grow into normal children. Space does not allow me to dwell further on these interesting facts and speculations.

We have, finally, to consider the management of these cases of severe wasting; and let me say at once that they demand from us great care and often much knowledge. There are no more prominent examples than these of the success which may follow unwearying attention to detail. Somebody said that the good physician is he who treats each case on its own merits. It is truly unfortunate that the day has but twenty-four hours, and so we cannot always do that. Still, there is a peculiar importance in that saying when we are dealing with infants who are severely wasted. And for that reason I shall not try to sketch out a particular course of treatment, and what I am going to say must be understood as applying only to some cases. Probably there will only be time to make a few remarks and allusions.

First, there is the wasting associated with congenital syphilis, and here there are usually signs of gastro-intestinal complication. Very often, indeed, a great amount of

flatulence is present, and the stools are green, showing—one would suppose—maldigestion going on in the small intestine, if no higher. We have to be clear in our minds about the frequency of a coincidence of diseases. If the syphilis is not clearly bad, no genii is there to tell us that the wasting is due to it. I have not the smallest doubt that many cases are lost through ignoring this idea. It ought to be in our minds when treating wasting associated with syphilis. The first thing is to be certain that syphilis is there at all. If so, it ought to be treated; but this is sometimes of secondary importance, and some cases do very well without a single dose of mercury. These are the cases doubtfully syphilitic which recover weight by being dieted, &c., and which afterwards show a syphilitic process of some kind. A superstitious faith in mercury, as though it were going to do some conjuring trick at short notice, is often disastrous, and so is a routine method of feeding. It is, perhaps, not the least of the offences of what is called "sterilized milk" that it gives a handle to routine.

A word now on mercury. I shall be glad to have your experiences with mercury in high triturations. My timidity is such that I seldom use these triturations. There seems an agreement that mercury should be given in rather large doses, of course for short periods; say, 1 gr. of grey powder or  $\frac{1}{2}$  gr. of calomel two or three times a day; an inunction of blue ointment two or three times a week may be combined. Mercury is not contraindicated, of course, by the presence of gastro-enteritis, and Ringer long ago showed that vomiting at times ceased when mercury was given. "Snuffles" should certainly be specially treated. The nasal obstruction interferes with sucking, and the infected mucus, often full of streptococci, gets into the stomach and causes a gastritis, and is absorbed into the blood and may cause a broncho-pneumonia. I usually start with glycerine tampons. The nostrils are dealt with alternately three or four times daily for three or four days together. The glycerine must be thick and anhydrous. Koplik and some others advise a  $\frac{1}{1000}$  solution of sublimate in a nasal syringe. A recent plan is to insufflate calomel. The 1x trituration comes in

here, and 10 gr. of this are blown up each nostril three times a day. I believe no case should go without the experimental use of potassium iodide.<sup>1</sup> It is noteworthy that this drug is often withheld from syphilitics of any age, but it is quite certain that if this practice were questioned, no rational excuse could be found for it. I consider the facts about syphilis at all ages prove in a perfectly conclusive way that iodide should be started not later than six months after infection. The subject of syphilis is quite confused by the arbitrary terms secondary and tertiary. Such terms impress upon the medical student a notion that the one stage has to precede the other; and that is a pathological error of the first magnitude, which has cost many people their health, if not their lives. In treating children we must beware of this notion; and I suggest an evening dose of 5 gr. or more of KI in early infancy. Dr. Carter (of this city) not long ago showed that iodide took about forty-eight hours to be eliminated, if no longer; but a daily dose seems to me wise to ensure a continuous effect, and it often, in my experience, stops the incessant crying of these unfortunates. Reverting to mercury, I cannot find that infants in this country have had hypodermic or intramuscular injections. Here and there an isolated case may have been reported, but the method seems not to have been used on a large enough scale to command attention. Lewin, that ardent advocate of sublimate under the skin, did not risk his plan on babies. But the results of weekly intramuscular injections are very brilliant. Fournier uses, among other preparations, a fine 5 per cent. calomel emulsion in sterile olive oil for adults. Colonel Lambkin's formula is mercury 1 part, lanolin 4 parts, liquid paraffin 5 parts. For a child, 2 or 3 minims  $\frac{3}{4}$  in. in the gluteal region weekly, or bi-weekly, would be suitable. Occasionally these insoluble mercury preparations have caused inflammation and poisoning, but this is very exceptional, and I believe the experiment is worth a trial.

<sup>1</sup> It should be said that Hochsinger always gives the yellow iodide of Hg. *per os* (about  $\frac{1}{10}$  gr. in pulv. acaciæ, *ter die*). Comby prefers daily inunctions. Neither considers potassium iodide necessary at the age in question.

In atrophy of any kind *nux vomica* seems to help. I use the 3rd centesimal tincture before each feed. Another favourite of mine is iodine, especially when the stools are loose and yellow. In cases of marked pallor iron is valuable, and I am fond of the ammonio-citrate and saccharated carbonate, 3 gr. of either for a dose. Iron with me has been more helpful in the cases for which calc. phosph. and calc. carb. are often given than these calcium salts themselves, unless they are very strongly indicated. Both human and cows' milk contain an amount of the phosphate in suspension which makes any addition on our part redundant. The above are the medicinal measures I suggest, but in no dogmatic spirit.

Probably hypodermoclysis has a future in these cases. The usual solution is normal saline (.3 to .5 per cent.), and it may be given twice a week. Baginsky (*Folia Therapeutica*, 1907) has reported some fine results in severe atrophy with gastro-enteritis, and injected as much as 100 to 200 cc. Quinton's method with isotonic sea-water is more highly spoken of, and has been used on the Continent for some years in these atrophies. Unluckily there is no Liverpool syndicate engaged in supplying the profession with this mixture, but I shall be happy to furnish any enquirer with the details. It is injected in doses of about 10 cc. into the scapular region every two or three days.

The following case illustrates another recent idea in treatment of atrophy, and is based on the discovery of vacuolation of the thyroid in certain autopsies on the atrophic. If special attention were directed to organs usually unexplored in the *post-mortem* room, curious finds might be made. On May 7, 1907, I saw a little girl (out-patient) at the breast, aged 3 months. The last five out of the eleven children of these parents had wasted and died in infancy. They had nearly all been breast-fed. This infant promised to be the sixth of the series, for it had already begun to waste. No clear cause could be elicited on enquiry and inspection of the parents. The infant slept well and was contented, digestion was normal, and evidence of syphilis past and present was lacking. There was considerable loss of fat, and to

great pallor. The initial weight was not ascertained, but Pfeiffer's tables give an average of nearly 12 lb. for the age. Nothing was done except to order thyroid in mucilage,  $\frac{1}{2}$  gr. three times daily. Breast-feeding, in spite of its possible defect, was continued. By May 17 we felt certain that improvement had occurred. On May 21 weight was 10 lb.; on June 10, 11 lb.; June 26, 12 lb.; July 9, 13 lb. The treatment was then stopped. Steady progress ensued, and the child is now a sturdy two-year-old. No diarrhoea occurred during the thyroid feeding, which lasted for two months.

One other case may be given to show an occasional cause of serious atrophy, and the right way out. Some two years ago I was consulted about a 6 months old boy who had been breast-fed for the first four or five months, and then placed on municipal milk. He had grown fairly well till his mother's milk gave out, and then had developed a habit of vomiting after his bottle. This by now had become constant after every feed, and the infant was greatly wasted. He was said to have a cough. In order to find out the nature of events I visited the house, and saw him given a small feed of corporation milk, which was greedily taken. He then lay contentedly for five minutes, during which time careful scrutiny failed to detect any visible peristalsis. A little dry coughing then occurred, after which the milk was vomited. I passed a catheter into the stomach to exclude stricture of the œsophagus. The problem was solved on noting some nasal obstruction and on looking at the other children; they both had adenoids and the characteristic physiognomy. This infant was at once referred to my friend, Mr. R. Craig Dun, who was of my opinion and wished to operate, but this was refused. Drosera was then given without effect. A few days later death occurred from malnutrition.

An instructive chapter might be written on incessant vomiting in babies. Adenoids is a most important cause; another is pyloric spasm. I do not refer to pyloric hypertrophy, but to the spasm which probably occurs there when too large or too hard curds are formed in the stomach of the bottle-fed. This is a very serious matter, and it is one for

the physician and the nurse. I may say that if the nurse does not know the right technique of stomach lavage it will probably fail, and death be attributed to the means for averting death. The infant is held half reclining, the head a little forward ; the tongue is slightly depressed, a No. 12 E rubber catheter compressed at the proper part is passed gently to the back of the pharynx and thence 7 in. from the lips ; 2 oz. of warm water are introduced and returned, and this goes on till the water comes out clear. The infant then has absolute rest for half an hour, when it can be fed. Lavage is done once a day, and curd-free diet given. These cases are of gastritis, with superadded spasm ; they often pass from doctor to doctor, because the vomiting resists bismuth and soda and somebody's brand of potato-flour. And that is unfortunate.

Coming now to diet, there is one rule, and it is that a certain high caloric value must be maintained, the rule being that whereas in average infants an average number of calories need be given for each pound of body-weight, in the atrophic this number must be exceeded. The most scientific way of going about this is to be aware of the caloric value of various foodstuffs, and to know that we are giving a high enough value in the preparations we order. Time will not allow me to say very much about this matter of caloric value, but it has been found that the average number of calories needed is about forty-five to the pound, or about 100 to the kilogramme, so that our food ought to exceed this figure—say 50 to 55 and 110 to 120, as we reckon in pounds or kilogrammes. Also it is well to know that cows' milk has a somewhat higher caloric value than human milk, and the value of fats is more than double that of proteins. Great care must be taken to avoid over-feeding these infants ; but at the same time I have repeatedly found that an atrophic infant will bear a food of high caloric value—a “heavy” food, to use the popular phrase—even though its digestion is clearly “out of order” at the time when this food is prescribed, and not only does it gain in weight but its digestion improves as well. Of course, that does not always happen, and in many cases it is more prudent, especially if

the state of the digestive tract is very unsatisfactory, to withhold milk of any kind for a few days. A good number of alternative foods are known, but I shall merely mention the most popular, such as broth and barley-water, albumen-water, and whey. All these may be disliked, but the chances are that the child will take at least one of the three for the time required. Whey is best made with the pepsencia of Fairchild and Foster; it may be boiled to destroy the sourness, and boiling, though it coagulates the lactalbumin, may be useful if there are milk curds already lying in the patient's digestive canal. After this, if the behaviour, the appetite, absence of vomiting, and improvement in the stools seem to warrant, one of the partly dextrinized starch preparations may be tried. Though I have spoken of caloric values, there is, I think, no doubt whatever that starch partly converted has a power independent of caloric value to bring these children on. A cheap and excellent food of that sort is Moseley's food; another is the old-fashioned Liebig's Malted Food. Yet another is the well-known mixture advised by Keller sixteen years ago: About 3 oz. of Liebig's malt extract, containing a few grains of potassium carbonate, is dissolved in a pint of water (solution 1); 1½ oz. of wheat flour is suspended uniformly in a pint of milk, and this strained through cheese cloth (solution 2). Solutions 1 and 2 are mixed in a saucepan, and stirred over a slow fire not too hot to destroy the diastase. In twenty minutes the mixture is brought to the boil; of this from 3 to 6 oz. are ordered for each feed. This method is more easily remembered than that of Sir William Roberts, which may be found in his text-book, and needs rather more exercise of the understanding. Both these formulæ for a fresh malted food are of great excellence in practice. After a week or more of this diet a great change is often noted. The infant is stouter, more contented, and appears to be digesting its food well. If that is the case the diet is kept up for one, two, or three months, after which it is changed for a fresh milk formula, such as milk with equal parts of malted barley-water, or a milk, water, and cream mixture.

I cannot miss out even in an abridgment the case of the

baby wasting because of deficient breast milk. There is seldom any difficulty if the mother knows that she has too little milk or if the infant has the recognized signs of hunger. But at times the signs of hunger are interpreted as signs of pain, and it often happens that the mother thinks she has little milk when she has enough, or that she is unaware of a real deficiency. If her infant is quiet, sleeps much, and digests well, the true state of affairs may be missed by her as well as by the doctor, though she has copious milk deficient in solids. Unluckily milk analyses are still expensive, but the first thing to think of is analysis, and it is bad practice to try and do without it.

Sometimes a converted starch mixture disagrees. I am not prepared to give any reasons for that. The physiology of starch-digestion in infancy is not completely understood. For example, there is no agreement as to the times required for digesting different kinds of starch. Some years ago starch digestion up to the second month was supposed to be a function only of the parotid saliva, a discovery associated with the name of Zweifel. But since then Moro, of Munich, has found a diastatic ferment in the pancreas of the newly born, and a wasted infant aged 6 weeks also possessed it. There is some reason, too, for thinking that as at a more advanced age so in infancy the large intestine possesses this function to a slight extent.

Returning to practice, when these foods disagree or fail, I am fond of ordering the peptogenic milk powder of Fairchild and Foster. It is prepared with milk by the full process, and taken in this way a number of severely wasted infants under my care have got on very well, and have been successfully reared. Then, of course, there are other ways of helping digestion, such as by putting pepsin and HCL into the stomach, and since there is a lessened natural output of these substances, that is good practice;  $\frac{1}{4}$  gr. of pepsin with two drops of dilute HCL are enough for a dose after each feed.

A short time after improvement begins I always order ten or fifteen drops of cod liver oil three times a day. There is some reason for thinking this oil superior to other kinds of



animal fat, and one must remember the high caloric value of fat in general.

Constant warmth of the whole body must be insisted upon. If the legs are cold, they must be warmed by artificial means day and night. Binders and conventional costumes are extremely bad, first because they entail much handling and therefore muscular exhaustion, second because they restrict the intake of air. Atelectasis is to be expected and need not be courted. The body is swathed in cotton-wool. Many of these babies have bronchitis, and the air they breathe must be warm. Formerly we had no doubt about the value of warm air, and even now the case against it is not serious. However, you know that Dr. W. P. Northrup has what are called extreme views on this matter. An extremist is not necessarily too extreme. First, the contemporary mean has to be proved better, and this has not yet been done. According to Northrup, if I understand him rightly, a feeble infant of this age would be eminently fit to breathe outside air night and day, cold, hot, moist or dry, so long as the air was pure. All I can say is, that I have not tried it, but that cold air certainly increases the amount of coughing. My present ideal is to have the window of the room where the infant lies wide open all day and, if not objected to, all night as well; a strong fire is kept up and the invalid screened from violent draughts.

Every instruction should be written down, and no detail omitted. It is the details which matter. Under the conditions of our existence one thing may be as important as another, it may be the most important thing, however small, at some moment when it is least considered, and only the thing called the human mind, which I for one am literally ashamed of possessing, fails to carry this knowable fact into practice.

Regarding prognosis, some parents expect us to reckon chances with the facility of a sharper at cards. Though the game of life is played with loaded dice, we do not know on which number the odds must be laid, because we did not arrange the game, or choose the players. So here I do not believe there is any means of foretelling the chances of

wasted 3 months children, in most cases, when they are first seen. Later on a shrewd guess may be made. Some gain weight in a curious way, gaining half a pound one week, and not at all the next. I should say if a child behaves in that fashion let the diet be continued and no alarm be felt. Also I think very wasted syphilitic babies on the bottle who have a bright expression and fair muscular activity at the fourth month are hopeful subjects. But we cannot reckon with intercurrent disease. At times an intercurrent disease is taken mildly; and that is strange. But even when taken mildly other diseases may supervene and kill the patient, perhaps because the resistance is lowered, or perhaps it is merely a *post hoc* matter. For example, I treated an atrophied baby for several months with success. At the fifteenth month it took measles rather mildly, with moderate bronchitis. Convalescence fairly began, but was interrupted by very severe ulcerative stomatitis, nearly the whole buccal cavity being involved in a confluent ulceration. Under vigorous measures this entirely went away, but before it had quite gone a left-sided pleurisy supervened, probably the same infection in another place. Five days after this began I withdrew 12 oz. of rather turbid serum. Three days later I resected a rib and evacuated a large amount of very turbid serum. The next event was broncho-pneumonia, and the child died a week after the resection. On the other hand, one of the worst cases of wasting I have yet succeeded with went through whooping-cough in its sixth month without very great trouble.

Perhaps 30 per cent. of these dreadful cases may be saved. But sometimes we have cause to regret that we have saved them. Two of my cases developed epilepsy after growing fat. One has an epileptic mother, so the psychosis may be supposed inherited. Epilepsy is inherited with great frequency. The other has apparently normal parents, and has epilepsy of a severe kind, and will no doubt become demented and die. This child was once very greatly atrophied, but even if it was syphilitic, which I have reason to doubt, the weight of evidence is against the two diseases being cause and effect in young children. Many are killed in later

infancy by broncho-pneumonia. A few develop hydrocephalus. Some have malformations of the heart, which, like hydrocephalus, one suspects to be a sequel of development under syphilis. The majority are slow in their advance, some do not walk till the fifth year, and are liable not only to infections, but to a lifelong habit of maldigestion and to a pallor uninfluenced by iron. In the case of the syphilitic especially, no one can say how late their morbid manifestations will continue, and how great a burden they may prove to those interested in their welfare.

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### SOME POINTS IN THE DIAGNOSIS AND TREATMENT OF PERFORATED GASTRIC ULCER.<sup>1</sup>

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FEW more alarming and serious disasters can befall a patient than the sudden perforation of a gastric or duodenal ulcer. Life in a few hours is placed in perilous jeopardy, and only the promptest recognition of the condition and the immediate institution of surgical measures for its relief are likely to avert a fatal termination.

I have on three previous occasions read before this Society papers referring to various aspects of gastric surgery (February, 1897, November, 1899, and May, 1906), but a recent case of perforated gastric ulcer has caused me to bring before the Society this evening a brief review of a condition I have not previously dealt with. I note that there has been no presentation of the subject to the Society here, and consequently no discussion, since the present Transactions commenced publication in 1893; though Dr. A. E. Hawkes brought before the Liverpool branch, in December, 1903, notes of a most successful case operated on by him.

When one speaks of perforation of a gastric ulcer I think

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, February 24, 1909.

we should include acute duodenal perforation as well, as the two cases are not, in the early stages, clinically to be distinguished from one another. In the vast majority of cases of duodenal ulcer, the ulcer is in the near neighbourhood of the pylorus—Dr. Mayo says within  $\frac{3}{4}$  in.—so that it will at once be seen how impossible it would be to differentiate between the two. It is said that duodenal perforation leads to symptoms commencing on the right side rather than generally over the abdomen; so much are the symptoms right-sided that a diagnosis of acute appendicitis has not infrequently been made in the secondary stage of these cases.

On the afternoon of Tuesday, December 29, 1908, I saw a lady in consultation with Dr. Burwood, Dr. Dyce Brown and Dr. Greig. From Dr. Burwood I obtained the following history, and as it is interesting and instructive, I give it in his own words. “The patient, a married woman, is 43 years old, and has enjoyed excellent health all her life, never having had any illness of any moment. She has always had an excellent appetite and has kept the functions of digestion going by a judicious dietary. About ten years ago she began to complain occasionally of indigestion; there was pain between the lower part of the interscapular region, which was always relieved by taking food. The tongue was never at any time a ‘dirty’ one, nor was it red or irritable. The attacks lasted a very short time and were invariably relieved by colocynth 3x. In October, 1907, she had an attack of hæmatemesis, accompanied with pain, which I saw her through, and since then she has had occasional pain, sometimes severe, but not lasting long; but no vomiting, except once in August, when she was at the seaside. From that until December 29 she was practically well, not having any pain or inconvenience whatever. On Monday, December 28, she had a long walk to a railway station through snow and on a frosty, frozen road, and when she arrived at her destination she was chilled to the bone. She was at a dinner party that evening, and went to bed at 11.45 absolutely, as far as one could judge, quite well. At 1 a.m. she awoke her husband, saying that she was in frightful pain,

when some brandy was administered. Not getting any relief she asked for a dose of nux vomica, and as this did not do any good the husband came to me, and I prescribed the same in a lower dilution. At 3 o'clock she became alarmingly ill and I was fetched, and seeing the frightful agony she was in I at once saw the only relief to be had from her suffering was by administering chloroform, and this I continued off and on until 6 o'clock. As soon as the effect of the anæsthetic passed off the pain was there as bad as ever. At 7 a.m. I injected, hypodermically,  $\frac{1}{4}$  gr. of morphia. She was no better, and I gave another  $\frac{1}{4}$  gr. This was no good. Through the rest of the day, until about 5 o'clock, she was constantly having whiffs of chloroform and hypodermic injections of strychnine. During the whole of this time she was only sick once (in the early morning), and that was probably due, I think, to the chloroform. The vomited matter was chiefly fluid, and dark in colour, but no 'coffee-grounds' were present. There was no further vomiting. About noon she was greatly collapsed, her complexion took on a dusky, ominous hue, and altogether her state was very alarming."

When I saw the patient she had a pinched, anxious expression, was of an ashen grey colour, with hollow, sunken eyes; the facial condition we all recognize as due to some acute abdominal condition. She was lying with her knees drawn up, her respiration was shallow and catching, and almost entirely thoracic. Her pulse was 130, and had been rising steadily; her temperature was normal. She was evidently in great pain, and dreaded any movement; and talked in a short, quick manner, so as to use her diaphragm and abdominal muscles as little as possible. She described her pain as being agonizing, and that having started at the epigastrium was now spread all over the abdomen. On inspecting the abdomen it was seen to be slightly but uniformly distended; and on placing the warmed hand gently upon it, one was struck at once by the board-like rigidity of the abdominal muscles, especially at the epigastrium. Percussion excited pain, but light percussion gave a tympanitic note, and showed the liver dulness to

be most markedly diminished. No tumour could be palpated, nor was there any visible peristalsis. She had not passed flatus for some hours. She looked as if she had not long to live. A diagnosis of perforated gastric ulcer was made. In this case we had a history of a previously diagnosed gastric ulcer, with hæmatemesis, though the patient had considered herself quite well for some time; but it is well recognized that a perforation, like a hæmorrhage, may be the first indication of a gastric lesion, but premonitory symptoms are most commonly observed. The signs of perforation are not always as constant nor as typical as in this case. Sudden, acute agonizing pain is usually the first indication that an ulcer has given way, followed immediately by collapse, and then succeeded by a brief quiescent period; but cases have been recorded where there has been neither pain nor early abdominal symptoms, but in these cases there is nearly always the change in the aspect of the patient which is associated with an acute abdominal lesion. The amount of shock, too, varies considerably, but a steady rise in the pulse-rate following shock, however slight, is an ominous sign. In the very earliest stage there is usually rigidity of the abdominal muscles, and with care this can be readily elicited. Palpation must be gentle, and with a warmed hand. It is a very important sign, and one on which great reliance can be placed, and should make us suspicious, even when other symptoms are not alarming. As peritonitis ensues there is abdominal distension. Vomiting is an uncertain symptom—it is occasionally noticed; Dr. Dreschfield says it is generally absent. In the later stages it usually means the onset of septic peritonitis.

The absence or presence of liver dulness is an important sign. Dr. Dreschfield says "absence or considerable diminution of liver dulness" has been considered pathognomonic of perforation. This sign means free gas in the peritoneal cavity, which can only occur from perforation of some gas-containing viscus. If, when operating upon a suspected case of perforated gastric ulcer, gas audibly escapes immediately the peritoneum is opened, the sur-

geon is at once confirmed in the correctness of his diagnosis; the escape of serous fluid or pus alone not being distinctive of perforation. The earlier in the case diminution of liver dulness is recognized, the more important it is as an aid to diagnosis. Later, when the abdomen becomes distended, the transverse colon or small intestine may cause loss of liver dulness. In a case seen soon after a suspected perforation where there is no alteration in liver dulness noted, but where this is found to be diminished a few hours later, a diagnosis of perforation ought to be made with confidence. In the later stages of perforation, when peritonitis has supervened, there may be dulness in the flanks due to the presence of fluid exuded from the peritoneum and from stomach contents. In the case under discussion the perforation took place without apparent cause, and this is usually so, but I have known it follow some unusual exertion or strain, or after taking a heavy meal. There is not much aid to diagnosis in this direction.

All cases of perforation are not acute; in some, owing to the smallness of the perforation, the plugging of the perforation with omentum, or the slowness of the process of ulceration allowing time for the formation of adhesions, the symptoms are subacute or chronic. The peritonitis is local, and may lead to the formation of abscess, such as the subphrenic form. These cases do not require the same urgent and prompt measures as the acuter kind.

Having arrived at a diagnosis of acute perforation of the stomach, what is our duty? Is it possible for such a case to recover spontaneously? It is certain a few cases do so recover—generally owing to some special peculiarity, as an empty stomach, very small opening, speedy formation of adhesions, or possibly an error of diagnosis, but nothing which can be foretold or relied upon. Cases presenting symptoms which were thought to indicate perforation have been operated on and no perforation found. Drs. Deaver and Ashurst, of Philadelphia, give the mortality of gastric perforation, without operation, as 95 per cent. Statistics with regard to operations for acute abdominal conditions are not at present very reliable, as operative technique and post-operative methods are

constantly being improved upon, and mortality is thereby being lessened. The mortality following operations for perforated gastric ulcer at present vary from 20 to 50 per cent.—a few years ago it was much higher. In the next few years it will probably be much lower. But it is clear that the percentage of deaths after operation increases greatly with the length of time operation is undertaken after the perforation. Therefore, the earlier a diagnosis is made, and the sooner operative treatment is instituted, the more likely is the patient to recover, for I presume that there is no one who would not offer the patient the chance of an operation if such a course were in the least practicable. A diagnosis of perforation having been made, an operation was proposed to the patient and her husband, and accepted.

In these urgent cases, where every hour is of importance, there is not the time to make any elaborate preliminary preparation of the patient or of the surroundings; one has to do the best one can in the time available. Sterilized towels and water can always be obtained, and hands and instruments prepared as in a normally planned operation. The patient's abdomen is generally too painful to be prepared until anæsthesia has commenced. In this case the skin was freely washed with lysoform. As we had anticipated, the opening of the peritoneum, through an incision between the ensiform cartilage and the umbilicus, was followed by an explosive gush of gas and fluid, a yellowish, somewhat turbid fluid welling up profusely. It is really remarkable what a large amount of fluid is poured out into the peritoneum in these cases: sometimes it contains portions of food that have escaped through the perforation—in this case no food was seen. In an early case the fluid is thin and clear, but it soon becomes turbid, and later purulent. The fluid has been examined on many occasions, and at the beginning is generally found to be sterile. It is secreted by the peritoneum, and is of a protective nature, and is stated by some to be anti-bacterial. As much as possible of this fluid was removed by light sponging and by pressing the sides of the abdomen. The stomach was then brought out of the wound, and without any difficulty a well-defined ulcer the size of the tip of



the little finger was found at the pyloric end of the lesser curvature, at the extreme edge of the anterior surface of the stomach. Fortunately for the surgeon the most common site of a perforation is in the anterior wall of the stomach towards the lesser curvature. Some observers have stated that the perforation takes place on the anterior wall in 80 per cent. of all cases. If the perforation takes place on the posterior surface of the stomach or duodenum, it is more difficult to reach and, of course, adds to the length of the operation. From anatomical reasons these posterior perforations are generally of the subacute or chronic variety and lead to a localized rather than a general peritonitis.

The next step is to close the perforation. It has been suggested that the ulcer should be excised, but this can be but rarely necessary. The condition of the parts renders the procedure difficult; there is very free hæmorrhage, and it adds very materially to the length of the operation. The best method seems to be to first draw the edges of the perforation together by putting in deeply one or two interrupted sutures, which must be placed wide of the ulcer, because the parts immediately surrounding it are indurated, œdematous and friable, and the stitches easily cut through. Having carefully closed the ulcer in this way, the stomach wall is infolded over the site of the ulcer by Lembert sutures. If a piece of omentum is handy, it can be applied outside all. Another procedure advocated by some surgeons, but which I cannot think a justifiable piece of surgery, is now to perform a gastro-enterostomy. To do this at a time when the patient is in a most critical condition would, in a great many cases, turn the scale against a recovery. It is thought that the gastro-enterostomy will help in curing the ulcer should the patient recover. But is this so? Dr. Hale White, a shrewd observer, writing on the after-history of cases operated on for perforated gastric ulcer, says "that those who survive an operation for perforated gastric ulcer do so well that a gastro-enterostomy is quite unnecessary." I merely mention this procedure to condemn it.

Having sealed the ulcer, what should we do with the peritoneum? Here surgeons vary very much indeed.

Following Murphy and others, I regard the peritoneal effusion, whether it be serum or lymph, as a natural protective against the invasion of micro-organisms, and consider that deep sponging and flushing destroys this protection and opens the lymph channels to a rapid absorption of toxins from the peritoneal cavity. Beyond removing such fluid as came to the surface and obstructed the field of operation I left it, but allowed for free drainage by passing a sterilized gauze wick down to the site of the ulcer, above the stomach, and another below the stomach. I then opened the abdomen above the pubes, and passed another wick down into the pelvis, all of which began to act at once as drains. The epigastric wound was only partly closed by silkworm gut sutures. These drains are a necessary part of a procedure to be subsequently described. I am becoming more and more convinced that the sooner we get out of the peritoneal cavity in these acute abdominal cases the better for the patient and our results, and that to diminish the still too great mortality no elaborate operation to put a pretty finish to the case should be undertaken. That can be done later, if necessary, when the acute peritoneal condition has subsided. Our object is to save our patient's life, to rescue him from his immediate danger. From start to finish about thirty minutes was occupied. The patient was put back to bed in a semi-sitting posture. I am now about to go over some ground I traversed when in April last I read a paper on "The Ante- and Post-operative Treatment of Abdominal Cases"<sup>1</sup> before our Liverpool Branch. But as the subject has not been discussed here, and I find it is new to a good many, I think it will bear repetition.

Dr. Ryerson Fowler, of Brooklyn, has shown "that septic absorption takes place more rapidly from the diaphragmatic peritoneum than from any other area, and that absorption was least in the pelvic peritoneum; he therefore recommended that the head and trunk of the patient be well raised, and that the patient be placed practically in a semi-sitting posture, the intention being to limit the spread of infection by the gravitation of the infected

<sup>1</sup> JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, vol. xvi., p. 297.

fluid to the cavity of the pelvis, from which it can be removed by drainage." This is known as the Fowler position. Our next step was to institute what is known variously as enteroclysis, proctoclysis, or Murphy's method of continuous rectal saline infusion. Murphy's suggestion<sup>1</sup> "was to secure the absorption of large quantities of normal saline solution through the rectum, which reverses the current in the lymphatics of the peritoneum, making the surface of that membrane a secreting, instead of an absorbing, one, thus preventing the absorption of septic products. Aided by the posture of the patient, and the action of the diaphragm, the fluid gravitates to the pelvis, where it is removed by the drain." To carry out this an ordinary douche can, filled with normal saline solution at 100°, was placed at the end of the bed, raised a few inches above the level of the patient's buttocks, and connected with a long rectal tube passed through the anus. The can must be just high enough to allow the fluid in it to diminish by *absorption*. If it flows too quickly the fluid will act as an enema, and cause distress. Our patient absorbed four pints in the first twelve hours, the soaked dressings needing to be changed many times. The injection was kept up continuously for thirty-nine hours; it was then omitted for ten hours, and then continued for another twenty-eight hours, when it was finally discontinued.

Except for a short period of collapse on the second day the recovery was steady and uninterrupted, and the wounds had closed at the end of three weeks. During the first four days morphia was given subcutaneously twice and strychnine three times. Other remedies used were belladonna 1x, arsen. alb. 3x, lycodium 3x, and carbo veg. 5.

The "points" in the diagnosis and treatment of perforated gastric ulcer to which I desired to draw your attention have, I trust, been made clear to you during my reading of this short and inadequate paper. I have endeavoured to emphasize them as they would naturally present themselves in the course of a case under immediate observation.

<sup>1</sup> JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, vol. xvi., p. 297.

Dr. DYCE BROWN stated that he had seen the case in consultation with Mr. Knox Shaw. His clear and graphic description of the case left nothing to be now added. The diagnosis of perforation was very clear. The patient would not have lived many hours if she had not been given the chance of surgical treatment. In fact, this was the only alternative, and it gave her a chance. The operation was performed, and the successful result is as recorded

Dr. WYNNE THOMAS congratulated Mr. Shaw on the result of his treatment of the case. At the last meeting of the Society he (Dr. Thomas) had exhibited a specimen of a perforated duodenal ulcer which bore out the remarks of Mr. Shaw that it was very difficult to differentiate between a duodenal ulcer and a gastric ulcer. The ulcer was about three-quarters of an inch from the pylorus on the front of the duodenum. He believed it would have been a good case to operate upon, because the ulcer was easy to get at; and he thought the patient would have stood a chance of recovery. Unfortunately, however, the patient's age (65) militated against her getting well, as also the fact that she was taken into the hospital at a late stage. He had been called to see the patient about eight o'clock one evening, and found her in bed in a sitting posture, complaining of great pain in her abdomen, which she described as around the umbilicus. She was constantly vomiting, and her pulse was only 75. He thought, if he had taken her to the hospital straight away, and she had been operated upon, the patient might have been alive at the present time. The history was that she had had some pain in her abdomen for some days, which she had called indigestion. He saw the patient early the following morning, and found her pulse had gone up to 130. He removed her at once to the hospital, but she, unfortunately, only survived the removal for about twenty minutes.

In the February number of the *Review* last year, he had recorded a case of perforated gastric ulcer, in which Mr. Knox Shaw had kindly gone down and operated at the hospital after a delay of seventeen hours. That delay, he was sure, was the reason why the patient did not have a better chance of recovery. The patient had been treated in the hospital two years previously for gastric ulcer, and after a month had been discharged as perfectly well. Last year, however, Dr. Madden was called in to see the patient, a servant girl, whom he found in great pain. When Mr. Knox Shaw saw the case he said it was hopeless to think of doing anything, as the patient was

then moribund, unconscious, pulseless, with cold extremities, dusky in appearance, and almost lifeless, but he (Dr. Thomas) wished to give the girl a chance, and suggested transfusion. He accordingly began transfusion, and the pulse returned to the wrist, and the patient revived and spoke. He went on transfusing, and the operation took place. It was a very difficult case. The ulcer was found at the œsophageal end of the stomach, close to the œsophagus, and was very friable. After the operation, which lasted an hour, the patient was got back to bed, but she, unfortunately, died that evening. He had transfused about four or five pints. He thought much could be done in an extreme case by transfusion. In that case the patient had been so collapsed that the heart-beats could not be heard, even with a stethoscope, and yet by transfusion the patient was able to go through an operation of an hour's duration and survive some hours afterwards. He thought, in cases of perforated gastric ulcer, one should operate, and operate early, and, if necessary, transfuse in order to give the patient a chance.

Mr. DUDLEY WRIGHT also congratulated Mr. Knox Shaw on the excellent result of the case. He recalled one case of perforated gastric ulcer which was so very unusual that he would occupy the time of the Society for a few minutes in giving the particulars. He was called one evening by a colleague in the country to see the daughter of a mutual friend. They saw the patient—a young girl aged 13—in association with another doctor, who had diagnosed the case as one of perforated appendix. The patient, about five hours before, had been seized with an extremely acute pain in the left side of the abdomen extending up into the loin; there was also some distension of the abdomen, and those were the only symptoms at first. There was some tenderness, apparently when the first doctor had been called in, about the umbilical region, and upon that the doctor had diagnosed appendicitis with possible perforation. When he (Mr. Dudley Wright) saw the child it in no way resembled an ordinary abdominal case. Her face was flushed; she was crying out from acute pain in her back, her pulse was about 100, and there was slight, if any, hardness of the abdomen, and there was a certain amount of abdominal respiration. The liver dulness was not diminished. There was really nothing to go upon. The temperature was slightly subnormal, and altogether it was completely unlike an abdominal case. He, at anyrate, did not think it was a case for operating. His friend agreed with him, and the other doctor withdrew his diagnosis, because the aspect

of the case had changed so much since he first saw her. The latter gentleman, when he was first called in, had given the patient a hypodermic injection of morphia, which seemed to make her quieter. The patient, after getting violently maniacal, collapsed, and died the same night. At the *post mortem* a most extraordinary condition of affairs was revealed. There was a very slight amount of fluid in the abdominal cavity, and no sign of peritonitis. When he lifted the viscera there did not appear to be any tear; there was certainly nothing down in the appendix, but on taking the stomach up he found it was enormously distended, and so thin were its walls that it was quite transparent. Turning up the stomach to look at the posterior wall, there was a tear in it from one end to the other. There was no ulcer. It was simply a very much dilated stomach, and he presumed the tear had occurred when the child had got its stomach full of wind; but what had caused it he did not know. The fluid in the peritoneal cavity he presumed to be the beef-tea and medicine administered. The only history that could be obtained of any stomach trouble was that the child, some years ago, had had what was called gastric fever, and she had always been a "gobbler." He was quite at a loss to account for the extreme thinness of the stomach wall; it was as soft as blotting paper. The doctor had taken the stomach away for examination, but, unfortunately, he fell ill afterwards, and it was lost.

Dr. WATSON mentioned a case, on the authority of one of the junior surgeons of Liverpool, which was interesting on account of the duration of the illness subsequent to the date of rupture. His friend had taken in a young man aged about 30. There was well-marked history of pain and vomiting, and the physical signs were all very distinctive of perforated duodenal ulcer. Although the case appeared absolutely hopeless—the pulse being practically not to be felt—the physician transfused and brought the patient so far round as to enable an operation to be performed. The rupture had taken place three days before the patient was operated upon. It was a duodenal ulcer, situated on the posterior aspect, and it involved a rather prolonged operation. His friend put in seven drainage tubes—he did not waste much time over a peritoneal toilet—and the patient made a very satisfactory recovery. What the last speaker had said reminded him of the case of a girl who was brought into the hospital suffering from dyspeptic symptoms. They were all inclined to think it was a case of hysteria owing to inability to discover any gross patho-

logical lesion. The patient remained in hospital for some considerable time and was then discharged; they were satisfied there was not much the matter. About three weeks afterwards she was readmitted, and within three or four days was dead. A *post mortem* was made and it was found that the large intestine was three parts ulcerated away. There was one long strip in which a third of the wall of the large intestine was wanting. Whether that was a later stage of a condition analogous to that shown in the attenuated gastric wall he did not know. It was a most striking case to come across, because, although the girl had complained, the physical signs were practically absent. Even with regard to the stools no abnormality could be traced.

Mr. EADIE, referring to the point of liver dulness, said the absence of any signs of liver dulness was a very good sign, but he had only just recently seen a case demonstrated to a Fellowship class in which there was no absence of the liver dulness; and the demonstrator mentioned that he found as many cases of perforation with the liver dulness still present as with it absent. A few days ago he (Mr. Eadie) had seen a case where the patient had walked into the hospital. There was some doubt as to what the disease was in the receiving-room, and the case was used to demonstrate to the Fellowship class, and the class was asked to give opinions as to what it thought the patient was suffering from. Out of a dozen men two expressed the opinion that it was perforation. All sorts of diagnoses were hazarded by the class. One was acute pancreatitis. Probably that was advanced because the previous day there had been a case of pancreatitis due to blocking of the duct by a worm, which had presented all the symptoms of a ruptured stomach. The patient, who walked into the hospital—a girl aged 17—was operated upon, and it was found there was a perforation. No attempt was made to sew it up. The omentum was put over the region of the perforation, and a gauze drain put in that region and also put above the pubes. The patient had done exceedingly well; he had seen her about three weeks previously, and one would have thought she had had no trouble of the kind whatever. Mr. Eadie asked Mr. Knox Shaw what the condition of the pulse was when he first saw his patient, because he thought a great deal more stress was to be laid on the condition of the pulse than on the temperature. Mr. Mansell-Moullin said the pulse was of more importance than anything else in abdominal cases. With regard to the condition of the ulcer, did Mr. Knox Shaw find out whether there was any induration round about the perforation? Another

point was with regard to leucocytosis. Recently a great deal of stress had been laid upon the early presence of leucocytosis in abdominal cases. He should like to know whether anyone had had any experience of such cases.

Dr. CASH REED (in the chair) asked Mr. Knox Shaw what his experience was of what he might call a "leaking ulcer." There had been a very remarkable case in the Hahnemann Hospital at Liverpool. There appeared to be no doubt whatever to those of the staff who saw the case that an ulcer existed and that if it did not actually perforate at anyrate it was leaking; [and a very positive opinion was given that an operation ought to be performed immediately. The patient declined, and eventually, he was bound to say, she got perfectly well. The patient came in at a very early stage of the complaint, which made the whole difference between recovery and non-recovery by the method which was adopted—namely, starvation. It would appear that Nature seemed to form some kind of localized peritonitis. He had been very much interested in what Mr. Shaw had said with reference to the gauze wicks. How long did he allow the gauze wicks to remain? In a recent case they had had in the hospital at Liverpool of an extra-uterine pregnancy, they had had some difficulty in the following way. All that was anatomically bleeding it was possible, of course, to tie in the usual way, but there was a very large area which contained an immense blood-clot from blood which had evidently been very gradually effused from the sac. Around this clot there seemed to be some effort to define an enveloping membrane, but it was of such a fine trabecular character that one could not deal with it by tying. He thought the right thing to do was to stuff the cavity full of gauze, which he did, and everything went perfectly well; but the question arose how soon ought one to remove that gauze. He had always read to the effect that it should be removed in sixty hours, but for some reason he thought he would remove it in forty-eight hours. It was not a very easy matter; certain adhesions had formed, but he believed that if he had left it the usual sixty hours it would have slid out with the greatest ease. He would like to know the length of time it was desirable to leave the gauze in the abdominal cavity. With regard to Fowler's position, it appeared to him that as time went on that position would be less and less necessary, because there was less and less introduced into the abdominal cavity which was septic when one performed an operation. Therefore, except for what is actually inherent and arising out of the disease itself, it would appear scarcely necessary to place a patient in Fowler's position.



because, as he took it, it was with the object of arresting the absorption of septic products from the diaphragmatic serous membrane this position was adopted. In looking back one found that there were far less cases of pleurisy due to sepsis after abdominal operations now than formerly.

Mr. KNOX SHAW, in reply, said he found that most men relied upon the following points in making a diagnosis—the initial symptoms of collapse and pain, the rapid pulse, and the rigidity of the abdomen; and yet it had been placed on record that an abdomen had been opened on account of these symptoms, all of which were brought about by the onset of the menstrual period. There were considerable difficulties in the diagnosis of these cases. With regard to the indications of entero-clysis, he would use it in the case of any abdominal operation, followed by extreme shock, or he would start it at once if he had a case of septic peritonitis to deal with. The indication for stopping it was when the drains ceased to act. The President had asked about gauze wicks. Gauze wicks might be used for two different objects. One was used to stop hæmorrhage, and the other was employed to act as a drain to drain off fluid from the peritoneum due to the disease or from the rectal infusion. He put in new gauze wicks every twenty-four hours. To get them out he used peroxide of hydrogen lotion, soaking the gauze wick with the peroxide. The President had also asked about the Fowler position. That position was not meant for cases of abdominal operation without sepsis; it was primarily meant for a septic condition; but he had found that patients were very much more comfortable and happier if they were raised somewhat in any case, so that he allowed his patients much more freedom of movement than formerly.

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### PRURITUS ANI.<sup>1</sup>

BY DUDLEY D'A. WRIGHT, F.R.C.S.ENG.,  
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PRURITUS ANI, the subject dealt with in this paper, is a good illustration of the maxim which says that we may judge of the intractability of a disease by the number of remedies which have been advertised for its cure.

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, February 4, 1909.

I do not think that there are many that have been in practice for even a short time who have not had some experience of the difficulty in completely curing this symptom. I say "curing" advisedly, for alleviation, or even temporary suppression of the trouble, is not usually difficult, whereas to rid the patient once and for all is a very different matter.

The underlying condition which brings about the pruritus is in most instances a form of dermatitis. We have present in the part most of the factors, such as lack of cleanliness, the occurrence of perspiration with imperfect means of evaporation, the presence of micro-organisms or discharges from the adjacent bowel, as well as the daily evacuations—all of which conduce to the production or maintenance of an inflammatory state of the skin. Moreover, the frequent disturbance of the circulation of the parts supplied by the hæmorrhoidal vessels through functional disorders of the liver and digestive organs, and the production of loose folds of skin around the opening of the bowel resulting from occasional attacks of thrombosed external piles, are further factors worthy of consideration.

It is not often that the pruritus is continuous. Even in the most aggravated cases the patient may have longer or shorter periods of freedom from the irritation, though in such it is seldom that the eczema or keratosis which are the usual accompanying objective signs entirely disappear after they have once become established, except under suitable treatment.

In the acute attacks there is present a considerable amount of redness of the skin with some fissuring, and this is not only in the region around the anus, but is often more marked backwards to the coccyx, or forwards towards the scrotum or labial folds. These fissures of the skin nearly always run longitudinally, and often there is one long fissure which lies in the sulcus between the folds of the nates.

After a time the parts assume a condition of keratosis, the skin affected becoming a dead-white colour, usually moist, and often emitting a somewhat offensive odour from putrefaction of the secretions, and when this stage is

reached the torment produced by the irritation is often extreme; and being usually worst when the patient is warm in bed, it may seriously interfere with his rest.

It is not often that true anal fissure of the painful type is associated with pruritus. This kind of fissure appears to be connected with an entirely different train of pathological circumstances, which it is not necessary to deal with in this paper.

There are certain etiological points which I will touch upon, as I consider them of importance. I presume that in a large number of cases the local condition is an expression of some form of toxæmia, either acquired or self-induced. Its common association with lithæmia is proof of this, but there are certain articles of diet which my experience has taught me to warn the patient from taking, and probably the greatest offender is coffee. What it is in this drink that brings about the trouble I cannot say, but it has more frequently been the cause of it than tea or any other beverage.

Excess of fatty articles in the diet, especially butter, may likewise produce the same result. I believe this may be due to a form of acid intoxication. The splitting up of the fats in the intestine favours the accumulation of butyric and other fatty acids, which are prejudicial to the patient.

Salt, too, I believe may be a cause when taken in excess, and I recall one case in which its abolition from the dietary did more than anything else to get rid of the disease.

Excessive smoking may also indirectly be a cause of pruritus.

There is another condition I should mention which is at times an agent in producing the disease. It is the occasional discharge of an acrid fluid from the anus, which irritates the parts around and sets up eczema and its attendant evils. In these cases examination of the anal canal will reveal the presence of small pockets of mucous membrane, often with papillæ at their edges. The pockets are formed by enlargement of the valves of Morgagni, which are situated about  $\frac{1}{4}$  in. above the "white line" of Hilton. The fluid appears to be secreted in the pockets, and may be there retained for

a time and discharged at intervals, with the result above-mentioned. I have known the removal of these pockets cure pruritus, and certainly the excision of any such vascular growth, such as is liable to arise from hypertrophy of the papillæ situated in this region, is strongly indicated, as they may be the cause of much annoyance when they are large enough to descend into the sphincter region and be grasped by the muscle.

We now come to the subject of treatment. Of course, local cleanliness is a *sine qua non* in this complaint. After every action of the bowels the part should be cleansed with water. Soap is not necessary; indeed, I believe it is harmful. If to the water be added some hazeline or carbolic acid to the strength of 1 in 80, the cleansing will be more efficiently done, and both of these lotions have a sedative effect on the nerves of the part. After cleansing in this manner, whatever application is ordered should be put on, and if this be done in the morning it is as well in any case to bathe the part at night with water as hot as can be borne and reapply the dressing, for in this way the itching which comes on directly the patient gets into bed is prevented. With regard to ointments or lotions for this complaint, their name is legion, and I can only mention a few of the drugs which have been used locally.

Chief amongst these are carbolic acid, tar, mercurial preparations, and menthol. The prescription I order most frequently is an ointment composed of  $\mathfrak{z}\text{i}$ . of citric ointment to  $\mathfrak{z}\text{i}$ . of benzoated zinc ointment, to which is added 5 gr. of menthol to the ounce.

A preparation containing carbolic acid gr. xxx., tar  $\mathfrak{z}\text{iss}$ ., and oxide of zinc  $\mathfrak{z}\text{ii}$ . to  $\mathfrak{z}\text{ii}$ . of simple cerate ointment is also useful, and it may have menthol added to it.

Other tar preparations are the liquor carbonis detergens and oleum cadini. A lotion may be made of  $\mathfrak{z}\text{iss}$ . of the former, with  $\mathfrak{z}\text{i}$ . of eau-de-Cologne to  $\mathfrak{z}\text{viii}$ . of water. This rapidly relieves the pruritus and is easily applied. Equal parts of cade oil ointment and hamamelis ointment suit both the pruritus and the eczema. Lotions are usually more pleasant for the patient, as they do not stain the linen, as do most ointments.

In cases which do not respond sufficiently to these simple measures, more active treatment is indicated, and that which I have found most helpful is the application of a strong solution of nitrate of silver to the whole of the irritable area.

I do not hesitate to apply this, even if the skin be the site of a considerable amount of eczema—indeed, I look upon this as an indication for the treatment. Previous to applying the silver nitrate the part should be well swabbed over with a 5 per cent. cocaine solution. After about three minutes, when sensation has been annulled, the silver may be applied by means of a cotton-wool mop wound round the end of a pair of sinus forceps. It should be applied somewhat vigorously, and care should be taken to rub it well in between the redundant folds of skin so frequently situated around the anus.

The parts should be then smeared over with some oily preparation, and a piece of wool placed between the folds of the nates to keep the surface apart. It is well in all cases where there is excessive moisture of the parts to advise the patient to use the wool pad in this way. Or, a dusting-powder may be used to keep the parts dry, but it is necessary to remember that salol preparations may undergo decomposition when associated with the secretions of the part, and become a source of irritation so that they should be avoided.

The application of the silver nitrate often leads to an aggravation of the eczema for a day or two, but this quickly subsides and the fissures begin to heal. Before this is completed another application can be made, and repeated, every third or fourth day for some weeks if necessary.

At the end of this time the superficial layers of the skin will have peeled off, and usually the patient benefits very considerably from the treatment.

A more radical method of treatment is the use of the thermo or electric cautery. I have used the latter with good results in a very obstinate case with much thickening of the perianal skin, with peculiar corn-like formations in the sulci, as well as on the ridges of hypertrophied skin.

Before applying the cautery point, local anæsthesia was produced by subdermic injection of "Waite's anæsthetic," and the operation was painless. One quarter of the area to be treated was done at a sitting, and I should not hesitate to do this again, completing the treatment in one sitting if necessary. It is scarcely necessary to warn against producing an anal stricture by destroying too much perianal skin in this way.

X-rays have been advocated as a cure for the disease under discussion. I have no doubt that under certain circumstances it might be of great benefit, but I have had very little experience of its action. I have treated one case with it, and without getting any benefit after two weeks' trial, the applications being given for five minutes every third day with  $1\frac{1}{2}$  milliampères running through the tube, which registered 7 on the Benoist scale. I tried the mercury vapour lamp on this same patient afterwards, and the eczema and pruritus both disappeared after two weeks' treatment, and one other case of long standing likewise gained great benefit from this form of light.

We have in radium one of the most potent substances for the relief of pruritus of any part of the body. Dr. Deane Butcher, in a paper before the British Medical Association, recounts how he had an itching eczematous spot on the ankle, which had been present for five years, and had caused him much trouble for one year with intolerable itching. He irradiated the patch for ten minutes, and repeated this treatment a week later. There was a slight reaction on each occasion after twenty-four hours, but the itching was immediately relieved and the patch entirely disappeared after the second treatment.

He narrates another case of a young lady who suffered from pruritus and eczema vulvæ to such an extent that her condition was pitiable. The trouble had lasted several years. A few applications, extending over about four weeks, entirely cured the trouble.

Schwartz, of Vienna, has shown that the  $\gamma$ -rays of radium have a primary action on the neurilemma of the trophic nerve fibrils, the lecithin of the neurilemma being

decomposed into other substances, such as methylamine. This selective action on this part of the nerve probably accounted for its anæsthetic powers. The  $\gamma$ -rays also have a bactericidal effect.

Lately there has been put upon the market a "radium" ointment made apparently from finely pulverized pitchblende. I have tried this both in a case of pruritus ani, as well as on a patch of itching psoriasis on my own elbow. In both cases relief was noticeable.

There is not much to be said under the head of operative measures, beyond what I have already said. Removal of the hypertrophied folds of skin around the anus is indicated in bad cases, and, of course, it goes without saying that any rectal conditions, such as piles of fibrous or vascular growths of the anal canal, should be dealt with. The occurrence of the pockets formed by the folds of Morgagni, previously mentioned, should not be overlooked, and when present each one should be slit up so as to get rid of any possibility of secretions being retained within the folds. This is most readily done by means of the galvano-cautery under a general anæsthetic.

Finally, as regards drugs. The internal use of remedies may not only cure the case without our having recourse to local measures, but are helpful even when the latter are undertaken. The following remedies have been useful in these cases, viz.: Plantago, teucrium, thuja, graphites, petroleum, schirrhinum, and, according to Dr. Clarke, radium in high dilution.

I am conscious, gentlemen, of the defects of this paper. It is "sketchy," and presents nothing new to you. However, the subject is one which we are all at some time or other brought into contact with, and I trust that what I have written may be the introduction to a useful discussion.

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Dr. JAGIELSKI, after congratulating Mr. Dudley Wright on his excellent paper, said he himself put dietetic treatment before medicinal. He quite agreed that all such foods as tea, coffee, and alcohol should be discontinued, and likewise thought that mustard, pepper, onions, and other such seasonings tended to bring on the complaint. He especially condemned the practice of taking

“appetizers” before dinner in order to make a better meal, which afterwards proved too much for their digestion. With regard to treatment, he thought the cold water treatment in all its forms—the injection of cold water, the drinking of cold water, and cold hip baths—was an excellent remedy. Besides the remedies Mr. Wright had mentioned he had found mezereum a very good drug for itching. He remembered a case of a little child about 8 years old. The pruritus was extremely acute, and could not be cured by any of the ordinary remedies or even the cold water treatment. He noticed that the child was very fond of sweets, and told the mother not to let the child eat them. The mother, however, said she could not prevent him obtaining sweets at school. After a little thought, he administered internally argent. nit. in the 30th dilution, and the child made a wonderful recovery.

Dr. DYCE BROWN said there were one or two matters in regard to which he ventured to disagree with Mr. Wright. Mr. Wright spoke of pruritus ani and dermatitis being practically part of the same complaint, but he (Dr. Dyce Brown) had not found that those who were troubled with pruritus ani were specially liable to attacks of dermatitis. He did not deny the possibility of tea, coffee, butter, salt, and tobacco being in some people a cause of pruritus ani. He said “in some people,” because what would affect one person might not affect another. But he had had a case which made a great impression on his mind as to the cause of pruritus ani and the effect of treatment on dietary lines, independently of medicine altogether. The patient had suffered from pruritus ani from young manhood. His sleep was disturbed at nights by it, and after stools, which were quite regular, he suffered from pruritus most intolerably, and to relieve himself he had to use considerable friction. He was perfectly healthy in every other way. For some reason or other the patient put himself upon a vegetarian diet, and also stopped drinking beer, spirits, or wines: the pruritus ani began to diminish from that time and has now completely disappeared. The curious thing was that, although Mr. Wright had condemned salt, tea, butter, and tobacco, the patient had still continued to take such things, and also pepper without any prejudicial effect whatever.

Dr. CLARKE entirely agreed with Mr. Wright that coffee was a frequent cause of pruritus, but it was also true that the thing which might cause pruritus in one case would not cause it in another. It seemed to him that pruritus ani was a rather valuable constitutional indication. Dr. Pratt, of America, had introduced a regular system of treatment, which he called “orificial surgery,” and had practised it with no little success. It was quite true what



Dr. Pratt had pointed out that the orifices of the body were very important indications of general states. For instance, if the corners of the mouth were ulcerated it was a certain sign that something wrong was going on in the constitutional state, and the same remark applied to irritated states of the anus. In his (Dr. Clarke's) opinion, in the greatest number of those cases the dyscrasia was of a sycotic nature, and would best be met with sycotic remedies, for example, thuja or nitric acid. There was another remedy which he found of very great use, namely, phosphorus. Mr. Wright had mentioned radium in its external use. Almost every one of the conditions mentioned by Dr. Deane Butcher he (Dr. Clarke) had treated successfully with radium given internally. He had given it in single dozes of the 30th dilution once a week or even went to the 20th decimal or the 6th, and he had found a number of cases of pruritus yield very rapidly to this remedy. He once had a patient under his care who, not getting better as quickly as he liked, went under light treatment. The light which did him the most good was the blue light. With regard to the case mentioned by Dr. Jagielski, he (Dr. Clarke) had found that excessive indulgence in sugar produced pruritus.

Dr. McCULLOCH mentioned he had had some experience in regard to the X-ray treatment, both in the ordinary chronic and in the diabetic forms of pruritus. It was understood that the anæsthetic effect was due to the blunting of the factism or tropism of the protoplasm, to use a biological term, and this followed upon a dissociation of the lecithin molecules present. He found that in filtering the rays, if X-rays were used through thick leather or aluminium plates, a better superficial effect was obtained, because of these rays being unduly penetrating; even the rays from a soft tube were too penetrating in some cases, the effect on the superficial layers was thus often missed. Hence it was that the ultra violet frequencies which are least penetrating from whatever source they were obtained, acted molecularly on the morbid elements of the epidemic layers in a more ideal fashion without the need of filtration. The same applied to radium, which had very superficial effects if applied directly in the way suggested, but with a thin plate of mica or celluloid as filter. Similar effects could doubtless be obtained by proper filtering of X-rays and judicious application of them. It was always necessary to obtain evidence of a reaction after the third or fourth application and this should never exceed the first degree, short of the exudation of lymph serum from the underlying lymphatic capillaries. He had had two cases recently which had done very well indeed under the filtration method.

Mr. EADIE enquired whether any of the members had found thus of any use in the condition. He had noticed a number of cases in patients of gouty or rheumatic diathesis. He always insisted on his patients not scratching the part. If a patient refrained from scratching and gave the part a chance to heal, he was certainly relieved, at least temporarily. With regard to coffee being a cause of the complaint, he remembered the case of a patient—a tea-drinker—who suffered from pruritus ani; he had to go to Germany, where he could not obtain tea and therefore had to take coffee, and that man returned from Germany perfectly well. During the time he had been taking coffee he had had no trouble from the complaint, but directly he started tea-drinking the pruritus returned. He (Mr. Eadie) laid stress on the point that pruritus ani was only a symptom. He remembered the case of a man who came to him about six months previously suffering from a stricture, and a catheter was passed. The man afterwards told him that he had been suffering from itching of his anus for years, but since the instrument had been passed the irritation had entirely disappeared.

Dr. CASH REED (in the chair) said Mr. Wright had not particularly dealt with ulcers just inside the anus, but he (the President) thought that was the most common cause of pruritus ani; if the anus was dilated a small ulcer would frequently be found just inside. The three remedies which he had been accustomed to use with more or less success were nitric acid internally, and ointment of sandal wood 20 per cent. externally, and calomel dusting powder.

Mr. DUDLEY WRIGHT, in reply, remarked that the condition was a very difficult one to treat. With regard to radium, he would like to ask Dr. Clarke, whether it was a trituration of radium itself which he used, or only some fluid which had been made radioactive by the application of radium.

Dr. CLARKE said it was radium itself.

Mr. WRIGHT, continuing, said Dr. McCulloch's hint was a very excellent one, for it had never struck him (Mr. Wright) at the time that by filtering the rays a better superficial effect would be obtained. With regard to Dr. Eadie's advice, he found it was almost impossible to stop patients from scratching themselves; and as to the incident Dr. Eadie mentioned about the coffee, it simply went to show that what caused the condition in one person did not cause it in another; there were many different exciting causes, one might be dietetic and another entirely local, and because coffee cured the complaint in one person it did not necessarily follow it cured it in another.

## MINUTES OF THE SOCIETY MEETINGS.

THE FOURTH MEETING of the Session 1908-9 was held at the London Homœopathic Hospital on January 7, 1909, at 8 o'clock, Dr. Stonham (Vice-President) in the chair. There were also present Dr. Dyce Brown, Dr. Burford, Dr. Clarke, Dr. Cooper, Dr. Cronin, Dr. Roberson Day, Dr. Eadie, Dr. Ellwood, Dr. Goldsbrough, Dr. Ham, Dr. Clifton Harris, Dr. Granville Hey, Dr. Jagielski, Dr. Johnstone, Dr. Byres Moir, Dr. Frank Nankivell, Dr. Neatby, Dr. William Roche, Dr. W. Ross, Dr. F. Watkins, and Dr. Wheeler. Dr. Hare, Pathologist, and Dr. Marriott, Resident Medical Officer, to the London Homœopathic Hospital, were announced as visitors.

Under the auspices of the Section of *Materia Medica and Therapeutics*, a paper was read by Dr. Burford, of London, entitled "A General Review of the Defensive Powers of the Organism against Malignant Disease: a Working Hypothesis for its Therapeutic Treatment; Personal Experiences with Cacodylate of Soda as a Remedy." A discussion followed, which with the paper appears on pp. 99 and 121 of the current issue of the Journal.

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THE FIFTH MEETING of the Session was held at the London Homœopathic Hospital on Thursday, February 4, 1909, at 8 o'clock, Dr. Stonham (Vice-President) in the chair. There were also present Dr. Speirs Alexander, Dr. Dyce Brown, Dr. Clarke, Dr. Cronin, Dr. Roberson Day, Dr. Eadie, Dr. Ellwood, Dr. Vincent Green, Dr. Greig, Dr. Ham, Dr. Granville Hey, Dr. Jagielski, Dr. Johnstone, Dr. Octavia Lewin, Dr. McCulloch, Dr. Macnish, Dr. Frank Nankivell, Dr. Neatby, Dr. Powell, Dr. Purdom, Dr. Cash Reed, Dr. William Roche, Dr. Wynne Thomas, Mr. Knox Shaw, Dr. Watson, Mr. Dudley Wright. Dr. Goldsbrough sent an apology for absence.

## NEW MEMBERS.

William Henry Watts, M.R.C.S.Eng., of 1, Wellington House, Regent's Park, and Frederick Wells Beville, M.R.C.S.Eng., L.R.C.P., of 2, Brock Street, Bath, were elected members of the Society.

## VISITORS.

Miss J. A. Lewin, M.B., and Dr. Hare were announced as visitors.

## SECTION OF SURGERY AND GYNÆCOLOGY.

Mr. Knox Shaw read a paper under this section entitled "Some Points in the Diagnosis and Treatment of Perforated Gastric Ulcer," which was followed by a discussion, and which with the paper appears on pp. 151 and 160 of this issue of the Journal. Then Mr. Dudley Wright contributed a paper on "Pruritus Ani," which several members discussed, and which appears on pp. 165 and 171.

The SIXTH MEETING of the Session was held at the London Homœopathic Hospital on Thursday, March 4, 1909, at 8 o'clock, Dr. Stonham (Vice-President) in the chair. There were present also Dr. J. Hervey Bodman, Dr. Dyce Brown, Dr. Burford, Dr. Clarke, Dr. George Clifton, Dr. Cooper, Dr. Cronin, Dr. Roberson Day, Dr. Eadie, Dr. Ham, Dr. Hey, Dr. Jagielski, Dr. Macnish, Dr. Byres Moir, Dr. Neatby, Dr. Pincott, Dr. Powell, Dr. Searson, Dr. Storrar, Dr. Wynne Thomas, Dr. Wheeler, Mr. Dudley Wright.

Dr. Goldsbrough and Dr. Thomas Simpson sent apologies for absence.

## NEW MEMBER.

Alexander Henry McCandlish, M.R.C.S.Eng., L.R.C.P.Lond., of 43, Royal Crescent, Holland Park Avenue, W., was elected a member of the Society.

## DEATH OF DR. A. C. CLIFTON.

The death was announced of a veteran member of the Society in Arthur Crowen Clifton, on February 16. Dr. Clifton was elected in 1861, was President in 1898, and sat on the Council in 1894 and 1899. A vote of condolence with Mrs. Clifton, Dr. George Clifton, and other members of the family was moved by Dr. A. E. Hawkes, of Liverpool, in the following terms:—

"That this Society place on record its appreciation of the work and worth of our lamented colleague, Dr. Arthur Crowen Clifton, one of the oldest members of the Society, that his presence from

our midst will be sadly missed, and that we desire to express our sincere sympathy and condolence with his wife and the other members of his family."

Dr. HAWKES made many touching references to the personality and work of Dr. Clifton, and gratefully acknowledged his own personal indebtedness to him as a teacher. Born into controversy, and nurtured and surrounded by it, it was not to be wondered at that Dr. Clifton grew up with that independence which characterized him, and that he generally held his own.

Dr. GEORGE BURFORD seconded, and spoke in feeling terms in support of the resolution, which was carried by all the members present rising in their places.

#### MEMORIAL TO THE LATE DR. CLIFTON.

At this meeting it was resolved that as a memorial to Dr. Clifton the collection of photographs of Members and Fellows, past and present, of the Society, which was presented some time ago by Dr. Clifton (1905), should be suitably mounted and framed. Up till now these interesting photographs have remained more or less inaccessible on the bookshelves of the Society. The collection contains an excellent likeness of Dr. Clifton, worthy of enlargement, which might form a leading feature of the collection. It is believed that a sum of £25 or £30 would cover the cost of a suitable gallery and a carbon enlargement of the donor, and it is known that such a means of preserving and exhibiting the photographs would have met with Dr. Clifton's approval. A donation of 5s. is invited from each member to cover this outlay and to provide for the reproduction of some of the likenesses which are fading. If this proposal meets with the approval and support of members the collection can be extended by the addition of present members.

Donations to the Clifton Memorial Fund should be sent as soon as possible to the Hon. Secretary of the Society.

#### DEATH OF DR. H. C. ALLEN, OF CHICAGO.

The Vice-President announced also the death of Dr. H. C. Allen, of Chicago, who was a corresponding member of the Society elected in 1904. Dr. Allen was connected with Hering College, and was a well-known writer and teacher of *Materia Medica*. A vote of condolence with the widow of Dr. Allen and with his colleagues in the Hering College was moved by Dr. Searson and seconded by Dr. Dyce Brown.

given without relief. One day the pounding sensation had much increased; she was dizzy and nauseated, her face was flushed, the eyes suffused and carotids throbbing. Atropine 3x was prescribed, to the great relief of the symptoms. The throbbing tinnitus disappeared after the first dose and did not return. (Dr. W. H. Phillips in *The Cleveland Medical and Surgical Reporter*, March, 1909, p. 110.)—ED.

**Cratægus Oxyacantha.** *Provings.*—Cratægus has been submitted to a test-proving at the University of Michigan. Two provers were chosen, and full details of their history, general health and habits are given. Pulse tracings were taken daily before and during the proving. The drug was started on December 1 and continued for fourteen days. For the first four days the 3x preparation was administered, two doses every hour, then 2x in the same way for two days, and for the remainder of the proving the tincture. For two days five doses every hour of the tincture were given and then increased to every one half-hour; the drug was then administered in liquid form in water. Thirty drops of the tincture in water were given four times a day, and finally forty drops for four doses two hours apart. Under the 2x and 3x preparations no symptoms appeared. The effect of the drug became apparent when the tincture was given. On the second evening of this, prover No. 2 noticed dizziness lasting a few minutes; the pulse-rate became lower with no change in character. Prover No. 1 experienced no dizziness, but the pulse-rate was lowered and firmer. When the dose was increased and the interval made longer between the doses, a marked decrease in pulse-rate was noted in both provers. This symptom came on in the evening, and they suffered from lack of air. The pulse-rate became as low as 56 and was much weakened. Examinations of urine and blood were negative. Compared with other heart drugs cratægus appears as less powerful than digitalis or strophanthus and more prolonged in its effect than adonis vernalis. (Dr. Claude A. Burrett in *The University Homœopathic Observer*, January, 1909, p. 10.)—ED.

**Enteric Fever.** *Vaccine Treatment.*—MM. Pescarolo and Quadrone have lately been using a vaccine whereof 5 cc. contain one milligramme of attenuated culture of *Bacillus typhosus*. Beginning with subcutaneous injections of 0.5 cc. to 1.0 cc., they found rise of temperature accompanied by rigors, lasting several hours. Later on at the site of the injections there were

swelling and pain, but these could be obviated by the local application of a small bladder of ice. The injections are made once or twice a week, and if the variations in the sero-reaction of these patients be followed, it is found that the agglutinating power of the serum increases rapidly. The effect of this treatment upon the general condition becomes evident at the end of from three to seven days. Lastly, after the second injection the general and local reaction are much less intense. MM. Pescarolo and Quadrone have treated in this way twenty cases of grave typhoid of the septicæmic type with most satisfactory results. (*L'Art Médical*, January, 1909, p. 74.)—J. G. B.

**Immunity and Homœopathy.**—Following the researches of Sir. A. E. Wright, and quoting Dr. Neatby of the homœopathic school, Dr. W. H. Walters, of Boston University, records further experiments with various opsonic indices. The following extracts from this paper are of interest: (1) To investigate the action of hepar sulph. in material doses as a promoter of suppuration several experiments were made. The indices of the progress were taken repeatedly under identical conditions. The result was the conclusion that hepar in single strong doses and in a number of comparatively small ones is capable of materially decreasing the resistance to staphylococcus infection. (2) A patient, Miss S., came to the Massachusetts homœopathic hospital early in May, suffering from chronic diarrhœa of some years' standing, the cause undemonstrated. Her index to tuberculosis and staphylococcus was 1·02 and ·98 respectively. Her index to the colon bacillus was ·45. On account of her history having shown marked improvement formerly from the use of sodium sulphate in homœopathic preparation it was decided to try this and watch the variation, if any, in the index. She was under observation in the hospital for nearly a month, but with all other conditions identical to those present subsequent to the beginning of the treatment. On June 16 she was given hypodermically sod. sulph. 200x, with a dose repeated on the 22nd. On June 26 the index was found to have risen from ·45 to ·7. On June 28 it was ·88. On this day a third dose was given. On July 1 the index was ·96, and on July 4, 1·6. At this time one dose of sodium sulphate 30x was given in water and so repeated at intervals of a few days thereafter. The index on July 12 was 1·3, July 24, ·6, July 29, ·9. During the entire time there was steady improvement in the clinical symptoms, until the patient went home early in August with practically normal intestinal functions and feeling in excellent general health. (*Hahnemann Monthly*, December, 1908, p. 881.)—ED.

**Leprosy.** *Serum Diagnosis of Atypical Form.*—M. M. Gaucher and Abrami have been working at Hansen's bacillus in the hope of arriving at a serum diagnosis of atypical forms of leprosy. The technique used by the author was as follows: "After removing, with the usual antiseptic precautions, a subcutaneous leproma in a patient affected with undoubted tuberculous leprosy, we removed from this leproma all apparently healthy tissue adhering to it. The nodule was then chopped very fine and dried *in vacuo* for sixteen hours. At the end of this time the diseased tissues form a sort of brownish paste, of fatty appearance, but perfectly dry, which can be preserved in a sealed tube in the ice-chest. It is with this paste that we made the emulsion used in our research for the *reaction de fixation*. For this purpose 1 gramme of extract was mixed with 10 grammes of 8 per 1,000 sterilized solution of sodium chloride. The tube containing the mixture is strongly shaken, then placed for two days in the ice-chest in order to avoid contamination of the emulsion. At the end of this time the liquid is turbid, of a milky-white appearance, with a supernatant greasy ring which must be decanted and rejected; at the bottom of the tube are found the broken-up fragments of the leproma. It is with the supernatant liquid that our series of researches have been made. A drop of this liquid examined under the microscope shows the presence of Hansen's bacilli, *débris* of cells invaded by these bacteria, and numerous cellular remains. We have, therefore, to deal with an *antigen* of mixed composition containing at the same time a large quantity of specific bacilli and the products of tissues infiltrated by them.

"The search for the reaction of fixation, effected with the antigen thus prepared, after a contact of four hours at 37° C. between this antigen and the various serums tested, furnished results of remarkable precision. In eight patients attacked with tuberculous leprosy, the reaction, repeated many times, was constantly positive and very intense. On the contrary, with the serum of thirteen patients suffering from divers acute affections, of sixteen syphilitics, two cancerous patients, three lupus cases and seven cases of pulmonary consumption, the reaction was constantly negative. Three tuberculous cases alone gave a slight fixation.

"Applied to the differentiation of syringo-myelic conditions and the nervous forms of leprosy, this method gave the following results: In eight patients attacked with typical syringo-myelia whose serum was obligingly furnished by M. M. Marie and Claude, the reaction of fixation was entirely negative. The same was



observed in a case showing all the symptoms of Morvan's disease. On the contrary, in a patient suffering from tropho-neurotic leprosy, the reaction, tested for on repeated occasions, was always positive and very intense. The serum of another patient with analgesic panaris of the Morvan type furnished also a strongly positive reaction. In both cases it was impossible to affirm on clinical grounds alone the leprosy nature of the ailment.

"Complementary researches showed, furthermore, that the serum of these lepers possessed a very energetic anti-complementary power in presence of very different antigens; placed in contact with emulsions of *Bacillus typhosus*, of Friedländer's pneumobacillus, of staphylococcus, &c., a very intense reaction of fixation was obtained." (*L'Art Médical*, January, 1909, p. 55.)  
—J. G. B.

**Magnesia Phosphorica in Angina Pectoris.**—In the course of an interesting paper on the homœopathic treatment of heart cases, Dr. Wallace McGeorge writes thus of magnesia phosphorica: "In one case, where subsequently the *post mortem* revealed calcified coronary arteries and a calcareous deposit on the aorta, mag. phos. 6x in hot water relieved the paroxysms and lessened their duration so much that the patient begged for 'some of those powders.' After a year it was only in the last week of life that the medicine failed to relieve." Dr. McGeorge states that magnesia phosphorica is excellent in intercostal neuralgia, and, like cactus, it has the constricting sensation round the chest, only in less degree than cactus. It quickly relieves when pain radiates from the heart in all directions. It works better when given in hot water. (*Hahnemannian Monthly*, January, p. 41.)—ED.

**Petroleum in Otitis Media.**—A young lady, aged 27, a teacher, had been losing her hearing for two years and suffered from continual buzzing and whizzing, increased in damp weather. Slight vertigo. Inspection of the ear showed a thickened, slightly depressed drumhead, the malleus moving easily during suction and compression. Inflation showed marked tubal obstruction, and only the smallest bougie was admitted. Hypertrophic pharyngitis was present. The tube was further dilated by bougies. Massage and the high-frequency current were used for some months, with some improvement in the hearing. Some homœopathic remedies were given with little improvement until petroleum 6x was administered, especially on the indication of aggravation by

damp. The improvement was prompt, continuous and permanent. (Dr. William H. Phillips in *Cleveland Medical and Surgical Reporter*, March, 1909, p. 109.)—ED.

**Phytolacca Decandra.** *Summary of Uses.*—In a study of phytolacca, Dr. A. H. Starcke, of Kansas City, sums up the therapeutic uses of this remedy as follows: (1) Sore throats and diphtheria characterized by deep redness, pain on swallowing, shooting pains from throat to one or both ears. Continuous desire to swallow, increased by hot fluids, burning and dryness. (2) Rheumatic and neuralgic conditions increased at night, causing restlessness but increased by motion, pains like shocks. (3) Mammary inflammations and abscesses. Nodules with profuse secretion of milk and pains radiating from nipple all over body. (4) Inflammation and indurations of lymphatics.

Phytolacca is also of probable use in malignant disease of the skin and in *la grippe*. (*Journal of the American Institute of Homœopathy*, March, p. 98.)—ED.

**Sanguinaria.**—Dr. Wallace McGeorge contributes a short paper on sanguinaria, in which its use is extolled in *la grippe*, diseases of the chest and neuritis. In chronic sick-headache this medicine is indicated, especially when there is prostration and exhaustion. In *la grippe*, when there is languor, prostration, headache, cough, pain in the chest, with great desire for rest, especially with depression and indifference to life. The sanguinaria patient is better for resting, but is not worse from motion. In diseases of the chest the breath and sputa smell badly, a dry cough is present waking from sleep, lessened by sitting up; cough continues until flatus is discharged, pains in chest and prostration. In valvular disease with lung involvement, phosphates in urine, loss of flesh, and circumscribed flush in one cheek, sanguinaria is called for, and will start the patient on the road to recovery. In right-sided neuritis, especially affecting the deltoid region, with inability to use the limb, but relief on touching the part, sanguinaria will be curative. (*Hahnemannian Monthly*, December, 1908, p. 930).—ED.

**Sodium Bicarbonate in the Vomiting of Pregnancy with Acetonuria.**—Following the researches of Drs. Blodgett and Starbuck, of Boston, U.S.A., a case is recorded by Drs. Wynne Thomas and George Burford of severe vomiting in pregnancy dependent on the presence of acetone and diacetic acid in the

urine, in which sodium bicarbonate had a prompt and dramatic effect. The patient was aged 36, and three months pregnant. The usual homœopathic remedies were tried without effect. Nothing could be retained in the stomach, and the patient was losing ground rapidly. The bicarbonate was given dissolved in water, 30 gr. being spread over twenty-four hours. In seven days all vomiting had ceased, the patient rapidly gained strength and appetite, digestion returned, and a mixed dietary was taken with ease and relish. After nearly a month's stay in the hospital she left to all intents and purposes absolutely well. (*British Homœopathic Review*, March, 1909, p. 167.)—ED.

**Tellurium in External Auditory Dermatitis.**—A patient who had had chronic dermatitis of the external auditory canal with moist scales and foul, irritating discharge was treated by careful cleanliness and swabbing with ichthyol and given graphites. No improvement ensued, however, until tellurium 6x was given, the ichthyol being continued. The trouble then quite ceased, and there has been no return. (Dr. W. H. Phillips in the *Cleveland Medical and Surgical Reporter*, March, p. 110.)—ED.

**Thuja in Chronic Scleritis.**—Miss R. had suffered from chronic scleritis for two years, sometimes more, sometimes less, but never well. The left eye showed typical scleritis at the inner side of the corneal margin, with marked injection of the deep vessels, very sensitive to light and touch, with dull, heavy, aching pain. Tests for constitutional maladies were negative; various measures were tried, such as atropine, merc. sol., rhus, and ammon., and finally pot. iod. gr. 20 t.d., with only little effect. Thuja  $\phi$  gtt. ii. t.d. was then given, and improvement began immediately. In two weeks the eye was clear, and the subjective symptoms had all gone. (Dr. W. H. Phillips in the *Cleveland Medical and Surgical Reporter*, March, p. 112.)—ED.

**Thuja in Chronic Laryngitis.**—A man, aged 65, had been hoarse for years, and had almost lost his voice. He had pachydermia laryngis. He was first treated locally and given thuja 30x with temporary improvement, but the trouble recurred. Thuja  $\phi$  gtt. v. t.d. was then given and local treatment stopped. Six weeks later the voice had much improved and the vocal cord approximated very well. The patient expressed great satisfaction at the result. (Dr. W. H. Phillips in the *Cleveland Medical and Surgical Reporter*, March, p. 111.)—ED.



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*All communications and exchanges to be sent to*  
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SOME EXPERIENCES IN THE MEDICINAL  
TREATMENT OF CANCER OF THE BREAST,  
THREATENED AND MANIFEST.<sup>1</sup>

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THE subject of this paper would need no apology were it not for the fact that it immediately follows another dealing with the same disease. Still, as it approaches the question of the treatment of this disease from a different standpoint, its only effect can be to supplement and not detract from Dr. Burford's extremely important observations, and it is for this reason that I have ventured to give you another paper on cancer.

My object in writing the last paper, which I had the honour of reading before you, was to endeavour to lay for ever the ghost of disbelief in the fact that the wave of remedial action produced by a remedy will continue for many days after a single dose of the remedy is given,

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, March 4, 1909.

and that such doses, when repeated at sufficiently long intervals, are capable of curing disease previously pronounced incurable. In order to do this I related a case of advanced "tabes mesenterica" cured in this way, and I had to weary you and myself by detailing at great length the case of a previously rapidly growing carcinomatous tumour, which was changed into one almost equally rapidly diminishing by the pure action of single doses given at long intervals; it being impossible for anyone, however sceptical, to say that any cause for this result was at work except that of the doses so given. This case had the additional advantage of proving that such doses can not only act curatively on non-malignant disease, but that they had the power in some cases of genuine cancer of inducing absorption of the tumour by the system, together with almost complete disappearance of all cachexia. The case was a test one, for the abdomen had been opened and no less an authority than Mr. Bland Sutton himself had declared the tumour to be one of colloid carcinoma of the great omentum.

It was of the first importance to prove this action on malignant disease as a fact which could not be refuted, for by so doing it entirely changed the aspect of succeeding abdominal cases in which operation had not been performed and visual evidence was not forthcoming to testify to the undeniable malignancy of the condition, and it for ever dispelled the argument with which one had been satiated in the past, that "because the patient got better, therefore it could not have been cancer." Hence medicinally cured cases in the future which present convincing clinical features of malignancy, though no operation may have been performed to add additional testimony to this fact, can now be much more readily accepted as those of genuine cancer.

My present object is to put before you evidence in support of my contention, which is merely an echo of that of my late father, that "cancer can be far more efficaciously treated by medicine than by surgery"; and let me here hasten to add that all references to surgery in this paper imply removal of the original or succeeding growths by the

knife without any medicinal treatment being given at the same time with a view to attacking the underlying constitutional condition.

I desire to spend as little time as possible upon theorizing, but there is one all-important point I must touch upon, and I hope to-night to learn the opinions of those present on this, for the views of homœopaths, who appreciate the subtle processes underlying the visible manifestations of disease, are of far greater value than those of the old school observers, whose science teaches them to treat disease by dealing only with its cruder and more obvious effects.

The teaching of the past has been that cancer is a purely local disease at the start, that it tends to kill by producing progressive marasmus and asthenia, and by the occurrence of secondary deposits throughout the system, and that these secondary deposits are all due to direct infection from the primary growth. This was, undoubtedly, a very rational view to take when the first observers investigated the disease, for they first saw a tumour which increased in size, and noticed that cachexia and secondary growths followed later. What more natural than to suppose that these secondary phenomena were directly due to the first tumour, and what more rational treatment could they suggest, holding this view of the case, than to remove the tumour without any delay? for by so doing they would be freeing the body from the source of infection.

Let us, however, for one brief moment have the temerity to shuffle off the traditions of the past, and suppose that this view is entirely erroneous, and let us regard the disease as primarily a constitutional one with the occurrence of growths as purely secondary phenomena, the cachexia also being due to this original cause and not to the primary growth, except in so far as this may interfere mechanically with the functions of the body, or produce a septicæmic condition when breaking down. If we take this view of the disease, in what a different light does operation appear, for if this be accepted, then it is about as rational to remove a cancerous growth with the object of curing the patient of his disease, as it is to remove an ulcer in the intestine in

the hope of curing enteric fever; yet the latter might be removed with advantage if it was on the point of bursting, as might the former if its pressure on vital organs mechanically threatened life. But this is an entirely different thing from removal being undertaken with a view of curing the patient, and before a decision can be arrived at as to the removal of the growth, a question of the gravest import has to be faced—viz., whether this very removal does not greatly aggravate the original underlying constitutional condition, and so tend to shorten life.

Let us suppose that this first tumour is in reality an outlet for the systemic condition (and some colour is given to this idea by the observations of Dr. Clarke, who has noticed that patients previously showing signs of ill-health actually improve in health temporarily on the first appearance of a cancerous growth), if we then suddenly deprive the system of this outlet, it is conceivable that it must find an outlet elsewhere, and that in the effort to do this the disease may gain very materially in virulence.

Certainly by no other hypothesis can one explain such cases as are unhappily by no means rare, of which I mentioned an example when joining in the discussion on Dr. Burford's paper. I will give a brief summary of the case again:—

It was that of a lady, aged 56, who came to me on February 10, 1906. She had suffered from constipation all her life, and told me that she had noticed three lumps in the side of her breast a short time ago, two of which seemed to her to have disappeared, but the remaining one had rapidly increased in size in the last few weeks. I found a tumour about the size of a walnut, and of medium consistence, in the outer quadrant of the breast, there being an enlarged axillary gland present which was not very tender.

I explained to her that the rapidity of growth was evidence of marked malignancy, and I placed before her the two sides of the question of treatment, giving her to understand that with the exception of one or two men the whole profession advocated immediate removal of such growths, but that my experience so far did not justify me in recom-



mending this course, as I had good reason for believing that operation tended to shorten life. It must be borne in mind that this was three years ago, so I could not speak with the same weight of experience behind me as I can to-day. Nevertheless, I told her emphatically that if she decided on operation she must have medicinal treatment at the same time, as otherwise disastrous results would assuredly follow, and I recommended her to obtain Mr. Dudley Wright's opinion.

She, however, refused treatment and did not consult Mr. Wright, and two days later I heard that she was going into Charing Cross Hospital for operation. Here the radical operation was performed, the whole breast being extirpated, together with all the axillary glands and as many glands as possible in the arm and forearm. A few months later her husband informed me that the disease had broken out in the spine, and she died in great agony in December of the same year, *ten months after the operation*.

Oh! but the surgeon would say when asked to explain this unfortunate catastrophe, the case came too late for operation to be of any use. Nevertheless, no time was lost directly it became evident to her that rapid growth was taking place, and all tissue was removed which could be regarded as infectious (allowing for the moment the view that such tissue was infectious), together with all the glands in the neighbourhood, so that it was out of reason to imagine that any such tissue was left behind. Yet this disseminated and infinitely more malignant affection followed in the short space of a few months. Also, if this case was too advanced for operation, then practically no case should be operated on, for it is rare to get one in a much earlier stage. "But," would come the answer, "the tumour had obtained some size before operation, and infection of the system from it could have conceivably occurred before it was removed." Very well, I would reply, but why is it that in the several cases I have treated with medicine alone I have never seen a similar result; and what about the case which Dr. Gilbert described in a recent paper delivered to the Cooper Club and subsequently published in the *Homœopathic World*?

For those who may not be acquainted with it I may say that it was one of a single lady aged 45 who, at the menopause, complained of slight tenderness below the nipple, there being no signs of general ill-health. No mammary swelling could be found, and she was treated with hydrastis, conium, belladonna, phytolacca, and belladonna fomentations. Two to three weeks later a slight hardening of the breast was detected, *no larger than a split-pea*, but there was no evidence of enlarged axillary glands. A surgeon was consulted, who advised immediate operation *as a precautionary measure*, though no sign of malignancy existed. The radical operation was performed in this case also, total removal of the breast and all the axillary glands being carried out. Yet within a few months similar symptoms developed to those in the last case, producing, in Dr. Gilbert's words, "torments of pain," by attacking the spine, so much so that she wished to commit suicide. Morphia in large quantities were required, and the scene closed with death in ten months after operation; so that the time taken for the manifestations of recurrence, and the site affected, were strangely similar in these two cases. It seems to me that this case alone must prove to any thinking mind that the primary growth was not the source of infection, for no case could be operated on earlier or under more ideal conditions.

Another case very similar to this was given by Dr. Gilbert, but no doubt you have all come across many cases of this kind, and nothing would be gained by my detailing any more of them, though I could a tale unfold of many such, which have come to me with diffuse carcinosis following operation, and for which I could do little except afford temporary alleviation of suffering.

I do not wish it to be thought that my object is to disparage operation by picking out some of the most unfortunate results with a view of leaving an impression that all cases so treated are similar. It must, however, be admitted that this treatment is almost invariably followed by death within two years, it being rare for life to be extended over three years. I have yet to come across a case not treated homœopathically which has lived over this

time, in which evidence is forthcoming that the growth removed was proved microscopically to have been cancer, and I am sure that many have been erroneously led to take an incorrect view of the efficacy of operation by cases of non-malignant adenomata being diagnosed as cancerous before operation, no further steps being subsequently taken to prove the correctness of the diagnosis.

The man in the street with such facts before him would be inclined to censure the profession at large for still continuing to insist on operation, but I myself cast no such aspersions, for one must bear in mind that the allopath knows how powerless are his methods of drug administration to deal with any chronic disease, and especially those of a malignant type, and he naturally does what he considers best, though it is assuredly a very poor best.

But if the non-infectivity of the primary growth be accepted, the question might be asked, "How does one account for the enlargement of the glands?" And my reply to this would be that these naturally enlarge in consequence of the mechanical irritation set up in their vicinity by the growth. They may certainly become infected by direct extension of the growth, but if they do they tend to cease enlarging beyond a certain point (or at least this is my experience when the disease is treated medicinally), and in any case this direct extension is very different from a general systemic infection occurring from the primary tumour as a central focus.

And now before detailing a few medicinally treated cases to illustrate the non-operative point of view, I feel it incumbent upon me to say a few words about a drug which figures rather largely in some of them; I refer to "*Scrophularia nodosa*."

When mentioning this remedy in my last paper, I noted that I had found it had a special affinity for breast tissue. This fact was gradually borne in upon me, so that I can fix no particular time when I became aware of it. The provings of the drug throw no light on the question, for the very good reason that the provers were males. On looking through the cases of breast tumour published by

my late father, I found only two in which it had been used. In one it formed one of many remedies given, being chosen on the indication "irritable nipple," apparently, and in the other case, which I shall be describing later, it assisted in the removal of a cancerous nodule.

However, I shall place before you some of the evidence I have on the subject, and this, together with your own future observations, will enable you to estimate how far my deductions are correct. I have picked out the following case of simple adenoma to illustrate my contention.

A lady, aged 44, of dark complexion and active disposition, complained to me on *January 8, 1904*, that she had been advised to have her left breast removed, because of the presence of a lump which had been first noticed two years before. Although it had varied in size in the past, it had of late been enlarging more noticeably, and the pain, which she said had been always present, had become an increasingly prominent factor. This she described as neuralgic in character, with great heat and burning, it being somewhat relieved by taking arsenicum. The whole condition of the breast was aggravated by the period.

I found more or less general tumefaction and tenderness of the outer half of the left breast, the swelling being somewhat indefinitely divided into three or four sections. Very slight tumefaction existed also in the right breast, but this was much less defined, and no tenderness could be detected on this side. The nipples were unaffected and the axillæ free.

Although this was no less than five years ago, I evidently placed great reliance on the action of this remedy, for although considerable want of confidence was apparent in the patient, due, as she explained, to the unexpectedly youthful appearance of the physician, I nevertheless had the temerity to considerably accentuate this feeling by prescribing a unit arborivital dose of *scrophularia nodosa*, telling the patient at the same time to take no other medicine for a fortnight, and to let me hear from her at the end of that time. I mention this that it may dispel any idea of "suggestion," which necessarily needs confidence for its efficient exploitation. On *January 26* (a fortnight later) I received this communication by post: "*That dose had a wonderful effect, positively uncanny. Since taking it there has been no return of the pain, or even grumbling, and no return of that feeling of heat and unpleasant sensation, as if it would burst. The lumps, I think,*

*have slightly diminished, and I am altogether feeling very much better. I can still hardly realize that the pain has absolutely gone, after having had it, more or less, for so long."*

In reply, I asked for a report in a week, which was delayed for another week, and was to the effect that there had been bilious vomiting, and that menstruation had failed to come on at the appointed time (though this had never occurred before); also that eight days previously some very red spots, varying in size, had come out on the neck and chest with a small head to them. They developed all over the body and especially on the right side of the chest. Many of them appeared as holes  $\frac{1}{4}$  in. long and a few were to be seen low down on the feet, but none were present on the face. Their heads had fallen, and they had flattened out, leaving the skin rough. Many had run one into the other, and the eruption was still visible, though dying off. The report concluded with the assertion that there had been no irritation and that no similar eruption had been seen before.

I am not prepared to affirm that these symptoms were not due to a reaction following the remedy, and have therefore put them on record. They were, nevertheless, sufficiently like chicken-pox to warrant me in advising the calling in of local aid. This was not carried out, and these particular symptoms cleared up under bry. 6 t.d.s., a slight return of pain in the breast being noted later. This was instantly cleared up by another dose of scroph. nod. I need give no further details of this case except to say that the breasts recovered their normal consistence and that no further trouble has been experienced in this direction, though other matters needed subsequent treatment.

I have had other adenomatous cases which have yielded equally readily to this drug, but time presses, and the case I have given is sufficient to demonstrate my point and to give some justification for my having used it in some of the following cases of carcinoma of the breast.

A lady, aged 49, of dark complexion and spare build, consulted me on *October 30, 1905*, saying that her case had been diagnosed as cancer, and that immediate operation had been advised, which she absolutely refused to agree to, owing to her knowledge of the results obtained by this treatment of several of her relations and friends, who had since died. She had suffered from a lump in the left breast for some years, which remained in a stationary condition till eighteen months ago, when, apparently as the result of anxiety and shock, consequent on the loss of her husband, it

began to show signs of activity and became fixed, having previously been movable.

It has increased in size of late, and a constant nagging pain is felt with occasional stabs through the tumour; great tenderness is also present, and dragging and pain are brought on by raising the arm or using it much.

She has been losing flesh considerably lately, being more than a stone below her usual weight. The bowels tend towards constipation, requiring a laxative occasionally.

Her early history gave evidence of a blow to the breast fourteen years before, and much ovarian trouble, including salpingitis

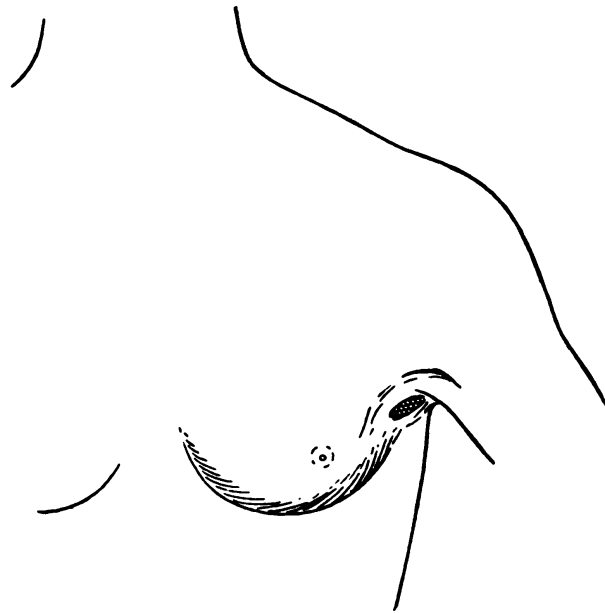


FIG. 1.

with abscess formation; but the pelvic organs now no longer troubled her, the climacteric having occurred six years before.

The family history was extremely bad, her mother having died of cancer; a brother and sister had also both succumbed to the same disease affecting the bowel, and insanity existed among her grandfather's relations.

*On examination* I found a small hard, more or less rounded tumour, about the size of half a walnut, in the outer and upper quadrant of the left breast. It had invaded the skin, which was puckered and firmly adherent to it, and there were large tender glands, in size about two walnuts, in the axilla, besides which the

tissues above the tumour lying over the tendons of the pectoral muscles were swollen and tender. The nipple was retracted by cord-like ducts, which could be felt stretching between it and the tumour.

I cannot go into minute details of the treatment of this, or any other of the cases I am putting before you to-night, as time will not allow of it, but one or two notes will not be out of place. I commenced treatment with a dose of *scrophularia nodosa*, an ointment of the same being applied under the arm, and when I next saw the patient *a fortnight later* the report was to the effect that she had not been well in herself. *The tumour had felt decidedly worse the day following the dose, but had been decidedly easier the last four to five days. There had been some pain, but nothing to what it was, and she could lie much more comfortably on that side.* The only noticeable objective change was a decrease in the tenderness of the glands. *Bowels acting daily, no laxative being required.* I gave no more internal medicine, the next report, *a fortnight later*, being one of general systemic disturbance. Severe abdominal pain with diarrhoea and vomiting, followed by constipation and distension of the abdomen. Pain had been experienced all round the neighbourhood of the tumour, under the biceps, up the left shoulder and side of the neck, though *less pain was evident in the tumour itself, which was decidedly less tender.* I found all the muscles of the left arm, shoulder, axillary and supraclavicular glands very tender, as were the abdominal muscles, and, incidentally, tenderness was also present in a right floating kidney.

Here was a picture which, I venture to say, one of our *confrères* of the opposition would regard as the result of pure coincidence, due to some outside cause, such as chill, &c., but to you gentlemen who watch the curative and not the chemical action of remedies, its cause must be fairly clear. Obviously a reaction had occurred in which the resisting forces of the whole organism had come into play, resulting in a form of temporary toxæmia in which those useful eliminative organs, the bowels, took on excessive action, and pains and tenderness were found in the glands and muscles.

“Theory, pure theory” would be the antagonistic fraternal answer to this, because no microscopic phagocytic or other battle had been demonstrated as taking place

in the blood ; but, gentlemen, are we justified in endangering patients' lives by obstinately delaying the recognition of obvious clinical facts, until they are forced down our throats by laboratory experiments ?

As enough stimulation had, in my opinion, been given to the system for the time being, I now prescribed china 3, t.d.s., and a fortnight later she told me she had been altogether better, though suffering from *some general aching from head to foot*. The abdomen had gone down again, the bowels were acting regularly, and pain had been quite absent from the axillary glands, though some was felt, in slight degree, in the tumour. *Her breathing, she said, was much better*, allowing of her running upstairs, though this had been previously impossible, and she was now able to take a hot bath without feeling faint.

I cannot devote more time to further details, except to quote a typical instance of the effect of lobelia erinus, which I found it necessary to give later on. This remedy, I may say, was almost invariably followed by marked benefit in the general condition. For example, on *February 16, 1907*, shortly after an attack of influenza, the symptomatic picture was as follows: has felt tugging pains at the back of the nipple, with a feeling of dragging beneath the tumour. The heart has been upset, rapid in action, and dropping beats at times (not specially on exertion). Some retching was experienced yesterday with headache, and she has been having some general muscular rheumatic pains lately. Lob. erin.  $\phi A$  was given, and on *February 28* (a fortnight later) she said: "I have really been remarkably well. The breast nagged for two days after the dose, but since then *I do not remember being, or feeling, so wonderfully well for a long time*. The only trouble has been some neuralgia at the back of the eyes. Appetite decidedly better, and general muscular pains much better."

Other remedies than those mentioned were, of course, required when special indications called for their use, and among these the nosodes have been of distinct value. However, it will suffice if I say that in spite of ups and downs, with occasional ominous threatenings of gastric trouble, and one or two attacks of influenza, her general health continued to improve, as did the tumour and its surroundings, and *she gained flesh considerably, returning to her normal bodily weight*. Her health now, three years and four months since she first came under treatment, and four years and ten months since malignancy first showed itself, is excellent in



every way. She has some pain occasionally in the tumour, but it is often absent for weeks at a time, being neuralgic in character, and certainly not due to any increase in the size of the growth.

The only change the tumour has undergone is a slight redness and oozing from the portion of skin involved. Its size is apparently absolutely stationary, though a small glandlike nodule appeared below it on one occasion *and subsequently disappeared again*. The glands in the axilla were at one time harder and more swollen, causing tension to be felt on raising the arm, but they have since gone down and are now somewhat smaller than when she first came, and the arm can be moved freely; also the swelling over the pectoral tendons has gone.

One peculiarity of the case was the appearance, on three or four occasions, of petechial spots, about the size of a shilling, over the thighs; but the most marked feature was the occurrence of muscular pains of a rheumatic character, which tended to alternate with the breast symptoms to a certain extent.

Rheumatic pains of this character have been noted by other observers as by no means infrequent in cases of carcinoma, and have been hitherto ascribed to the chance occurrence of carcinoma with rheumatism. My view is that these pains are not true rheumatism but are part of the general blood condition, and that they are due to toxic matters specially associated with this disease which are present in the blood. I find them characterized by pains in the muscles, tenderness being generally present in the affected areas, together with a tendency to shift from one set of muscles to another. I think they are sufficiently definite to deserve a name of their own, and I should be inclined to suggest that of "CARCINOMYALGIA" as fairly fitting the case.

As I have mentioned lobelia erinus in this last case, I thought you might be interested to have a few details of a case published by my late father and quoted in Dr. Clarke's "Dictionary of Materia Medica," especially as I am at the present moment dealing with a recrudescence of the old symptoms.

Her age, on July 11, 1900, when she consulted my father, was 36, and the history was briefly as follows: For the previous three weeks a hard swelling had been noticed lying close to the nipple of the left breast. Shooting, stabbing pains were present at times, and the condition had been diagnosed as cancerous at the West London Hospital, operation being insisted on as imperative; this, however, she had refused.

It seems the mass was found to be about the size of a marble, being closely connected with the skin above the nipple, and this skin was reddened and scabbing and threatening to break down. The nipple itself was much retracted and slightly eczematous. Below the breast was seen a soft lipomatous mass, its size being

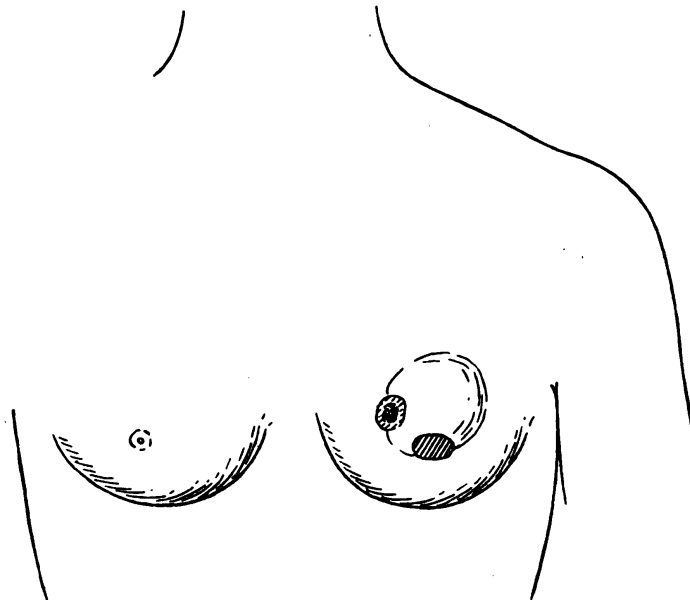


FIG. 2.—Lower shaded mark represents the retracted nipple.

that of a turkey's egg. It was feebly organized and unencapsuled, and it had made its appearance some eight years back, after she had been in the habit of carrying trays. Though perceptibly increasing in size, it caused her no inconvenience other than a mechanical one, and it presented no signs of malignancy, though the lump in the breast was obviously cancerous in nature. For the rest she was cachectic-looking, dark-haired, and subject to delayed and irregular menses. *Lob. erin. φA* given in unit doses at long intervals removed the breast tumour and materially reduced the pendulous mass, a final dose of *scroph. nod.* being given when signs of a return of the trouble occurred.

From this time, onward, the breast maintained a perfectly normal appearance till *December 29* last, when, after a long period of domestic anxiety, involving the nursing of her late husband through a long and tedious illness, together with financial difficulties, she came to me complaining of a return of the breast trouble, which had been coming on for some weeks.

I found a lump of medium consistence lying above a very retracted nipple, its size being about double that noted by my father. Drawing, aching and shooting pains were felt, which were increased by moving the arm. Coincidentally with this her health had become impaired, and she had lost all desire for food.

I gave lob. erin  $\phi$ A, and *eleven days later* she told me the breast felt worse the first two days, but that it had felt easier since. It was, however, still painful at times.

Recent observations had led me to believe that the action of unit arborivital doses was enhanced by intercurrent doses of the nosodes, and on this occasion I administered a dose of scirrhinum 100.

*Seven days later.*—Felt better the first two days both in herself and in the breast, but not so well again since. Lob. erin  $\phi$ A.

*Seven days later.*—Drawing pain was felt in the tumour soon after the dose; the surface became red at one point and finally burst, discharging thick, yellow, slightly offensive matter.

I found the opening located at a point above and internal to the nipple, the tumour itself being somewhat reduced in size. Scirrhinum 100 was given.

*A fortnight later* she informed me that she had felt shaky and weak in herself, with no desire for food up to within the last three days (*i.e.*, eleven days after the last dose); also the breast had been painful and very sore, with a tendency to bleed. There had been an increase in the discharge, which differed only from the previous discharge in being less offensive and less thick, though its appearance was similar. However a change had come over the scene in the last three days, for she had been feeling much better in herself, with a very much better appetite, and the discharge had lessened. Bowels regular and sleep good. Swelling smaller. Rep. scirr. 100.

*A fortnight later* (*i.e.*, on February 23 last), very much better in every way. Trifling discharge and no pain to speak of. The tumour had also further decreased in size. I gave another dose of scirrhinum 100; and, if nothing has prevented the patient attending to-night, you will be able to judge of her condition for yourselves.

When I saw this patient, towards the end of 1903, I found the former pendulous mass described by my father to be now reduced to a flat-topped, circular, movable tumour of the consistence of hard india-rubber, its diameter being rather less than that of a florin, and the skin covering it white in colour. Certainly its appearance and consistence did not suggest that its nature was cystic. Between this time and her recent visit to me on account of the breast, I had had occasion to prescribe indicated homœopathic remedies at various times for gastric ulcer and a few other troubles, and I can only conclude that some of these acted on this swelling, for when I looked for it this last time I found nothing left but a piece of flabby skin occupying its former site.

The evidence points, so far, to her getting rid of the mammary growth much quicker this time than before, and I ascribe this to the part the nosodes have taken in the treatment this time.

My next case is that of Mrs. G., aged 63, who came to me on *May* 24, 1905, having been told that she must have an immediate operation for mammary carcinoma, which she had refused. She informed me that five weeks before she had first noticed a hard swelling in the right breast, her attention having been attracted to it by discomfort, which soon developed into pain of a throbbing character. She had suffered from obstinate constipation in the past, the bowels only acting, with the assistance of cascara, twice a week.

Her previous health had been good, except for a heart attack two years before and rheumatism, till recently, when general malaise had developed with loss of appetite. The tongue was furred, and she was liable to dyspepsia.

I could trace no definite malignant family history. Her father died of hepatic trouble with dropsy, which might have been a cancerous condition, and her mother's death was due to fatty heart.

On examination I found a rounded swelling centrally placed in the breast, for which I can find no better simile for size and shape than a halfpenny bun, though, of course, it was much harder than this. It measured roughly  $2\frac{3}{4}$  by 3 in. in each diameter. A hard gland existed in the axilla the size of a walnut.

Such dimensions attained in five weeks meant that we had to deal with a very rapidly growing tumour, which was obviously of malignant type. That it had existed in the breast much longer than this may be taken as impossible, seeing that its presence was so marked, owing to its consistence, that it would inevitably have been detected during ablutions. Certainly Dr. Croucher, of Eastbourne, who subsequently very kindly attended her, expressed no doubt as to the malignancy of the condition; and if he is present with us to-night I hope he will favour us with any observations he himself made on the case.

I commenced with a dose of *scrophularia nodosa*  $\phi A$ , and on June 7 (a fortnight later) she reported to the effect that there had been less pain the first week, but more again the last week. Her appetite was no better and the sleep had not been so good, but what caused her the greatest astonishment was the fact that *the bowels had acted every day with clockwork regularity. This, she said, had not occurred for years.*

I found no appreciable change in the tumour, and gave another dose of *scroph. nod.*  $\phi A$ .

June 21 (fortnight).—Was very well up to the 16th, with hardly any pain, but since then has had a pain "*as though the tumour wanted to burst,*" with throbbing pains down the arm. *Bowels absolutely regular and appetite now quite good. Axillary gland smaller.*

After this I continued the same remedy at longer intervals, and on August 27 (two months) she reported that for four days after the last dose she suffered from extreme tenderness, so much so that it prevented her putting on her boots and made it difficult for her to dress herself. After that it got better gradually, and is now only slightly tender when touched. She said that *on the whole she had suffered far less pain than formerly*, there being times when scarcely any was felt. Its character when present was "dull and throbbing."

Later *lob. erin.*, *carcinosin*, and *ruta grav.* were given in the same way, the exhibition of the latter being attended with the greatest relief, so much so that she said on December 13 (four months later) that the pain was only slight and of a grumbling character.

All this time *the tumour did not increase in size in any diameter*, which was a big point gained when it is considered that when I commenced treatment six months before it had been developing very rapidly, and there was *sensible diminution in the size of the axillary glands.* On February 7 (two months after the last note)

she expressed herself as wonderfully well: "*she never remembered having felt so well in all her life.*" This alone was an eye-opening statement for a patient to make who was suffering from malignant disease of more than nine months' duration, and which eight months before had been very seriously undermining her health. Her sleep, she said, was splendid, and *she took long walks daily, sometimes of over eight miles without fatigue*, which would not be bad for any lady of 63 years of age when enjoying normal health; and she subsequently informed me that her friends were much struck with her remarkably healthy appearance: a stranger, who knew nothing about her condition, remarked with envy that she wished she could enjoy such splendid health. Indeed, so far as looks went, anything more unlike a cancerous patient could not be imagined. She was well nourished, with a healthy, rosy complexion, and was able to do physically what many women of 50 in ordinary health could not attempt. She also repeatedly expressed her profound thanks that she had not submitted to operation.

And so she continued with unimpaired health and vigour, and no material change in the tumour from that mentioned last till June, 1906, a year after coming to me, when the tumour showed signs of pointing through the skin. This caused some return of pain, which was eased by lob. erin., leaving still some smarting, for which I prescribed violet compresses as a palliative. Then came the lamentable news that erysipelas had developed locally, for which Dr. Croucher attended her; it was accompanied apparently by abdominal pain and vomiting, with pain between the shoulders, and high fever.

In spite of all that could be done, toxæmia set in, and she passed away on August 18, 1906, one year and four months after I first saw her.

I think we may safely take this as a purely accidental attack, in which the carcinoma played no part, other than in providing an open wound which allowed of the germs of erysipelas getting a footing. Had she not been in such robust health the cancer might fairly have been said to contribute towards her death, but up to the time of the occurrence of the erysipelas her health had been exactly as I have described, with no evidence of cachexia or any secondary infection anywhere. There is absolutely no reason why, if this acute attack had not occurred, she

should not be living now, and I consider that, in view of other cases, there is every justification for this belief.

It is interesting that erysipelas should have proved fatal to this case, when one of the methods advocated for the treatment of cancer has been the inoculation of the tumour and its surroundings with the germs of this disease. After this experience, however, I should be very chary of adopting it.

My next case, that of Mrs. G., aged 62, came to my late father as long ago as *July 16, 1901*, with cancer of the left breast, which had been found six months before while she was at Matlock, whither she had gone in search of relief from gout. It consisted of a hard lump 2 by 2 in. in diameter, situated above the left nipple, the axillary glands being tender and full. The general symptoms seem to have consisted of constipation, excruciating headaches of a pulling, drawing character, and frequent micturition by day and night. The treatment began with lob. erin.  $\phi A$ , which *eleven days later* was reported to have greatly relieved the bladder trouble. A week later this dose was repeated with improvement generally, and subsequently lyc.  $\phi A$  seemed to relieve the gouty symptoms, and fer. pic. 3x, unit dose, to improve the gouty headache and still further help the bladder trouble, for she then only had to rise once in the night.

I must, however, skip further details and come to the time when I first saw her, two years later, on *September 28, 1903*. I then ascertained that, prior to consulting my father, she had been seen by Sir T. S. and Dr. Walter Kidd, who ordered immediate operation, which she refused. She said that when she first came the breast had been very puffy and more tender, and that it had been enlarging up to two months ago, but not since. I found a hard nodule, measuring now about 4 by 4 in., and a flattened nipple, but *no axillary glands were now to be felt*. She was liable to rheumatic pains affecting various parts of the body, which were apparently of the carcinomyalgic type. She was very sleepy, and suffered from intense pains down the back of the head, lower back, and limbs.

I commenced with various apparently indicated remedies, but made no marked progress till I gave lob. erin. again. Ner. oleander also gave some help, but her general health improved more under scroph. nod. than anything. Calendula also helped me with regard to the pain, as did ruta grav. I found a marked gain in her general health, though the tumour continued to slowly enlarge as

the years passed. Still, instead of wasting, the occurrence of cancerous cachexia, or secondary growths appearing, she maintained her weight, was able to get about and see her friends, and except for the discomfort of having to carry a lump in her breast, which caused pain at times, she was to all appearances in excellent general health, with a very respectable appetite, and she no longer suffered from the occipital and spinal pains, or the bladder trouble. She frequently expressed great amusement at some of her allopathic doctor friends, who had never seen the growth and could only judge of her health from her appearance and what she could do, for they scornfully ridiculed the idea of her having cancer, saying that it was quite impossible she could have kept so well all these years if she really had this disease; and I believe they even became quite sad at the thought that she was being deluded by an unscrupulous so-called doctor, who practised a contemptible heterodoxy called homœopathy. She, however, held her peace, and devoutly thanked Providence that she had not followed the advice of their school in the first instance.

At one time an attack of influenza woke up the trouble to an alarming extent, inducing rapid increase in the growth and general tumefaction in the surrounding tissues, but I managed to get it under control again with the help chiefly of lob. erin., and later found assistance from intercurrent doses of the nosodes.

The patient continued in this state of health till a few months ago, when the size of the tumour caused pressure on the arm, requiring her to remain recumbent most of the day, and her general health has not been so good of late; but here she is, none the less, *alive eight years after the first appearance of the growth*, and with no evidence of any secondary growth to be found anywhere.

Had she come at the first sign of trouble, I have reason to believe that it might have been possible to entirely eradicate the disease in a comparatively short time.

Still, time alone can prove in what proportion of cases this can be done, for the cases I have so far treated have mostly come to me when the disease has existed some time, and has obtained a firm hold on the system.

After all, if we are to compare the relative value of medicine and surgery in this disease, it is only fair that the physician should get his cases in the same early stage which



the surgeon demands; but this, in my experience, he very rarely does. It is an unfortunate fact that if he does get such a case and cure results, he gets no credit for his achievement, for the malignancy of the condition is denied on the ground that no time was allowed for the development of cachexia.

Another case somewhat similar to the last is one I have had the pleasure of treating with Dr. Clarke. The disease first appeared in the form of a nodule in the left breast, with enlarged axillary glands, as far back as December, 1904.

Unfortunately the physique of the patient was very bad, and her vital forces had been undermined by chronic ill-health in the past, to which frequently recurring attacks of influenza had contributed no small share. Indeed, it has never been my misfortune to meet with an individual who was more susceptible to attacks from this disease, the mere receipt of a letter from a friend suffering from influenza being sufficient to determine an attack on one occasion.

This malevolent disease I have ample cause to dread, for by its peculiar facility for seeking out the weak spots in its victim, it has the power of undoing months of patient treatment in cancer cases. One may be congratulating oneself that complete control has been gained over the disease in some case, when an attack of influenza will supervene and light up all the old symptoms in a most disheartening way.

You will, therefore, readily understand that it has been a hard uphill tussle to treat this particular patient, and many remedies have been brought into requisition, the nosodes having given material assistance.

There are few cases in which some special feature does not stand out which is worthy of note for future use, and that which impressed me in this case most vividly was the effect of the first dose of *ruta*  $\phi$ A.

At that time (August 29, 1907) things had not been going so well of late. Evidence pointed to the tumour getting out of control, and marked congestion had developed external to the growth towards the axilla, causing pain of a shooting, throbbing character. She complained of feeling extremely weak and drowsy,

being much too fatigued to venture out of doors, and she was also suffering from acute depression. She had a great repugnance for food, and some pains—apparently of the carcinomyalgic order—had been marked of late in the legs. Taking the intense depression as the main indication, *Ruta g. φA.* was given, and a week later she wrote to say *that she had felt much stronger since the day following the dose. The pain had been much less, she was much less depressed, had lost her drowsiness, and her appetite had returned.* When I saw her six days later I found *the congestion had greatly subsided, and the tenderness over this area, which had previously been very marked, had now gone.* She was also able to raise the arm from the side without discomfort, though this was impossible before. Since that time *ruta* has played a very important part in her case. The tumour, which is wholly external, is now smaller than it was some time ago, owing to *necrosis having occurred in several places.* It was interesting watching the process, for one would first detect signs of a fissure forming in a previously level area, and this would gradually deepen, its sides finally necrosing and leaving a plane surface again at a lower level than formerly.

One very satisfactory result is that *the glands in the axilla, which were large and fixed firmly together, have of late distinctly decreased in size, some of them having again become freely movable.*

Here, then, we have another patient who, in spite of very great constitutional debility, is alive over four years from the incidence of the disease, and with no sign of secondary deposits in any part of the body. Indeed, Dr. Burford, who saw her a short while ago, after making a thorough examination, expressed special gratification at the fact that the manifestations of the disease had remained so completely isolated.

The next case possesses many very interesting features, among which may be mentioned her continued strength and activity throughout, in spite of her age, which was 70 at the time she first consulted my late father, on *March 21, 1901,* for a lump in the left breast, described as 1 in. in diameter and movable. She seems to have been subject to liver derangement, cramps and pains in the lower limbs, but the notes do not mention how long the tumour had existed before she came for treatment. This latter seems at first to have been directed especially to the general condition, and included such remedies as *calc. carb., cholesterin,*

ammon. hydrochlor., &c., in frequent doses, together with a few unit doses of fer. narthex., myrist. mosch., stram., &c.

I first saw her on *March 26, 1904* (two and a half years after the appearance of the growth). I found it about 4 by 4 in. in size, and occupying a somewhat unusual site, being in the upper and inner quadrant of the left breast, and firmly adherent to the skin, but causing no pain.

The general health was very good, and she complained of nothing, except occasional cramps in the legs and a tendency to flatulent dyspepsia.

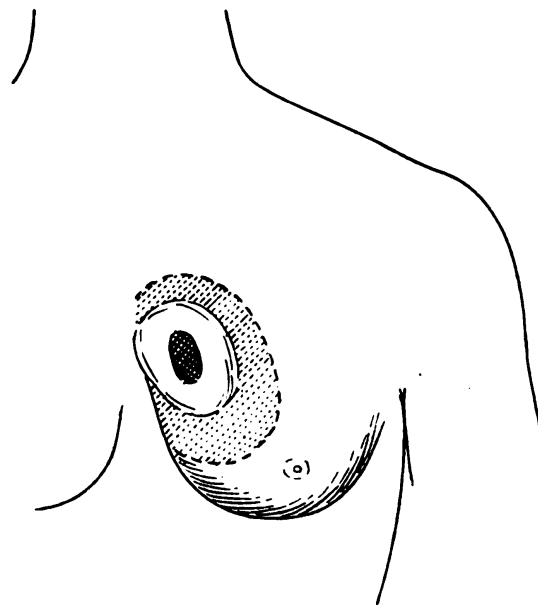


FIG. 3 (A).—Shaded area represents induration. It was more diffused than the sketch would suggest.

I gave a dose of *thuja*  $\phi$ A and saw nothing of the patient for two months, when on *May 20, 1904*, I found that a reddish area, of about 1 by  $\frac{1}{2}$  in., had appeared over the surface of the tumour, the size of the latter not having materially altered. Rep. *thuja*  $\phi$ A.

Further minute details are unnecessary, as nothing of special note occurred till *June 12, 1905* (one year after the last note), when some hæmorrhage was complained of as occasionally occurring, and an irritable eczematous patch had shown itself below the growth, due, no doubt, to some oozing which was taking place from the broken skin. After this (*i.e.*, about four years after the disease first appeared) several attacks of very severe hæmorrhage

occurred, which were treated with hamamelis internally and adrenalin locally. Many of these attacks were quite alarming in their severity, one in particular, which came on when she was out shopping, saturated all her garments before she was aware of its occurrence. Up to this time she had enjoyed excellent health, travelling up to town from Southampton for shopping, and to visit her friends, and she thought nothing of going to picture galleries and entertainments. In a word, she enjoyed excellent health. Now, however, the hæmorrhagic attacks became so frequent that she could not go far from home. For instance, here is an extract from my notes :—

*March 8, 1905, severe hæmorrhage at 7 a.m. and 5.30 p.m.*

*March 9, 1905, moderate attack, 2.30 p.m.*

*March 10, 1905, moderate attack, 2.30 p.m.*

*March 12, 1905, moderate attack, 2.30 p.m.*

That is to say, they were occurring every few days.

The hamamelis acted only temporarily in checking individual attacks, and I then tried adrenalin internally without effect, so finally decided on a dose of ruta g.  $\phi$ A.

This had so marked an effect that she was able to travel up to town and see me again, the hæmorrhage being only slight. Another dose given later *was followed by hæmorrhage the next morning*, but after that there was only slight oozing to be dealt with. During this time and previously *the growth had been gradually breaking down and coming away*, leaving a flat ulcer with induration around it; and now comes the remarkable fact that *instead of this induration continuing to spread, as it would have done if untreated, it steadily lessened*, leaving the formerly infiltrated tissues quite soft, and *the ulcer itself steadily contracted in size*.

This contraction was so marked that the surrounding tissues became puckered into folds radiating outwards from the edge of the ulcer. During all this time, and in fact throughout her whole illness, *she never suffered any pain*, and only trifling discomfort from the smarting of the ulcer.

The most marked improvement in her health undoubtedly dated from the time I commenced to give ruta at intervals. I was fortunate in having a most excellent nurse to look after her, who took a keen interest in her case and gave me accurate reports in the intervals between her visits. This nurse's former duties as matron of a hospital had made her completely sceptical as to the possibility of any treatment being of the slightest avail in cancer, but she was soon convinced after watching this case

for a time, and is now an ardent advocate of homœopathy. She carefully observed the effect of the various remedies, and noticed that *the doses of ruta were almost invariably followed by offensiveness of the discharge from the ulcer the next day, and that afterwards the surface of the ulcer would become clean and free from odour.*

The patient now *began to gain strength rapidly again; she frequently travelled up to town and continued to be marvelled at by her friends. The ulcer still further contracted, and everything pointed to her living for many years to come. Then came my old enemy, the arch-fiend influenza, which attacked her in a*

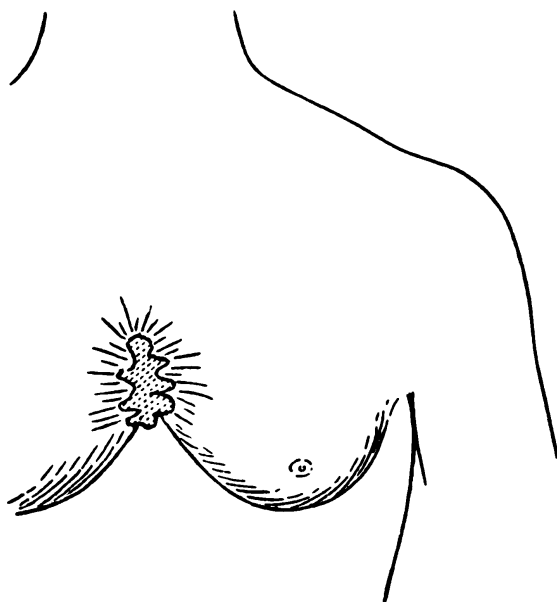


FIG. 3 (B).—Showing left breast pulled upwards and inwards, with skin puckered.

severe form and weakened her considerably, added to which she fractured her thigh when getting out of bed one day. This was the last straw, and on June 28, 1907, she passed peacefully away, without suffering any pain, this being *over six years after the first appearance of the growth*, which in itself most certainly did not cause her death, though it undoubtedly weakened her by the previous hæmorrhages. Her age when she died was 77.

Dr. Murray, of Southampton, attended this patient from time to time, and therefore had ample opportunity for watching her case, and if he is here to-night I hope he may add something to my remarks.

I must only hurriedly mention another case of a lady aged 45, who for two years prior to coming to me on *November 14, 1906*, had suffered from a lump in her left breast which had recently taken on rapid growth, and which *I found surrounded by considerable infiltration of the breast tissue*, making this breast much larger than the other; there were, however, no glands to be felt in the axilla. Steady treatment with unit doses, in which scroph. nod., has played a prominent part, has resulted in a complete restoration of the breast to its normal consistence and size, and reduced the lump to an insignificant size.

No one could swear that this case was cancerous, though it was so diagnosed before she came to me, and she had been told that she must have it operated on, as no other treatment existed which could be of any avail. It can, however, be said to come under that wide class of cases which may be termed "threatened cancer." We all know the immense significance of a previously quiescent growth suddenly taking on rapid action with increased growth, and especially when there is evidence of infiltration of surrounding tissues. My experience all points to the fact that if this breast had been removed the patient would be well on the road to the grave now, instead of enjoying the best of health and strength two years and four months since the first symptoms of malignancy became evident.

The last case I give you because it is an ideal example of true medicinal curative action as propounded by my late father, the truth or falsity of which I set myself to prove after his death.

It was that of a cloak-room attendant, aged 40, whom a lady patient of mine sent to me because of her rapidly declining health, which made it a great struggle for her to even carry out the light duties which had been given her on account of her health. She came to me on *August 9, 1905*, and I found her to be a very ill-nourished, debilitated woman, of dark complexion. Her mother and aunt had both died of cancer of the breast following operation, and her past history included an operation for appendicitis three years before. She told me that *for the last eight years she had suffered from pain in the left breast*, which followed on a blow a year or two before. Six years ago she first noticed a lump in the breast, for which she consulted Dr. C., of Middlesex Hospital,

who recommended operation. In view of her mother's and aunt's experience she refused this, so a belladonna plaster was applied over the breast. This induced a localized eruption on the skin, which, however, died away after its removal. The lump had remained without any change that she was aware of till a short time ago, when the pains she habitually suffered from became acute and of a shooting and knife-like character; these radiated from the breast into the axilla and down the arm to the fingers. Quite recently a new lump had developed below and externally to the other, and her health had become much worse, with loss of appetite and increasing fatigue on exertion. She had also noticed

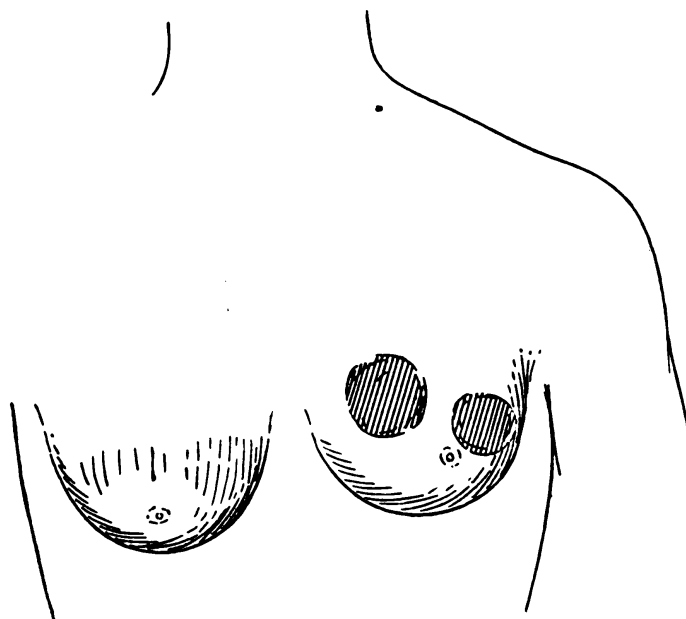


FIG. 4.—Showing left breast raised and projecting, right breast pendulous.

for some time past an increasing difficulty in raising the arm on that side. *For the last ten years she has been obstinately constipated, the bowels requiring pills before they would act.* She had recently applied another belladonna plaster locally, which had relieved the pain and brought out white spots on the skin. *On examination I found two separate hard nodules lying in a line, from above downwards and outwards, the upper measuring 2 by 2 in., and the lower 2 by  $\frac{3}{4}$  in.* Any attempt to raise the arm above the horizontal was attended by dragging and pain, though I could not detect any glands in the axilla.

I carefully questioned her as to whether she had obtained any benefit from the belladonna plaster besides the relief of pain, and elicited the reply that she thought she had put on a little flesh again since using it. This was too valuable a hint to miss, as it implied a general beneficial action, though the remedy had clearly been applied in the wrong way if a general systemic effect was to be obtained. I therefore gave a unit dose of atrop. bellad.  $\phi$ A. She was prevented from coming till four weeks later, on September 7, when she told me that *the breast had been very painful after the dose for two to three days, and that it then got much easier, the knife-like pain went, and she could feel the lumps becoming very much softer.* Now comes the main point. Coincidentally with this local improvement she suffered from *retching and vomiting.* On two occasions she had had *diarrhœa* (a most unusual occurrence with her, as was the vomiting, neither being accountable on the score of any particular food taken). Also, *at the last period she had lost more than usual,* and she had been troubled by *fits of coughing* with the *expectoration of thick yellow phlegm.* Altogether feels very weak and thoroughly run down.

Surely the most obdurate sceptic of curative medicinal action could not fail to see that this was a particularly brilliant example of Nature's true eliminative action. Here was evidence of the excretory organs taking on action with a vengeance, even the uterus being made to take its share in the general upheaval; no mere physiological or chemical action in the comparatively insignificant amount of belladonna given being capable of producing any such effect.

The man who would put this result down to "chance" could hardly be congratulated on his mental outlook, for this would imply a wilful shutting of the eyes to obvious facts, which is a very different thing from honest doubt which promotes enquiry. Yet I venture to say there are few of the old school who would not find some cause for these effects, however unlikely, rather than admit that they were the result of curative medicinal action.

*On examination* I found both tumours smaller and softer. At the time I am speaking of, I had recently made the observation, which I demonstrated in my last paper, that profound adynamia, due to excessive eliminative action, could be antidoted by the nosodes without any apparent deleterious inhibition of the



latter, and this case being a mild replica of the other, I decided to give a dose of scirrhin. 100.

September 21 (fortnight later).—*Is feeling very much better, especially the last week.* Beginning to feel like herself again. *Has not felt so well for months.* The tumour was more painful for a day or two after the dose, but this week has hardly pained at all. *Some diarrhœa is still present off and on. Bowels acting daily, either once or four to five times. Can now straighten her arm vertically above the head. Less loss at the last period. Her friends notice her greatly improved appearance.*

*On examination* the tumours were found to have still further decreased. S.V.R. given.

October 5 (fortnight).—*Bowels acting absolutely regularly ; cannot understand it. No pain in breast, and there is now no longer any tenderness as formerly. Breath catches her on exertion. Appetite not so good, but she feels stronger and able to work better. The last two days some itching spots have come out (chiefly round the left shoulder but also on the legs). Those who remember my last paper will find some significance in this last symptom.*

*On examination* I found the breast absolutely normal ; she said that she and her friends were dumbfounded when they found the lumps had gone, because the breast had remained unchanged, except for the recent increase in size, for over six years.

Though an attack of influenza occurred a little later leaving weakness behind it, for which I gave a unit dose of psor. 30, and one or two other remedies, the breast trouble never returned, and enquiries recently made elicited the fact that her health had been splendid ever since. (Case shown at the meeting.)

This case is a fine illustration of the folly of expecting to find "one specific remedy to cure all cases of cancer"; and this expectation has obviously been the stumbling block of the few investigators of the disease who have genuinely tried to find a cure for it. The manifestations of the disease differ so much in the various localities and individuals attacked, to say nothing of the diverse histological characters of the tumours themselves, that it would be illogical to suppose it possible to find one specific remedy to meet every case ; besides, our experience in treating other pathological conditions is entirely opposed to the "one disease, one remedy" theory.

The difficulty is, of course, in finding the indicated drug for each case, but I maintain that it will be possible to eventually define these indications *if we carefully note the results of the action of remedies on the disease itself in its various manifestations*. I am aware that many of our cult attach no value to such observations, yet it cannot be denied that no great advance in the treatment of the disease occurred till this method was adopted, and the results so far, I think you must admit, have been distinctly encouraging. I am led to believe that the indication of "the affinity of certain drugs for certain localities of the body" is a very important one, as instanced by *orinthogal and the stomach*, and *scroph. nod. and belladonna and the breast*. Another important localization, of which proof is gradually coming to me, is that of *ruta and the intestines*. I give this as a hint which I consider of great value, though I must leave its exposition to some future occasion.

This last case, and several of the others, illustrate the significance of restored natural action of the bowels, to which I called attention in my last paper.

The cases I have given to-night all point to the fact that *there is not such a great systemic danger, as hitherto insisted on, in the actual presence of a cancerous growth in the tissues, provided suitable constitutional medicinal treatment is employed*, and this opens up a very vital question: "How if, instead of it being dangerous to delay operation, *such delay might not be actually advantageous*, provided medicinal treatment is employed. Oh! what heresy when we consider the teachings of the past! But are you absolutely sure that the tumour is not an outlet for some blood condition which has hitherto resisted demonstration? If so, you are justified in holding on to the old tenets; but if not, then surely it would be more scientific to begin by treating the constitutional state till evidence of its being under control is forthcoming in the tumour ceasing, or practically ceasing, to grow before the knife is brought into requisition. One point which supports this is that there appears to be *a direct ratio between the rapidity of growth of a cancerous tumour and the rapidity, diffusion, and malignancy of the*

*recurrence of secondary growths after operation.* The instances I gave at the beginning of this paper were cases in point.

Another matter of equal importance, which the cases I have treated point to, is that *the wholesale removal of all the lymphatic glands, whether directly implicated or not, is unjustifiable.* Certain it is that when this procedure is carried out, the victim of a recurrence at the site of operation is in a plight far more terrible than she was before, for the destruction of the lymphatic circulation means the most appalling swelling of the arm, with, as you well know, the most agonizing pain and distress as the result. If it is once admitted that the local growth is not in itself, under ordinary circumstances, capable of infecting the system, the argument in favour of such a procedure falls to the ground.

Finally, I would refer you to a paper by Drs. Macalister and Ross in the *Lancet* of January 16 last, in which they claim to have found a definite reaction in the blood of carcinoma cases which is so distinctive that it may be used to diagnose doubtful cases. This bears out what my clinical experience has let me to expect, viz., that future research into the nature of cancer will be far more prolific of useful result if more attention is directed to the blood condition and less to the tumour itself.

Gentlemen, it will be many decades before the last word is said in the treatment of cancer, but if that word is ever to be spoken, it behoves us to abandon for ever that hopeless view of this disease, which has so effectually paralyzed progress in the past.

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Dr. CLIFTON, referring to the unit dose, said whether a patient was given a unit dose once a fortnight, or given medicine in the third decimal dilution two or three times a day, it was very much the same thing; but he thought, if the unit dose was given, the disease would be aggravated in the first two or three days, whereas in the other case it would not be. He had tried both methods, and had now adopted the smaller dose, repeated frequently. With regard to *scrophularia nodosa*, he remembered that it was forty years ago since his brother and Dr. Pearce first

called attention to it, and it was given as a tea for strumous diseases. It was a very common weed growing in Northamptonshire lanes, and at that time herbalists used it to a large extent. With regard to the cases Dr. Cooper had brought forward, he (Dr. Clifton) thought they were constitutional and tubercular or strumous cases. In nine-tenths of the cases of tumour of the breast it was no good taking any notice of what the patient said about it happening three months or three years previously; the whole previous family history had to be enquired into, and the probability was that either a tuberculous, a gouty, or neurotic condition would be found, and, in his opinion, that was what had to be treated, and not the tumour. He remembered about eighteen years ago a young woman coming to him saying that she had been told at the general infirmary that if she did not have her breast removed at once she would be dead in three months. He did not remove the breast, yet the woman was still alive and well. The medicine he gave was iodide of sulphur, and thuja and phosphorus for different constitutional symptoms.

Dr. EADIE remarked that Dr. Cooper had thrown down the challenge to surgeons. His own experience of medicinal treatment alone *versus* surgical treatment alone of cancer, especially in the breast, was all in favour of surgical treatment. With reference to Dr. Cooper's statement that the surgeon saw cases before the physician, he doubted that very much. His experience was the other way, except where the cases were inoperable. He thought Dr. Cooper had been guilty of comparing the worst cases which the surgeon had, with the best cases the physician had. He had taken rather a gloomy view as to the operative treatment, but he (Dr. Eadie) thought the results were now very good. In the last lot of cases of cancer in the breast collected at the London hospitals, in a considerable majority there had been no recurrence for three years. With regard to curing cancer with medicines, he thought it was quite a possible thing. As in the case of the mice which Dr. Burford had mentioned—although their form of cancer was quite different from human cancer—he did not see why spontaneous recovery should not occur in man too, if the constitutional condition of the patient could be raised. With regard to operation, his own feeling was that if a cancer was removable, and one could make sure the whole thing could be cleared away, it ought to be removed and the patient treated medicinally. If it was doubtful whether the whole cancer could be removed, one should consider well before operating. Many cases certainly did get worse after operation, but the question

was whether they would not have still more rapidly got worse if an operation had not been performed. With reference to the remedy being the indicated one, he thought that point could not be too well remembered. If one got the indicated remedy—not just treating the case empirically—much better results would be obtained. Dr. Cooper had criticized the removal of the lymphatic glands. It depended entirely on what view of cancer was taken, but he (Dr. Eadie) did not think Dr. Cooper had proved his point at all, that the secondary growth did not arise from the primary. Dr. Cooper had also made the statement that operative treatment in mammary cancer was almost invariably followed by death after three years, but that was quite disproved nowadays unless the teachings of our surgeons were entirely wrong. His own experience was that the majority of cases recovered.

Dr. SEARSON thought it was very important that the Society should on the one hand feel an anxiety to encourage the efforts of any member who was making original investigations and to applaud the courage which Dr. Cooper had undoubtedly shown in bringing forward his subject in the form he had that night, yet on the other hand they ought to be very jealous as a Society about giving their confirmation to any thesis, unless it was thoroughly supported by ascertained facts and results. He (Dr. Searson) was bound to say that the paper given that night by Dr. Cooper was, in his opinion, the least convincing of all the papers which he had previously read before the Society. He was not quite sure that the conclusions Dr. Cooper had endeavoured to draw from the clinical data with which he had been confronted had been perfectly justified by the cases he had brought before them. He (Dr. Searson) said this, although he had seen too much, especially lately, of the results of the action of homœopathic drugs carefully selected, not to realize their immense possibilities as curative agents. With regard to the diagnosis of cancer, the author has made a very strong point of the fact that some of the cases he had treated had been diagnosed as cancer by allopathic doctors. He himself was not prepared to regard that as a criterion of the correctness of the diagnosis. He remembered a case some five years ago where the patient had actually appointed to have the breast removed in a couple of days. The case seemed to him not to be a neoplasm at all, but an ordinary case of mastitis, which in a month's time absolutely disappeared under treatment. He was not sure that Dr. Cooper was justified in regarding a case as improved by drug treatment merely because the patient's general health appeared better. He

felt it was a very difficult thing to argue from one case of cancer to another, because they varied so greatly. With regard to the two cases which the author had shown, he (Dr. Searson) was not at all sure that they were clear cases of cancer at all; he especially alluded to the latter case. In the brief examination he had made he could not find any present evidence of breast swelling. With reference to the medicinal treatment of cancer, moreover, he felt that members of the Society when bringing cases forward might with advantage mention not only the cases in which they thought they had obtained successful results, but the unsuccessful ones as well, for general guidance. He should like to ask Dr. Cooper what method, if any, of drug selection he had adopted. Dr. Cooper had claimed the results as homœopathic cures. He (Dr. Searson) felt that homœopaths could not claim successes unless the drugs had been selected on purely homœopathic lines. His question was, Had the drugs been selected on homœopathic lines, or could Dr. Cooper give some indication of the reasons which had led him to select any of the drugs that he had named? In conclusion, Dr. Searson pointed out that no one had alluded to the advantage of the X-ray treatment with regard to cancer. He felt that no curative treatment short of operation had given the patient so much benefit, and his opinion was, that where such treatment had been excluded, the patient had not been given the fullest chance of recovery.

Mr. KNOX SHAW thought a great difficulty in making accurate observations on carcinoma was the uncertainty of the early diagnosis of the disease. There were, unfortunately, too many mistakes made—proved after operation—in diagnosis. Another point on which every practitioner who set out to try a method of treatment ought to be clear, was the natural history of the disease. His own experience of thirty years told him that some untreated carcinomatous cases continued a very long time without ending fatally. There were two kinds of cases. Some of the cases which the author had described were cases of the atrophic variety, and if the tumour was examined microscopically, an excess of fibrous tissue with a very small area of carcinomatous infiltration would be found. Such cases did exceedingly well with or without operation. Some of the cases which the author had described undoubtedly still had the disease, and he (Mr. Shaw) maintained that Dr. Cooper would have been wise to have operated first and treated afterwards. In some of the cases described, the patient had had the misery and discomfort of an open sore for many years, whereas, if an operation had been performed, that discomfort might have been avoided.

He was certain that no one was justified in saying that a case which was operated upon could not recover. He would also like to point out that it was quite possible for a woman to go about for a very long time with a carcinoma in her breast without knowing it. In some cases he had seen it had been perfectly impossible for the patient to have arrived at the condition in which she was in, in the short space of time since the carcinoma was first said to have been noticed. Patients with carcinoma of the breast might look exceedingly well for a long time after the onset of the disease. Twenty-one years ago he operated on a lady for carcinoma of the breast. Eight years afterwards she came with a mass of malignant glands in her axilla; this was removed, and the patient is now alive and quite well. He thought stress should be laid on the fact that patients should be placed under a course of treatment which should be continued for some years.

Dr. NEATBY said he thought in the first place the members ought to endeavour not to range themselves on one side or the other of the controversy which had taken place on so many occasions; they should not range themselves into medical camps and surgical camps; operative camps and non-operative camps. The time had come for both surgeons and physicians to recognize that some cases required operation and some did not. We should endeavour to find indications as to which were which. Dr. Cooper had shown that practitioners could do a great deal by medicinal treatment of the patient rather than of the tumour, and possibly a cure of the tumour might be accomplished by treating the patient. There was no doubt there were more diseases than one, embraced under the general clinical term of "cancer." Dr. Eadie had spoken of the cases which recurred after incomplete removal. He (Dr. Neatby) thought the question as to the rate of the growth was of importance in deciding whether to operate or not. The slowest growths might be left alone. Incomplete removal might possibly be made up for by after-treatment. Mr. Shaw had referred to the atrophic form of cancer and spoke of it as being not unfavourable for operation. He (Dr. Neatby) should say that such cases did better without operation. Nature was forming the fibrous barrier in the vicinity of the carcinoma and probably endeavouring to strangle the vitality of the cancer cells, and if that barrier were removed by operative means, probably much damage was done to the patient. A question that had been much discussed was as to the accuracy of the diagnosis of cancer. In connection with the last annual Congress a Therapeutic Clinical Commission as to the nature and treatment of cancer had been

inaugurated, and one of the points that was insisted upon, and which it was hoped to bring before practitioners, was, that wherever it was possible, corroborative diagnosis should be furnished by the operator so that it might not be limited to his one personal observation. He did not agree with all that Dr. Cooper had said; he thought in some instances he had taken a somewhat one-sided view, but he thought the Society was very much indebted to Dr. Cooper for what he had brought before them. In connection with scrophularia, Dr. Cooper had said the reasons why there was no evidence that scrophularia affected the breast was that all the provings were in men. He thought Dr. Cooper was mistaken. There were very few provings at all to start with, but one of the provers was a woman. With regard to the appearance of the patient, that was no guide at all to the extent of the disease. Many a woman who was suffering from advanced cancer appeared in the most robust health. They had had a painful illustration of that only a short time ago in the wards. The patient was a healthy-looking, flourishing woman who had been, to within about three weeks of first noticing anything wrong, most active. She suddenly developed great abdominal distension and swelling of the legs. It was found there was a lot of fluid, and the whole pelvis was full of a cancerous mass and the omentum was a huge cake of colloid carcinoma. Yet the patient appeared in rude health a few weeks previously. He thought all could support what Dr. Eadie and Mr. Shaw had said about the long lasting results of many thorough operations for cancer. With regard to uterine cancer, and especially with regard to corporeal cancer of the uterus, there were many cases, which had been operated on years ago, going about at the present time quite well. The proportion of cervical cases was less favourable. He thought it was a mistake to relegate all cases to the physician alone or to the surgeon alone; practitioners ought to try to play the part of both.

Dr. WYNNE THOMAS said Dr. Burford had told them that by triturating the skin of the embryo and injecting it into a mouse, skin carcinoma was prevented in that mouse: also that by skinning the embryo of the mouse and triturating the remaining body and injecting that, carcinoma would not develop except in the skin; but he had not told them completely as to whether emulsifying or triturating up the whole embryo, including the skin, would prevent carcinoma of any kind developing in the mother mouse.

Dr. BURFORD replied that no information was given with regard to that point at the meeting.



Dr. J. HERVEY BODMAN remarked that a long series of observations embracing large numbers of cases would have yet to be made in order to settle the question whether medicinal or surgical treatment was the more efficacious in cases of cancer of the breast; the evidence brought forward in this paper, though encouraging, was not sufficient to provide an answer to this question, but he thought Dr. Cooper had proved what he had set out to prove in his previous paper, namely, that cancer can be acted upon and controlled by remedies given in unit doses. What Dr. Cooper had mentioned about the association of pains resembling muscular rheumatism had also arrested his own attention on several occasions, and he had intended to ask Dr. Cooper about it if the point had not been contained in the paper. At the present time he had a case of a person who came under his care about two years ago undoubtedly suffering from carcinoma of the breast, which was noticed first two and a half years ago. The patient absolutely refused operation. She was put under medicinal treatment and the disease had made no substantial increase. In that case there was present in a marked degree the accompaniment of pains like muscular rheumatism in the deltoid and intercostal muscles, the pains being very frequent and troublesome. On questioning the patient that day he had ascertained that she had not suffered from such pains prior to the development of the cancerous tumour. There was evidently some association between the two conditions. Another point which was of interest in the case was that very often, instead of the muscular pains alternating with increase of activity in the growth, the two conditions went together, and when that occurred, the region of the tumour altered in character. At such times there was an actual increase of swelling and tenderness and also of the weight of the involved breast, followed by gradual return to the usual condition. The patient was over 60 years of age. He thought it probable that much light might be thrown on the problem of cancer by careful and prolonged observation of individual cases.

Dr. Hery thought the members would agree that by Dr. Cooper's treatment the pain of the patients had been alleviated in a great measure. As a result of seven years' hospital experience he could fully corroborate what Mr. Shaw had said as to the result of treatment after operation. The first case which Dr. Cooper had exhibited that evening seemed not only to the speaker but to others to be a case of atrophic scirrhus. Such cases were known to go on untreated for many years. He would hand round a photograph of a case which came to the

hospital a few weeks ago. The patient was altogether beyond surgical treatment. One thing he remembered with regard to history was that the case had been going on for at least four years, and when the patient presented herself there was absolutely no trace of breast tissue to be found in the position of the right breast. The last case to which Dr. Cooper had referred was by no means convincing; it might have been a case of chronic mastitis, or chronically inflamed cysts. Dr. Cooper had referred to the red and painful swelling of the arm which often followed operation in cases of carcinoma. In almost every case where glands were present an enlarged gland was found lying over the auxiliary vein and in contact with it, and it had been pointed out that if that gland were not carefully sought for and removed, swelling of the arm was almost certain to result. In many cases where the gland had been demonstrated and removed swelling of the arm had not resulted, or, if it had, it was much slighter than was often seen. With regard to X-rays, Dr. McCulloch's idea was to irradiate the glands, and not the growths themselves. Dr. McCulloch had given the proof in one case of epithelioma at the angle of the mouth in which he treated the glands and not the sore itself, with the result that the ulcer had quite filled up and the induration had almost disappeared.

Dr. COOPER, in reply, said that he was greatly handicapped by the lateness of the hour, which rendered it impossible for him to adequately reply to all the points which had been raised. He had expected much opposition to his views, and the result had amply shown his surmise to have been correct. He was surprised at Dr. Clifton's suggestion that the cases he had given were in reality tubercular, seeing that they presented the typical characteristics of malignant disease. It was always difficult to grasp all details when listening to a paper read, and he felt sure that Dr. Clifton would alter his opinion if he carefully read over the cases when the paper was published. In comparison to malignant disease, tuberculous disease of the breast was extremely rare, and it would indeed have been a remarkable coincidence for so many cases of the latter disease to have come to him for treatment, to the exclusion of cases of the former disease. He presumed that the remedy, *scrophularia nodosa*, was associated in Dr. Clifton's mind with tuberculous manifestations, and that because it enjoyed a past reputation in the treatment of such conditions, and had acted beneficially in the cases detailed, Dr. Clifton had concluded that they must be tubercular. He (Dr. Cooper) deprecated the narrowing of the action of a remedy

to one, and only one, class of case. He had endeavoured to show that its field was a very much wider one than this, and, with all due deference to Dr. Clifton, he considered that he had given ample proof in support of this claim. He had no desire to lay down any hard-and-fast rules with regard to the treatment of cancer of the breast, but he maintained that his cases proved that far better results could be obtained by medicinal treatment than from the employment of surgical measures unaccompanied by constitutional remedial measures. Mr. Knox Shaw and Dr. Eadie had dilated upon the splendid results derived from operation in many cases, but these did not quite come under this heading, seeing that they had been all treated homœopathically at the same time.

Dr. EADIE, interposing, said that was not so, the good results having been obtained without medicinal treatment.

Dr. COOPER said he was very glad to hear that Dr. Eadie had enjoyed such a unique experience. It was, however, in direct opposition to his own observations and that of many medical men of wide experience with whose views he was acquainted, and he regarded neglect of medicinal treatment on the part of a surgeon, after operating in cancer, as very culpable. Certainly his own experience went to show that if patients suffering from this disease were medicinally treated, and not operated on, it was rare for secondary growths to develop.

Dr. SEARSON, interposing, asked Dr. Cooper if he knew what had caused the fracture in the case he had described, because he (Dr. Searson) considered it very suggestive of secondary deposit.

Dr. COOPER replied that it was remotely possible that this might have been so, but that there had been no previous symptoms to suggest it, and it hardly seemed probable in view of the fact that the patient's general health and strength were so well maintained for so many years, up to the time of the influenzal attack which proved fatal. Dr. Searson must no doubt be aware that cases of spontaneous fracture like this were by no means rare in old people who were not suffering from cancer. Dr. Searson's previous statement that he was not impressed with one of the cases shown *because he could find no sign of disease in the breast* was, to say the least of it, highly entertaining, seeing that the case had been shown *for this very reason*. Setting aside the fact that the condition had recently developed malignant characteristics, it was surely remarkably significant that the tumours which had resisted previous treatment and had remained in the breast so many years should be dissipated within a month

or so of the exhibition of the remedies described. He had been challenged with having given his most favourable cases only, so that no proper appreciation of the percentage of good results was possible. His answer to this was that he had not given *all* his good cases, and that the number of those he had had in which secondary growths had developed amounted to only two. One of these remained free from secondary growths *for no less a time than six years*, during which time she enjoyed very good health and travelled a great deal. She then, unfortunately, fell down-stairs and injured her arm and spine, and this shock to the system so weakened her resisting forces that metastasis resulted. The other had suffered at the hands of a so-called Swedish masseur prior to coming to him. The massage had consisted in squeezing the nodule forcibly every day with such violence that it caused agonizing pain and undoubtedly greatly aggravated the trouble; for when the patient came to him she not only had the original nodule, but several smaller ones which were present in the skin all over the breast. His inference was that she probably had disseminated nodules in her other organs at the same time. He did not consider this last a fair case, as it was obviously most unfavourable from the start. In view of the above facts he thought they would agree with him that the proportion of good results was remarkably high and amply bore out his contention. A suggestion had been made that many of the tumours were of the atrophic scirrhus variety, but a careful investigation of the cases would show that at the time they came for treatment, although some of the growths had existed for some time previously, they had recently shown signs of very rapid development, which certainly discountenances the suggestion that they were of the atrophic form. In some of the cases the recent rate of growth had been so great as to be very alarming. He was greatly indebted to Dr. Bodman for his interesting observations with regard to the association of muscular pains with these cases, so closely bearing out as they did his own experience.

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FIBROSITIS (FIBROSIS) : ITS SIGNIFICANCE,  
SEQUELÆ, AND RESOLUTION BY ELEC-  
TROLYTIC AND ACTINIC METHODS: A BIO-  
LOGICAL STUDY.<sup>1</sup>

BY DR. HENRY McCULLOCH, M.B., C.M. GLASG.

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Hospital.*

MR. PRESIDENT AND GENTLEMEN,—Let me first say how greatly I appreciate the kindness extended to me, when I was invited by a senior member of the Society—to which I have so recently had the honour of being elected a member—to read a paper on any pathological subject that appealed to me. Realizing, as I did, the seriousness of the undertaking, as well as the fact that it is one thing to have general opinions, another to place them in logical sequence upon paper, my apprehensions were in no wise lessened. Having however, had the advantage of living for the greater part of my professional career on the borders of an ancient civilization, and in close touch with wild Nature and her ways, I have every confidence in submitting for your consideration certain views, obtained by contemplating the vital processes, through “the field glasses” of science, as compared with those, not less important, through the uninterrupted use of the microscope. The choice of a suitable term to adequately express the subject in hand, and one that has been so much debated, was my first difficulty. The inseparable idea of “inflammation” seemed to dominate everything else. It has been the vogue to employ the termination “itis” in all cases where the reactive processes are characterized by inco-ordinate action together with an attempt at co-ordination of function. Its sole merit must be its convenience in cloaking our ignorance of the exact causation in most of the conditions to which it is applied. The late Professor Coats made it a point, to instil into his

<sup>1</sup> Presented to the Section of General Medicine and Pathology, April 1, 1909.

pupils, how far, and in what cases, we were justified in employing the term, and to what extent the development of fibrous hypertrophy in the organs of the body was the result of the inco-ordinate process known as inflammation. He looked upon fibrosis as one of a series of reactive changes which the tissue-cells undergo, in response to extracellular or intracellular noxious stimuli, resulting in the deposition of certain crude cells, whether this occurred in the mechanism of necessary replacement, or in that of the functional defence of a cell. I propose to consider the physiological inception of these changes, which lead ultimately to the different morbid states seen in the cells and tissues, the cumulative effect of the combined cellular inco-ordination, and the perverted influences of these cells upon other cells and organs not primarily involved. I hope to do this in a wide and comprehensive manner. I shall ask you to picture the human organism in a biological sense and of spheroidal shape.<sup>1</sup> In this we have a zonal blood circulatory system with a central heart enclosed in a muco-cutaneous membrane. The functions of this fluid, the blood, are not performed within the heart or main channels, but away in the peripheral capillary zone. In this zone we find the lungs, the intestines, the liver, the kidneys, the spleen—to name a few organs. Then we have an intermediate zone with less numerous capillaries, including the skin, muscle, and glands. Again the marrow, connective tissues, osseous structures, and interstitial tissues, with a still smaller capillary zone; till the joint fringes and cartilaginous structures are almost beyond their reach.

To proceed to the reactive processes. In recent years a vast flood of light has been shed on these, as you are all doubtless aware, by the epoch-making discoveries of Professor Metchnikoff, discoveries that were ridiculed, and were long in being generally accepted. The discoverer of the phenomenon of phagocytosis is a zoologist, and he naturally defines "inflammation" in the sense that we understand it—as inco-ordinate or improper injection by the leucocytes—of

<sup>1</sup> Fig. 108, p. 272, "Adami's Pathology," 1909; and McCulloch "On Cancer and Tuberculosis," 1907.

any noxious material, organic or inorganic. That is to say, that so long as this phenomenon occurs under normal harmonious conditions, there are no manifestations of abnormality; and the symptoms of redness, swelling, pain and heat, only appear when the physiological mechanism becomes chaotic. This state of affairs evokes accessory mechanisms, which add to and emphasize the symptoms just mentioned. The fascination of the phenomenon of phagocytosis still occupies the minds of pathologists so much, that the *accessory mechanisms* I am about to discuss are completely lost sight of, and do not seem to be capable of being realized. I refer to the mechanism of "*segregation*," which is on a par with that of phagocytosis, and an extension of it; the difference being, that the former is more a mechanical and less a chemical process than the latter. Normal phagocytosis may be said to be purely a chemical process. But when *massive* stimuli have to be dealt with, speaking in a microscopic sense, phagocytosis alone is inadequate and impossible; "*segregation*" is evoked, and both processes may proceed *pari passu* (*Lancet*, January 26, 1906: "Observations in Auto-Vaccination," McCulloch).<sup>1</sup> This is very well shown in Metchnikoff's studies on stimuli applied to the larval forms of *astropecten* among the metazoa. He found that the mesodermal cells were phagocytic in two distinct ways, first in the well-known way, and second—and of especial reference to the subject in hand—by "*plasmodium formation*," that is, when the noxious agents were too massive to be dealt with in the ordinary way. The mesodermal cells are seen to combine and encircle the foreign body. This union is so complete, that in this phenomenon the cytoplasm of these cells becomes organically fused together. *The nuclei emerge at different points and reproduce their cytoplasm subsequently; to repeat the process again and again if necessary.* The plasmodium is deposited in concentric layers, with the cell membranes of successive layers in between. Condensations of the protoplasm take place, according to requirements. We have here, an analogous condition to fibrosis in the higher

<sup>1</sup> Refer to picture, fig. 1, p. 12.

forms of life. This defensive mechanism is analogous to a host of defenders arriving *en masse* at the scene of action, where they divest themselves of their cytoplasm, leaving it *in situ* to vegetate, and to fulfil an important function. They exist by imbibition, forming a *plasmahaut*. A barrier is thus formed, between the noxious agent and the organism; this barrier may go through phases of condensation till calcification, the primitive faculty of such lowly cells, results. When a noxious agent, such as a diffusible toxin or alcohol, enters the human organism, it is as it were a massive substance incapable of being dealt with by phagocytosis alone. There is a gradual development of a certain type of leucocytes of mesodermal origin, in the lymphatic glands, capable of being produced on a vast scale; these are attracted by chemiotaxis to the walls of the blood-vessels throughout. Here they apply themselves to form a *plasmodium*, in order to oppose the undue entry of this noxious agent, and to confine it to the blood-stream, and thus facilitate its elimination by the lungs and kidney, as commonly occurs in the attempted elimination of alcohol derivatives or the purin bodies. The morbid conditions that follow are too well known to need enumeration; they are classified in the syllabus.

#### FORMS OF FUNCTIONAL FIBROSITIS.

##### (A) *Reactive and Segregative.*

- (1) Arterial, as in scleroses in general.
- (2) Venous, as in scleroses in general.
- (3) Lymphangitic, as in scleroses in general.
- (4) Mixed, as in Vincent's angina.

##### (B) *Trophic and Facultative.*

- (1) Replacement, as in original repair.
- (2) Mixed, as in callus and cicatricial states.

##### (C) *Neoplastic and Plasmodial.*

- (1) Transitional, as in scar tissue of primary union and sterile encystment, wheals, &c.



- (2) Productive, as in cheloid. Regrowth due to non-emergence of nuclei.
- (3) Vegetative, as in true fibroma and sarcoma.
- (4) Mixed, as in fibroids, scleroderma, carcinomata, &c.

It may be objected, that it is more necessary to prevent contamination of the blood-stream itself, this being pre-eminently the vital fluid, and that nothing outside of the blood matters very much. To this I would reply: the blood is a subsidiary body fluid, and merely a respiratory and excretory provision, and its functions are exercised in the capillary zone, which includes the various organs in that zone. On the other hand, the extravascular plasma or lymph is the *primary nutrient fluid of the body*, both in a genetic and in a physiological sense, and its functions are exercised away from the capillary zone, and throughout the vaster regions of the tissues where the blood hardly penetrates. But alas! as with phagocytosis, the fascination of hæmatology has overshadowed the consideration of the primary nutrient fluid of the body. "The lymph forms on the one hand an intimate means of communication between the blood and the tissue cells, and on the other it serves as a barrier between them" (Abderhalden). Professor Starling, in a recent treatise to which I shall again refer, says: "In the higher animals the cœlomic fluid is divided into several categories—that circulating within the blood-vessels, that subject to a slow current in the lymphatic channels, and the more or less stationary fluid which bathes every cell of the body. It is this last—viz., the tissue fluid—which is the most important for the vital activity of the body as a whole." And I would add that the so-called "wandering cells" inhabit this fluid, just as the red cells do the blood-stream; their presence in the blood is of secondary importance, and due in a measure to their vast numbers outside such channels. The end-products of the analyzed foodstuffs *enter the plasma* for synthesis, in metabolism; and they do not enter the blood directly. Moreover, it must be recognized that both phagocytosis and "segregation" are extravascular phenomena; so is fibrosis.

When the causative factor, toxin or germ, is *within the circulation*, it is arrested, as if by filtration, in the capillary zone. Here it is that the flotsam and jetsam are cast up, as in the ebb and fall of the tide, and they are dealt with more effectually in these regions. Hence the various interstitial nephrites and hepatites, arterioscleroses; the splenites and fibroses of rheumatoid and purin metabolism. But when these identical noxæ come into contact with the same cells, in proportionately lower grades commensurate with the molecular composition of the cells, they not only fail to disturb the co-ordinate processes of growth, but beneficially stimulate its activities, even to the extent of producing an immunity.

The fibroblast or embryonic fibrous tissue cell is usually looked upon as the parent of the connective tissue cell; I cannot conceive of this relationship. Fibroblasts seem to me to originate from the lymphoid glands under the mucous membranes, or from the large prickle cells of Malpighi in the skin, and they are to be found in granulation tissue in different phases of maturity, as well as in the wheals of insect stings or nettle rash. They are of lower organization than the connective tissue cells, which are fixed cells, and they take part in the general metabolism, while the fibrous cells are transitional, non-nucleated and vegetative in their existence obstructing metabolism. It is conceivable that the so-called plasma cells found in granulation tissue and in fibrotic foci are the emerged nucleated cells of the plasmodium, and they are closely related to the clasmatocytes of Ranvier. The connective tissue cell comes into being from a pre-existing cell of its own kind, is anatomically identical with it, and subserves tensile and supporting functions. The disturbance of growth under abnormal conditions, gives rise to variation in function, and subsequently to structural modification; but the tendency exists for a return to the *status quo* after the cessation of the disturbing factor, as is seen in the fibrosis of scar tissue. The normal fixed types of cells, which are in contact with such fibrous cells, undergo adaptation, and in course of time modification.

The primary nutrient fluid genetically is the plasma, secondary to which is the blood-plasma or liquor sanguinis; and it is the former which is solely, if not wholly concerned, in the reactive processes here dealt with. By studying the reactive changes in the lowest and simplest form of life Metchnikoff has elucidated similar processes in the higher animals. He showed, for example, that in the amœba, the nucleus plays an important part in the reaction to external stimuli. By cutting an amœba in two, one particle containing the nucleus, the other not, the wound in both soon closed, healing without visible mark or scar, though the vitality of the non-nucleated portion was briefer, the other continued unimpaired, but both were capable of prolonged existence in their normal environment.

On contact with the cutting edge of the instrument the tactism or law of specific sense, one would imagine, must have been evoked, followed by a condensation of its protoplasm along its free edge, and later by a process of centrifugal streaming of fluid containing proteid molecules, healing of the appendage resulted while in its natural environment.

By the application of a feeble interrupted current to an amœba Miss Greenwood brought about a certain inflammatory condition, followed by a process of exudation or extrusion of clear hyaline spheres from the surface of the organism. Further, the observations of Stahl on what he has termed trophotropism in the myxomycetes demonstrated the attraction to and the repulsion from chemical elements, such as oxygen and glucose; the former a diffusible and the latter a much less diffusible substance. He threw light on the phenomenon of chemiotaxis, which I am inclined to look upon as an extension of the forces at play within the cell between the nucleus and the ectoplasm of the cell.

It is essential that the constitution of the plasmic fluid in which all cellular structures are bathed is maintained in proper molecular concentration.

Now these living creatures are made up of solutions separated by walls and membranes which are permeable in different degrees, and between which continual reactive

changes are taking place. To know these changes and the actions exercised on them by external influences, and within them by intracellular changes, is to understand the vital processes.

A solution is a perfectly homogenous mixture, consisting of a liquid holding in solution one or more dissolved bodies, which may have been in a solid, liquid or gaseous state. The study of their physical properties led Avogadro to propound a method for determining the molecular weights of such bodies, and this is now known as Avogadro's law. The molecular concentration of a solution is thus defined, and it is found that a solution with a concentration of a gramme-molecule per litre is a normal solution, that which contains  $\frac{1}{10}$  of the molecular weight per litre is called deci-normal, and so on. Cryoscopy enables us thus to count the number of molecules contained in a litre of any given solution. It was found that dissolved matter molecules behave exactly like the molecules of a gas in similar solution, that is to say, they have a tendency to diffuse themselves in a homogenous manner, so as to fill all the space that the volume of the solvent affords. And the molecules of matter in solution, like the molecules of a gas, also diffuse themselves in a similar manner, giving rise to what is termed osmotic pressure. This osmotic pressure may be measured with precision by the same method of cryoscopy already referred to. Osmotic pressure is the force which determines the movements and the rate of exchange between solutions in immediate contact or separated by membranes more or less permeable. Substances in solution move from more concentrated regions towards regions less concentrated, while the fluid moves in the opposite direction. This movement constitutes the phenomenon of diffusion, and osmotic pressure is the motive force which, as it were, animates matter in this way and produces diffusion, hence "Brownian movement." Thus we have the orientation of the matter within the nucleus, which controls similar movement between the nuclear membrane and the cell periphery. The substances termed colloids are known to have very large molecules, their solutions have a feeble molecular concentration and

feeble osmotic pressure. The difference between these substances and crystalloids is merely one of degree, and all the properties of one are found in the other. The feeble osmotic pressure of the colloids of the cell, *i.e.*, proteids of every kind, has the greatest significance for biology and medicine. From what has been previously stated, it will be clear that in a liquid all points having an osmotic pressure greater than that of the contiguous parts, hypertonic points, or all points having a lesser osmotic pressure, hypotonic points, than other parts are centres of force, and these points have been called the positive and negative poles of diffusion. It has been shown that between these poles the same dynamic action is exercised and follows the same laws as between magnetic poles of the same or opposite name. Thus the phenomenon of chemiotaxis depends, not only on the chemical nature of the substance, but also on its concentration, and is negative or positive according as the concentration is feeble or strong. I would, however, commend to you Professor Starling's interesting work on "The Fluids of the Body," published this year.

I have endeavoured, in a very imperfect manner, to direct your serious attention to a profoundly interesting and important biological phenomenon which appears to me to elucidate the inception of the commoner fibrotic processes occurring in the body, the significance of which seems to have been entirely overlooked by the discoverer himself, and hitherto we have only heard the term "plasmodium" used in connection with a certain phase of the existence of the malarial organism. Such a new conception will, I trust, afford food for reflection to physiological pathologists and to physicians.

In one of his papers read before the Royal Society, John Hunter, referring to the then recent physiological discovery of the lymphatic system as part of the absorbents, said: "A discovery in any art not only enriches that with which it is immediately connected, but elucidates also those to which it has any relation." This, I think, radiotherapy has done in this instance.

To pass on to the consideration of the methods of

resolving fibrous hyperplasia, briefly, when this morbid condition interferes with the normal functions of organs or tissues. The time-honoured methods of the application of iodine externally, and of the administration of its potassium salt internally have had their day, though the organic combinations of iodine in high dilutions, recently introduced, still remain an aid to the physician, if they are necessarily slow and tedious in action.

By introducing a kathodal stream of sodium chloride into the tissues, joints recently ankylosed rapidly recover their mobility without forced movement or pain. A 2 per cent. solution of NaCl is used; the affected region is immersed in this and connected with the kathode, while one of the limbs is placed in a water-bath to which is connected the anode. The larger the area immersed in contact with the electrolyte, the better. The intensity of the current is gently raised, and is well borne up to 100 ma. for half an hour twice a week. Eight to ten such applications usually suffice to restore function. The Cl ions produce dissociation of the proteid molecules of the fibrous tissue cells by uniting with free Na ions in such tissues. The molecular constitution of the proteid elements of these *unfixed* transitional cells is such, that they are in a state of unstable equilibrium—that is to say, they possess numerous unsatisfied side chains which are by this means dissociated and broken off from those molecules that are stable or fixed. The HO ion or the iodine ion may be similarly introduced, and with similar though less tolerable results.

This method of cataphoresis has therefore a wide range of application in fibrotic conditions of the economy. Of actinic methods, the ultra-violet frequencies have the best superficial effects on similar proteid cell elements, but they rarely penetrate to sufficient depths of the cutis to meet all requirements, and are tedious.

The kathodal or Lenard rays of a Crookes' tube, owing to their deeper penetration throughout the cutis, fulfil this requirement, and thus are best applied around the peripheral margins of such morbid tissues, if the weak granulations are protected by lead foil. The X-rays can,

however, be made to include the effects of both the foregoing methods, by judicious filtration through a range of media, beginning with boiler felt and ending with aluminium discs, and they can influence the *unfixed* cells at any depth. But their further selective action for the proteid elements of the neuron, which is a fixed cell, has to be guarded against, in view of the trophic disturbance they thus induce, when applied in excess, indeed, two cases of fatal paraplegia thus occurred in Italy.<sup>1</sup>

This actinic action may be best compared to the decomposition of the silver salts on a sensitized gelatine film exposed to sunlight. In this case the inorganic elements are dissociated at the points of greatest frequency and penetration, and less at other points. The proteid molecules of unfixed cells, owing to their unstable state, are more easily dissociated; and being vegetative, have not the power of being regenerated; the disturbance caused does not give rise to any perceptible stimulus owing to the high rate of speed of the projectiles.

The dissociated products, viz., cholin, methylamin and CO<sub>2</sub>, diffuse with the plasma, and are duly eliminated by the emunctories. The action of radium may be said to occupy a position, in between those that have been described as actinic, but the penetration of its emanations are more limited and less under control than those of X-rays.

The late Professor Huxley, in his address at the International Medical Congress, held at York in 1881, made a remarkable prediction when dealing with the relation of the Biological Sciences to Medicine. He said: "Seeing that the actions called 'vital' are, so far as we have any means of knowing, nothing but changes of place of particles of matter, we look to molecular physics to achieve the analysis of the living protoplasm itself into a molecular mechanism. Living matter differs from other matter in degree, not in kind; the microcosm repeats the macrocosm, and one chain of causation connects the nebulous original of suns and planetary

<sup>1</sup> See *British Medical Journal*, July 20, 1907, p. 9.

systems with the protoplasmic foundation of life and organization. From this point of view pathology is the analogue of the theory of perturbations in astronomy, and therapeutics resolves itself into the discovery of the means by which a system of forces competent to eliminate any given perturbation may be introduced into the economy. *It will, in short, become possible to introduce into the economy a molecular mechanism which, like a cunningly contrived torpedo, shall find its way to some particular group of living elements, and cause an explosion among them, leaving the rest untouched.*"

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Dr. STONHAM (in the chair) said that the paper was a valuable one, but it had been a little difficult to follow it. The difficulty, however, did not arise from any want of clearness in Dr. McCulloch's statements. When Dr. McCulloch came to the practical part of the subject and the application of electrolysis he was touching on ground on which they could more easily tread. It was very interesting to hear that the use of sodium chloride and other compounds had such a wonderful influence in disorganizing or breaking up the fibrous tissues. He gathered that there was a certain amount of danger in the process, and that when there was an attempt to act upon the deeper tissues they had to give only just enough to act upon the more lowly organized cells, but not enough to act upon the more stable cells. Here the danger came in.

Mr. WRIGHT said that one or two points with regard to the influence of light on cells had been mentioned by Dr. McCulloch. It was very interesting to know that, just as photography had shown that certain chemicals, such as nitrate of silver, under the influence of bromine and gelatine, became more susceptible to the action of light, so it had been proved that, to a certain extent, animal cells could also be made more sensitive. A long series of experiments had been made with a colouring matter which itself had no effect whatever on bacteria, as far as they were themselves concerned in their activities; but, after having been submitted to the colouring solution and subjected to the ultra-violet light, the bacteria died much more rapidly than those which had not been under treatment by the colouring matter. This showed that it was quite possible to influence animal cells by means of some chemical so as to make them more susceptible to light and, possibly, to electricity. They knew that certain



substances, such as quinine and one or two other materials, when introduced into the blood, rendered the blood more fluorescent than it was naturally. It was proved by Dr. Bence-Jones some fifty years ago that the blood contained a fluorescent principle; and it was quite possible that, by increasing the fluorescence of the blood, they might be able to help the blood cells to carry more of the influence of the rays through the body and so affect the different parts with which they had to deal. A practitioner in America (whose name he had forgotten) had been treating cancer with the X-rays and rendering the blood more fluorescent by the administration of fluorescin. The results of this treatment were equivocal, but researches on the same line might very well be made.

Dr. GOLDSBROUGH regretted that the paper was not longer. He had hoped that Dr. McCulloch would have included some cases in which he had used the electrolytic process. The paper introduced them to a realm of thought which it was very difficult to follow, but it was one which they had to follow, if they were to advance upon the homœopathic line of therapeutics. When he read the synopsis of the paper he said to himself, "Here is the rationale of the homœopathic principle." One thing which had to be held in mind, when they were thinking of such a thing as resolving vital phenomena into the terms of physics and chemistry, was the resultant in vital processes. The resultant in vital processes was not a dissipation of energy, but an addition of energy. In vital phenomena the resultant was not a mere equation, as in physics and chemistry, but the new vital process which was set in motion subsequent to experiment. After they had experimented in physics and chemistry their experiment was done with, and they took account of the effect on the mind rather than the effect on the universe. In vital chemistry they had something in addition to consider. That was, he believed, a very important point indeed, which would have to be reckoned with and to be co-ordinated with physical and chemical knowledge when they considered the relation of vital phenomena to physics and chemistry.

Dr. ROBERSON DAY asked whether, in cases of treatment by cataphoresis, it would be better to have the anode in the solution which was being used, or the cathode, or was it a matter of indifference?

Dr. SPEIRS ALEXANDER said that he might be allowed, as a fellow-graduate of Dr. McCulloch, to congratulate him on this his maiden effort in the Society. They all felt indebted to him

for the erudite paper which he had laid before them. It illustrated the interdependence of the medical and the other sciences, and had introduced them into the domain of chemistry, physics, and electricity, besides that of pathology. In fact, as he had listened to Dr. McCulloch discussing the laws of the diffusion of gases, liquids, and so on, he almost fancied himself back in the University, listening to a lecture by the late Lord Kelvin, under whom he had had the privilege of being a student. Whether all that Dr. McCulloch had laid before them that evening could be claimed for homœopathy was a moot question. Whether the processes of electrolysis and actinic resolution could ever be shown to be brought within such a range was exceedingly doubtful; but, for the majority of them, he supposed that the chief interest of the paper would centre upon its clinical aspect. Mr. Wright had referred to one class of cases in the treatment of which they should be careful as to the action of light—namely, otic sclerosis, a form of malady which it was very difficult to treat successfully. If by electrolysis or actinic action something could be done to improve the condition without damage to the patient, there would be cause for great gratitude. In the ophthalmic out-patient department of the hospital one constantly met with patients who were suffering from the result of acute disease, in the massing together of ocular structures, which hitherto medicine had not been able to affect to a very great extent. If by some such means as had been mentioned they could help such sufferers, the gain would be inexpressible. If Dr. McCulloch would on some future occasion give them the results of any experience which he might have gained in the treatment of these conditions, it would be welcomed by the Society, and a benefit would be conferred not only upon its members but upon the public.

Dr. WHEELER said that he, like other speakers, wished that Dr. McCulloch had continued longer. Much of what he had said was new. The only thing that had occurred to him (Dr. Wheeler) to say belonged to the clinical side of the subject. The method of introducing drugs into the body was a very important one. They had not the least idea of what would be the effect on a healthy body of introducing drugs in the same way. The experiment would be well worth trying if anyone willing to undergo it could be found.

Dr. STONHAM said that there were cases in which potassium cyanide driven into a rabbit by electrolysis had killed it by the action of the cyanogen. Therefore some of the cyanogen must go far enough to affect vital parts of the body.

Dr. McCULLOCH, in reply, said that the vertigo which Mr. Wright had referred to was what one would expect in consequence of the tonic effects of the resolved *débris* during elimination. He had therefore never attempted electrolysis where the symptoms had been cerebral. He had with good effect used the X-rays through a small aperture, both with a hard tube over the mastoid and with a soft tube in treating the tympanum through the meatus, with marked improvement in hearing. Mr. Dudley Wright's remarks on the actinic effect on bacterial cells were exceedingly interesting. When he (Dr. McCulloch) was doing some research work with X-rays and radium to investigate the effect of these molecular agents on bacterial cells on living animal tissues, he confirmed the results of others, showing that bacteria escaped destruction unless they were quite on the surface, and the effect of the ultra-violet light on cultures was the same. He thought, as Mr. Dudley Wright had suggested, that, after considerable exposure to the light, bactericidal effects might be produced, but with damage to the tissue cells of the host. One was apt to imagine that with human tissues they might get similar results when the X-rays were applied, but he was afraid that such results never occurred. Experiments had been tried on animals which had been injected with bacteria, as in the case of rats. The animals had been subjected to the X-rays, and it had been found that the bacteria had been just as vigorous as before, so the bactericidal effect of X-rays or ultra-violet rays as a therapeutic method might be almost entirely neglected, where bacteria were under the thinnest epidermic or mucous layers. With regard to fluorescent substances and radio-active substances, he believed that Professor Blondlet was the first person to contribute researches to show that the nerve substance in certain animals was fluorescent but not radio-active. Fluorescence and radio-activity were not, he thought, quite the same thing. The emanations of either radium or of the X-rays were purely local when absorbed. They did not circulate in the blood or accumulate, like the cumulative drugs, in certain organs. He did not intend to imply that in electrolysis the neurons were unfavourably affected. When electrolysis was judiciously used they never got disturbance of the nerve functions, and therefore that danger did not exist in connection with electrolysis. A reference had been made by Dr. Goldsbrough to the quotation from Professor Huxley. In making the quotation he merely meant to imply that Professor Huxley's words were a remarkable prediction with regard to the use of a molecular agent which penetrated the tissues

without damaging somatic structures, and which yet produced profound effects at deeper points on abnormal tissues like cunningly devised torpedoes. He thought that Huxley's words were remarkable as a prediction. He agreed that they did not give any explanation of the underlying vital processes. Dr. Day had asked which pole of the battery was to be put into the solution. Some substances were electro-positive, and some were electro-negative. The anode being an electro-positive pole it should be used for electro-positive ions, and the cathode being the negative pole it should be used for electro-negative ions, whichever it was desired to introduce. As to the treatment of ear and eye disease mentioned by Dr. Alexander, he might state that he experimented about two years ago on a dog at Bournemouth which had a total opacity of both cornæ and was totally blind. The skin of the dog was patchy and in thick wrinkles in parts, but he could not diagnose the precise malady of the dog. The eyes of the dog being situated differently from the eyes of a human being—*i.e.*, laterally—he was able to apply the X-rays transversely without their penetrating the retina. The cornea became translucent and revealed a *Cysticercus cellulosæ* suspended from the iris in the anterior chamber. The cyst ruptured on paracentesis of the cornea. There was occlusion of the iris with synechia. The dog's skin was infested with this parasite, the pupa-stage of which it must have swallowed in human excrement previously. The dog's condition had improved since the treatment, and the animal could see a little and was still at Bournemouth. It had been nearly cured of its disease, but not of its blindness.

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### CASES ILLUSTRATING THE PROBLEM OF DOSAGE.<sup>1</sup>

BY GILES F. GOLDSBROUGH, M.D.ABERD.

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

MANY cases occur in the wards and out-patient departments of our hospital and in private practice which, other than being cases classified as belonging to some nosological variety, from various minor points of view are worthy of record.

<sup>1</sup> Presented to the Section of Materia Medica and Therapeutics, May 6, 1909.

Particular points of view, and the interest of recovery under homœopathic medication might demand that such cases should receive publication in our journals, but publication requires singular interest at the moment, which is often lacking, and the resolve of time abstracted from the immediate interest of new work. Much good clinical material probably thus remains buried in notebooks and may never see the light for the benefit of our art.

All cases medically treated come under the most general principles of the administration of medicines, namely, the selection of the remedy, and the preparation, quantity and frequency of the dose.

It might, perhaps, be possible to select a number of cases, apart from their belonging to a particular nosological variety, diverse in character, but interesting in themselves, yet which, apart from some most general principle governing all cases, would remain buried, but when so selected illustrate forcibly some most general principle which is continually representing itself for consideration.

There is, perhaps, no principle in treatment which has been subject to less certainty and excited more controversy than the preparation, quantity and frequency of the doses of homœopathic medicines, and for various reasons it occurred to me that when requested by the Secretary in charge of *Materia Medica* and *Therapeutics* for the Society to furnish a paper on *Nervous Diseases*, I might in preference string together the cases which follow, and offer them to the Society as illustrative of the ever-recurring dose problem. As far as my own personal action is concerned, were these cases not presented in this form they would remain buried in the hospital archives or in private notebooks.

Viewed as a series of cases, I have selected them, in addition to their interest on minor points, as illustrative of two principles in reference to dosage which, I think, from past experience, may be regarded as established principles of homœopathic practice.

These principles are :—

(1) That generalizations on questions of dose are fallacious, except the fundamental one—that the dose in

homœopathic therapeutics must be less than the physiological dose.

(2) Conclusions from individual cases or groups of cases are never more than relatively or approximately applicable to fresh cases. In other words, the problem of dose is always in some clinical sense experimental. A forecast of certainty is never possible.

By some adherents to generalization in favour of high or low dilutions it may be argued that I am here passing judgment myself in almost the same words that I am advising other people not to do.

In reply to my critics I should submit that my generalizations are negative rather than positive, and therefore plead that this criticism will scarcely tell against me.

By others it may be objected that it is scarcely fair to string together a number of cases to enforce certain preconceived ideas or conclusions, but again I should plead the negative character of my ideas, but positively assert that a speculative view is attractive and harmless when no practical interests are sacrificed in its enforcement.

Speculative judgment affords a circle of ideal likeness in which to present in an interesting and connected form things that are different, and consequently such ideas are more and better than a peg to hang discussion upon.

In addition to asking the Society to listen to a few interesting cases, I am angling for a good discussion, and if his negative conclusions leave their author stranded on the bank at the end of his sport without a fish and perhaps with his rod snapped in twain, he may still hope that his fish, escaped in the river of thought, may through his efforts to land him prove stronger and more wary in any fresh or future encounter with the bait.

Some years ago I ventured to present a paper<sup>1</sup> to the Society on the positive principle of dose in homœopathic medication as being required to be less than the physiological dose of the drug as required to produce symptoms in the healthy organism, other variations from this very general

<sup>1</sup> JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, vol. ix., p. 308.

statement being determined by experience. I do not intend to touch on this aspect of the subject this evening, but forthwith proceed with my cases.

*Facial Paralysis and Causticum.*

In the *Homœopathic World* for February, 1908, our esteemed Vice-President, Dr. Stonham, reports a case of facial paralysis occurring in his own person on which causticum *cm.* (Nash) appears to have had an immediate effect in aiding restoration of function.

Several doses were taken on August 26, when the paralysis of the seventh nerve supply was practically complete. In a week a great deal of movement had returned to all the muscles. The medicine was taken for one day again on September 1. On September 7 recovery was complete in all muscles. No other measures were used except systematic and regular voluntary efforts to move the weakened muscles.

Dr. Stonham had honoured me by asking my opinion and advice on his case. I recommended gelsem. first for a few days, to be followed by causticum in the twelfth dilution. In his own absolute discretion Dr. Stonham chose the dose mentioned with the most gratifying results, which by his coming to see me again I was able to verify.

Now in my experience, and certainly in the experience of old school authorities on the subject, it is unusual for facial paralysis, even in the simple form of neuritis of the seventh nerve, to recover so quickly as this, and I was much impressed with Dr. Stonham's case. There is mystery in what *cm.* (Nash) might mean as to the strength or preparation of causticum, but I had no wish to deny to my colleague his success with the preparation used, and it was a pleasure to congratulate him on his quick recovery.

I made a mental note that the next case of facial paralysis I met with (*cæteris paribus*) should have causticum *cm.*

In his report of the case readers will notice Dr. Stonham adopts a certain air of dogmatic triumph as against myself which I do not grudge him, but I venture to think his own case is matched by the following :—

E. D., a girl aged 16, occupied at home, came to the out-patient department of the hospital on October 15, 1908, suffering from complete paralysis of the right side of the face, which she attributed to chill. The case was simple and of the ordinary variety of facial paralysis, with no other obvious indication of ill-health. She received causticum cm., one dose of  $\eta$ iii. in sac. lac., with s.l., t.d.s. I also instructed her to exert her volition to move the muscles regularly and systematically.

On October 22 she returned very slightly better, complained of soreness down the side of the face, headache, and lachrymation was very troublesome. She received causticum 12,  $\eta$ iii., t.d.

On November 5 she returned very much improved, in fact nearly well. I introduced the case to Dr. Searson so that he might use the patient for demonstration at his Honeyman-Gillespie lecture, which he did. She then received causticum 6 t.d. I have not seen the girl since.

The soreness the patient complained of on the second visit might have been due to the attempted voluntary exercise of the muscles while they were paralyzed. This would naturally pass off when she was able to move them. I think, without doubt, Dr. Stonham's systematic movements aided his recovery, although also without doubt, apart from dogmatism on the question of dose, we have in causticum a most valuable remedy in facial paralysis, as indeed in other local palsies of the cranial nerves.

#### *Trigeminal Neuralgia.*

I have found cases of trigeminal neuralgia, the genuine *tic douloureux* of pre-pathological days, very difficult to treat successfully. I mean, of course, chronic cases, where the attacks of pain have become habitual and where everything has been done to remove any assignable cause, and yet the suffering of the patient remains. An excellent theory of the reason of failure is that insufficient search has been made for the similitum, and that more time given to particular cases, a more thorough study of the materia medica would render well-nigh all cases amenable to the remedy selected homœopathically, and perhaps the remaining small percentage of cases untouched by medicines so selected may yet find remedies when the materia medica has attained



to a more systematic and scientific development. Without doubt the self-discipline of the physician is an exercise he needs, but while this process is being pursued a particular patient's attacks of *tic* are recurring with clamour for relief, and crowds of other cases press for a like selection of their similar remedy.

Again, there is an important question in relation to the value of homœopathic treatment in nervous affections which, in my judgment, has not been adequately met by idealist homœopathic writers and theorists. I refer to the nervous system as an involution or inversion of vitalistic energy compared with the organism as a whole as an evolution or demonstration of such energy. Such involution or inversion can, of course, never be considered out of relation to the patient's consciousness or reflective experience in addition to the phenomena of his disease, which we may term objective symptoms. In the patient's subjective experience it is probable that the symptom pain to him, as localized in a particular anatomical region, or connected in the mind of the physician with a particular nerve-trunk, is never estimated at its true physiological or pathological value.

In the experience of pain something is always added or subtracted by the mind of the person who is suffering it. It is the business of the physician to estimate pain in its approximate true clinical importance with other symptoms; but such is the involved nature of the nervous system with the mind that pathological states giving rise to pain, nerve-trunk pain being eliminated—that pain will continue as evidence of exhaustion of the nervous structure after response to stimuli, leading to recovery from other more generalized or physiologically more localized bodily states, has had its effect. In other words I wish to suggest that in severe and prolonged cases of neuralgia the pain has not only in accordance with a physiological law of nervous function, become habitual, but in point of physiological recovery such a state has reached beyond the operation of the law of similars, and is amenable either to no recovery at all or to direct stimulation by improved nutrition, or some forms of medication other than the

homœopathic. If in these cases any improvement is possible, improvement by homœopathic medication is not possible until some degree of restoration of function has been previously effected by other means. In the light of this view, sources of local irritation being removed, neuralgia is to be regarded as a form of neurasthenia, in which sensory functional irritability is greatly increased, while the trophic equilibrium is markedly diminished; and until some balance of the latter with the former is restored, the nervous system is not in a state of equilibrium sufficient to respond to the homœopathic similimum as a means towards recovery from the severe pain complained of. If the view I am putting forward is correct, its bearing on the treatment of all forms of neurasthenia, as well as neuralgia, will be at once apparent. With this point, however, I am not immediately concerned at present. What I wish to emphasize in this paper is that such a view immensely complicates the problem of dosage, whether as affecting the homœopathic similimum or any other form of medication used as stimulus to restoration of equilibrium.

As illustrative of these points I cite the following case: M. E. M., a lady, aged 70, consulted me in September, 1907, for severe neuralgia of the right trigeminal nerve, from which she had suffered for four years. The patient is active, of a nervous temperament, inclined to brood and be over-anxious in her domestic concerns.

The history given was that four years ago she had been suffering somewhat from nervous exhaustion, was living in a house where painting was being done, and she required some attention to a molar tooth which had been accidentally broken. The latter attention was undertaken by a medical man, who extracted the tooth not very skilfully and allowed the patient to wash the cavity with cold water. Some pain in the jaw and along the course of the nerve immediately followed, but was not continuous.

The nervous exhaustion continued and gastritis ensued, followed by very severe neuralgia, not only of the inferior dental nerve, but of the superior and orbital branches of the fifth, and one of the attacks was followed by sudden dimness and almost loss of sight. Glaucoma was diagnosed and an iridectomy per-

formed within a few days after this happening. In reference to the operation the patient was promised that after the operation she would lose all her neuralgia. This she did, indeed, as far as the orbit was concerned, but not so in connection with the inferior dental nerve. Pain in this region kept recurring and defied all efforts for its amelioration. It was for this pain that I was consulted.

I found that the attacks were recurring irregularly. They were of an agonizing, tearing, shooting character, referred to a spot just anterior to the right auricle extending along the lower jaw and partially along the upper, excited by speaking, taking food, hot or cold drink, and subsiding gradually after a few minutes, only to recur at a longer or shorter interval with similar intensity.

With some attacks the patient could scarcely avoid screaming, and although as a rule she bore the pain quietly, she had considerable difficulty in restraining her emotions.

The general health, when I was called, was in very fair condition; there was slight discomfort and flatulence after food; a clean tongue. All retained teeth were sound, and there was a regular daily action of the bowels. Vision of the right eye was very defective, but no pain was complained of in the neighbourhood of the orbit. There was tenderness to touch at a spot in front of the auricle. The attacks of pain were, if anything, worse in the early morning, when they disturbed the patient from sleep.

My first prescription was spigelia 6, miii., 4 h., with some tablets of chamomilla 1x freely during an attack. I also ordered an ointment of adrenalin in vaseline, a small quantity to be rubbed on the skin near the ear twice daily.

In the course of reading for the "Summary" of the Journal<sup>1</sup> of the Society, I had come across an article in the *Therapeutic Gazette*, in which the author states he had used such an ointment in 500 cases of neuralgia with great success. He had experienced practically no failures in uncomplicated neuralgia, or neuralgia the result of neuritis. I regarded my case as an example of the latter condition; and if the statements of the author quoted were true, I saw no reason she should not receive the benefit of the adrenalin,

<sup>1</sup> JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, vol. xv., p. 350, 1907.

even while I was giving her at the same time some homœopathic remedies.

The report in four days was that the attacks immediately began to be less severe, the patient stating that the ointment seemed to excite them, and that she only applied it on one or two occasions, but the chamomilla tablets relieved.

The ointment was thereupon discontinued. The improvement, however, was not very marked, and in eight days the attenuation of spigelia was changed to the twelfth, and magnes. phos. 3x was given as a palliative. During October and the early part of November symptoms of gastric irritation manifested themselves, the pain in the face being less violent. Relief was afforded by arg. nit. and nux vom., but then the neuralgia in the face recurred with some violence, but not so great as formerly.

This sequence of symptoms seemed to point distinctly to arsen. alb., which, on November 20, was given in the twelfth dilution, and one-drop doses of chamomilla at the onset of the pain.

From this course much greater relief was obtained. So much so that I did not see the patient again until January, when she contracted influenza and had a slight attack of bronchitis with it.

This condition was met by eupatorium, bryonia, ars. alb., and kali bich., but the neuralgia reasserted itself in the course of this attack, and proved very intractable. As well as influenza to reduce her nervous energy, there were certain family anxieties which tended in the same direction. For the next two or three months she received ars. alb., spigelia in various dilutions, and on one occasion tellurium. It was at this stage I thought if something could be done to raise the nervous tone by direct stimulation the homœopathic remedies might have a better chance, and as in former years of practice I had seen a good deal of benefit from phosphorus in doses of  $\frac{1}{30}$ th of a grain in the form of a pill, I decided to give phosphorus, but with the tendency to gastric disturbance I was afraid that the pill form might disagree. So the patient was ordered the drug in extract of malt in the form dispensed by Burroughs Wellcome and Co.— $\frac{1}{64}$ th of a grain of unoxidized phosphorus to the fluid ounce—of this 2 drachms were to be taken twice or thrice daily. The relief to the neuralgia was immediate, the attacks occurring much less seldom after beginning this treatment, and the pain quite bearable. I only saw the patient once after September until the 20th of last month, when I made enquiries for the purpose of this paper. I found that the attacks are now very seldom and quite bearable,

that the malt extract and phosphorus has been of great benefit, but that only 1 drachm can be tolerated for a dose, as the larger doses caused gastric discomfort and nausea. I found the patient very cheerful and grateful for the relief which had been afforded her.

The two points on dosage which this case appears to me to raise are these : (1) Should the spigelia or arsenicum have been given higher and more seldom at first? From another arrangement of dosage, is there any reason to suppose that recovery could have ensued more quickly and certainly? (2) Are sensitive and neurasthenic patients susceptible to direct stimulation by lower dosage than patients otherwise constituted? Hence in adopting this method either by drugs, forms of alimentation, massage, or electricity, should this fact always be borne in mind?

*Colica Mucosa.*

The exhaustive paper on "Colica Mucosa," presented to the Society a few years ago by Dr. Speirs Alexander,<sup>1</sup> will still be fresh in memory of the members. In that paper magnesia muriatica is only mentioned casually as a remedy, but the following case will, I think, suggest that it has a well-defined sphere, and that probably the higher attenuations will be more serviceable.

The notes are by our late House Physician, Dr. H. P. Fairlie.

M. S., a single woman, age 39, post office clerk, was admitted to Quin Ward on August 21, 1906, sent in by Dr. Deane, and stated to be suffering from membranous colitis. The illness began four years ago and she had been attending the out-patient department for two years. She complained of pain, chiefly in the lower part of the abdomen and the epigastrium, always increased after standing some time, also always increased immediately after food. The bowels act fairly but with pain and tenesmus during defæcation, and the passing of jelly-like substance with the stool, and occasionally blood. No membranous substances are noted as having passed. She has been getting weak lately, and losing flesh. Has suffered from uterine displacement ten years ago, but

<sup>1</sup> JOURNAL OF THE BRITISH HOMŒOPATHIC SOCIETY, vol. xii., p. 172.

not worn a support. Menstruation is regular and free, with severe pain at the beginning. Patient is thin and sallow, perspires little, suffers with cold feet, is always chilly and feels cold weather > warmth > by rest. She complains of occipital and frontal headache < getting up in the morning, lasts all day and is > in the evening. Appetite is bad, she is not thirsty, the tongue clean. There is tenderness all over the abdomen, but no hardness felt. Resonance well up under the costal margins. The chest signs normal; pulse 80, regular; respiration 20. Temperature normal throughout stay in the hospital.

Patient was kept in bed and given a milk diet, and kali bich. 3,  $\eta$ ii., t.d. The bowels were moved by enema every third day (there was no natural action until September 7.) On September 1 she was no better, suffered much pain after the enema last night. Mag. mur. 6,  $\eta$ ii., t.d. Fruit, vegetables and biscuits to be added to the diet.

On September 6 she received mag. mur. 30,  $\eta$ ii., t.d. On September 7 there was a natural movement of the bowels although with a good deal of pain. Actions occurred again on the 10th and 11th, still pain and a good deal of mucus. Before an action occurred I ordered an enema of 4 to 6 oz. of warm olive oil, which was a source of much relief in the act of defæcation. On September 11, owing to the character of the stools (I remember the fact but not the character, which unfortunately is not stated in the notes), I prescribed leptandra  $\phi$   $\eta$ i., 4 h. The patient was now steadily improving, and on the 18th was put again on mag. mur. 30,  $\eta$ ii., t.d. Natural actions now occurred nearly every day, tenderness of the abdomen and the mucus in the stools disappeared, and by the end of September she was up and on the couch. The same treatment was pursued, and she was discharged cured on October 7. She had gained two pounds in weight while in the hospital.

Now undoubtedly the improvement in this case may primarily be attributed to the rest in bed and the alterations in diet. The body of the patient was probably hungry for rest, and warmth was grateful to it, but relief to the more urgent symptoms appeared to follow distinctly the use of mag. mur. in the thirtieth dilution. Our sources of knowledge of the effects of mag. mur. are Hahnemann's "Chronic Diseases," and as is well known the effects as there recorded are referable partly to pathogenesis and partly to clinical

results of taking the drug. On looking over the list of symptoms, however, the mind is obliged to come to the conclusion that such a list must possess at least a relative trustworthiness, and that the correspondence to the symptoms of colica mucosa is very marked except in the membranous character of the discharge, which, of course, was absent in my case. The stools of mag. mur. are sometimes very soft, sometimes very dry, sometimes mucus is discharged; but there is always pain on defæcation, and often tenesmus, and tenderness of the abdomen. I have frequently used this medicine in thin spare women of low nervous tone, subject to constipation and pelvic congestion, and have given it in the third dilution with manifest benefit. In the case recorded the improvement followed the thirtieth, after the sixth had been given without apparent effect, but the conclusion to be drawn from the case seems to me is that it is the whole course of treatment that was responsible for the cure, and that conclusions on doses or even on remedies in this case cannot be taken without a consideration of other measures which were employed.

#### *Acute Nephritis.*

The following case is interesting from its extreme gravity, the doubtful etiological origin, and the steady progress towards recovery under treatment from the beginning; but I bring it forward specially because from the point of view of dosage there is an interesting question of aggravation or reaction in reference to the administration of the nosode *influenzinum*. The notes are by Dr. E. Cronin Lowe, late House Physician.

W. B., a boy aged 7, was admitted into Barton Ward on July 29, 1907. He has for the past week been suffering from "cold" without cough, and has seemed weak and languid. Two days ago he complained of sick headache and pain in his left chest. Yesterday his legs began to be swollen and puffy. His previous illnesses had been measles, whooping cough and German measles. The condition on admission exhibited a state of general œdema, the skin was white and waxy, the face full and puffy, the hands, wrists, and legs pit on pressure, and the scrotum is œdematous. There was some doubtful dulness on percussion at both

flanks, but no distension of the abdomen or thrill was noticed. Examination of the chest disclosed defective entry of air, a few rhonchi, and diffused pleuritic friction on the left side. The heart sounds were normal, the pulse 136, and temperature 101° F. During the first twelve hours he passed 2 oz. of urine, which was acid, specific gravity 1015, and contained bright fresh blood. During the second twelve hours he passed 8 oz., and the third 6 oz.; appearance unaltered. On July 30 I saw the case and prescribed apis 12, ℥ii., every four hours, and milk diet. The next day the temperature ranged from 99·6° F. to 97·4° F., but other symptoms remained the same. On the 31st the quantity of urine was 7 and 20 oz. respectively. On August 1 he received terebinth. 30, two doses, the amount of urine being 6 oz. and 21 oz., in appearance the same. The temperature was now uniformly normal, the pulse ranging from 102 to 110, with a single drop to 88. The œdema and state of the urine were the same.

On August 2 he received terebinth. 3, ℥ii., 4 h., and a hot wet pack was ordered and given twice in the twenty-four hours. The amount of urine for that day was 10 oz. and 17 oz. respectively. On August 3 there was still blood in the urine and albumin measured 2 grammes per litre by Esbach's measurement. The œdema was less and chest symptoms much less marked, and the amount of urine 20 oz. and 27 oz. respectively.

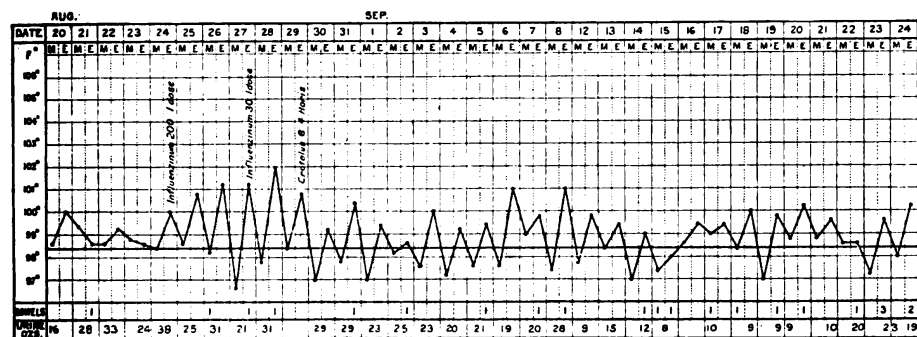
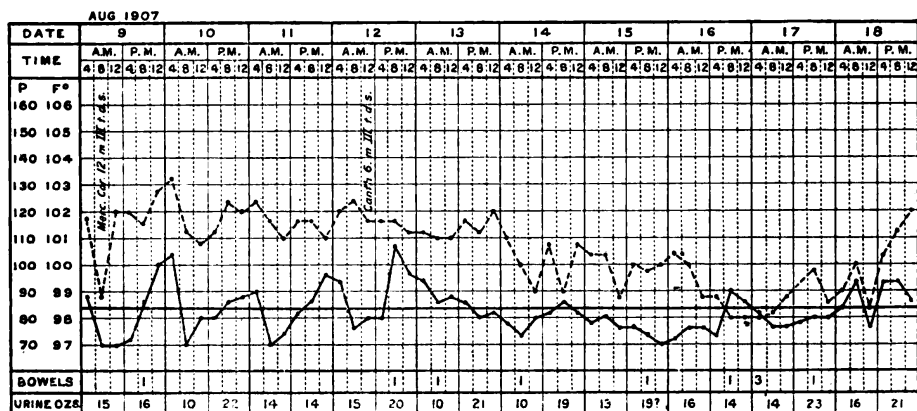
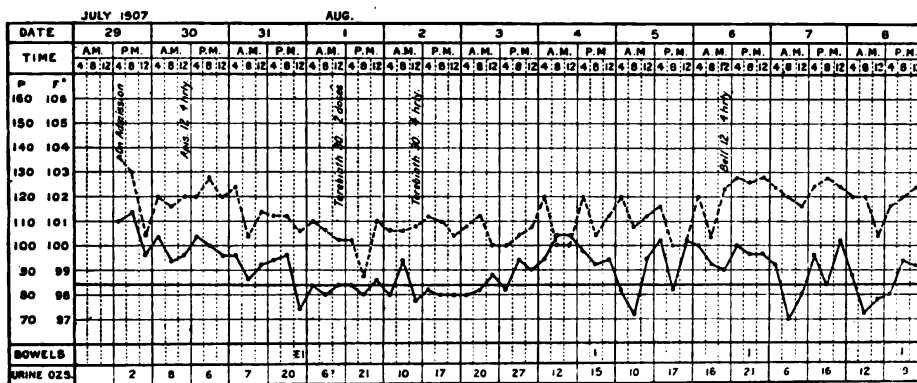
The next day the condition was less satisfactory, the temperature rising to 100·4° F. again, the pulse corresponding, the amount of urine being 12 oz. and 15 oz. respectively. The medicine was not changed, however, until the 6th, when he received bell. 12, 4 h. Mer. cor. 12 was given on the 9th, and cantharis 6 on the 12th.

The cantharis appeared to have a distinctly beneficial effect, for the quantity of urine improved, the temperature returned and kept at normal, the œdema was nearly all gone, and the chest condition no longer gave anxiety. Examination of the urine, however, yielded a similar analysis to those previously recorded.

This state continued until August 24, when as little progress beyond that already reached appeared to be made, and as the etiology of the case had never been quite satisfactorily cleared up to my mind, unless it were the result of influenza, on this date I ordered one dose of influenzinum 200. There appeared to be distinct effect from this dose. As will be seen from the temperature chart, a fluctuating temperature began on that date and



continued until the 29th. There was no other variation in the symptoms, the urine still exhibiting blood slightly, and the same quantity of albumin.



A second dose of influenzinum, this time in the thirtieth dilution, was given two days after the first. On the 29th crotalus 6 was ordered. From the latter date the

temperature gradient was milder, a subsequent rise to 101° F. being noticed on two occasions only. After this the case presents little of interest to record. Improvement was gradual but slow, and the child was discharged from the hospital cured on September 27.

For the last three weeks of his stay a ringworm was noticed on his scalp. This was treated locally while crotalus was being given internally for the kidney condition.

I may add I remember but one other case of acute nephritis which could be directly attributable to influenza, and this occurred in a woman about 55 years of age. The urine was dark and bloody in this case for six months in all. Towards the end of the time she developed phlebitis in her left thigh, but eventually recovered completely from both conditions.

In the child's case the fluctuating temperature which ensued when the nosode influenzinum was administered I attributed distinctly to reaction of the organism upon the fresh dose of the poison which had originally been the cause of the patient's ailment.

#### *Chronic Nephritis.*<sup>1</sup>

The following case presents an effect of belladonna of quite a contrasted type to the one just mentioned of influenzinum.

A. L., male, aged 37, an ironwork examiner, was admitted into the hospital first under Dr. Blackley, on February 15, 1908, suffering from nephritis. The illness dated from several months previously, the symptoms complained of being chiefly pain round the umbilical region and right side of the abdomen, cloudy, smoky urine and swelling of the hands and feet. The condition on examination showed the right side of the abdomen larger than the left, the right kidney being felt. The urine is smoky, of a specific gravity 1010, and contains microscopically, red and white blood cells, hyaline casts and squamous epithelium. While in hospital the man received terebinth. 3 on February 20, and canth. 3x on the 28th. The pain gradually subsided. On March 9 he was feeling very well, the urine was not smoky but it contained a trace of albumin and blood. He was discharged on March 17.

<sup>1</sup> Notes by Dr. W. P. Payne, House Physician.

On August 17 he was readmitted under my care in a state of general œdema. There was dropsy of the legs and scrotum, abdomen and base of the lungs. He had a troublesome cough, and could not lie down in bed. The quantity of urine being passed was from 30 oz. to 40 oz. Microscopic examination indicated a number of casts of various kinds, chiefly finely granular, and a number of leucocytes. Albumin was 4 grammes per litre by Esbach's process.

The man was kept in bed and given farinaceous diet, and cuprum ars. 2x for medicine.

In the *Clinique* for March, 1902, p. 73,<sup>1</sup> there is recorded by Dr. G. M. Hill a case of renal insufficiency from chronic nephritis, where this medicine appeared to act promptly and thoroughly in increasing the output of urea and relieving the patient markedly in other ways. The amount of urea was not estimated in my case, but I gave this drug, assuming that renal sufficiency was very inadequate. I considered this might be a suitable case.

On August 21, four days afterwards, the œdema was certainly less, but the cough was so troublesome that no rest was obtainable. The cuprum was substituted by ant. tart. 3, ℥iii., every four hours.

By the 30th he was much better, the left lung was clearer, although the right was still dull. On September 1 the œdema was almost gone, although a second microscopic examination of the urine showed a similar result to the first. The quantity now was from 45 oz. to 55 oz. Picric acid 6 was given on this date and ferrum picricum 6 on September 11.

On the night of the 17th he had a sharp attack of asthma. He was seen by the house physician early in the morning (about 8.30), who ordered mother tincture of belladonna ℥xxx. every hour until completely relieved, unless dilated pupils, dry skin, or delirium supervened. He received this dose hourly until 2.30 p.m., when I visited the ward. The asthma was practically gone and he appeared none the worse for the large doses of belladonna.

I certainly was astonished at the courage of the house physician and also that the man had not suffered. I remarked on what I thought was a dangerous proceeding,

<sup>1</sup> JOURNAL OF THE BRITISH HOMOEPATHIC SOCIETY, 1902, vol. x., p. 301.

and suggested that such doses should only be repeated with the greatest caution.

There was a slight return of the asthma in the evening, and two more hourly doses of belladonna were then administered. The patient had a good night and there was no recurrence of the asthma. The temperature rose, however, to 99·6° F., but fell again quickly, and the amount of urine, which had varied previously from 45 oz. to 59 oz., fell on the 17th to 34 oz., but it rose again next day, and on the 22nd it was 60 oz. This man was discharged from the hospital on September 22, very much improved.

I included this case in my list simply because of the incident with the belladonna. I could only explain the man's tolerance of such large doses (he received in all about 3 drachms of the pure tincture in six hours) by a theory that his disease had rendered him less sensitive to the action of this drug, rather than more sensitive in a state of disease, as we are accustomed to think.

#### *Chronic Eczema in Children.*

I wish to conclude my paper by citing two cases of chronic eczema in children in which an attempt was made to give medicine in single doses, to watch the effect when improvement began, and only to repeat the dose when improvement ceased. In the two cases the results were similar, as far as there being usually apparent effect from the medication, but it seemed to me impossible to pursue the plan thoroughly in one of the cases, because the eruption at times showed such a marked tendency to spread, and some local application became necessary.

The notes of the following case are by Dr. E. Cronin Lowe:—

E. B., a girl, aged 5, was admitted to Barton Ward on July 10, 1907, suffering from eczema. The history given was that the skin was quite clear until after vaccination at the age of 6 months, but had never been so since. The intensity of the eruption had varied and it had been subjected to all kinds of treatment. The child has had measles, chicken-pox, and this year

diphtheria, but no other illnesses. She is bright, with a good appetite, and the bowels are opened regularly. Both parents are healthy. The skin of the forehead, cheeks, hands, arms, legs and back is of a dry, rough, scaly nature, and on the fingers there are deep fissures with inflamed edges, which evidently have bled, probably from scratching. No vesicles or pustules were observable at this date. The history and condition evidently called for some constitutional medicine, and as the condition had been said to follow vaccination, thuja 30,  $\eta$ iii., two doses in the next twenty-four hours, was ordered and no other treatment. On July 19, no further doses had been administered, the note reads: "The improvement is wonderful already. The forehead and cheeks are almost clear of scales, the skin being soft and clean. The fingers and hands are much better. The scales from the legs, too, appear to be slowly clearing off."

Now was done what perhaps in the interest of the patient had better been left undone. She had another dose of thuja 30 administered. On the 21st the whole skin condition was much aggravated. The face, chin, and both hands exhibited plenty of scaly-looking eruption which appeared red and sore under the cuticle. No medicine was given, as it was thought if this was the effect of the thuja it might soon pass off again. On the 26th, however, it had not passed off except as regards threatening acuteness, and the eruption on the hands appeared to be taking on a pustular character. *Viola tricolor* was now given,  $\eta$ iii., t.d.s., until August 2. On July 29 the condition was improving. The deep redness everywhere was better and the pustular condition had disappeared. The scales were drying up. On August 2 the strength of the *viola* was changed to the 3x,  $\eta$ ii., t.d.s. As far as pustulation was concerned and deep fissures no more was seen of them, and a general improvement ensued, but the skin did not assume again the soft feeling which was noticed after the first two doses of thuja, so that on August 12 it was resolved to give occasional doses of thuja again, only this time in the 200th dilution, and watch the effect. The patient received one dose on August 12, 19, 23, and 26, and on September 2 one dose of thuja cm. (Nash). There was steady improvement until September 6, when slight signs of pustulation showed themselves again on the fingers, for which *viola tricolor* was again given, this time in the thirtieth dilution, night and morning, and continued until the 13th. On the 16th the patient was discharged quite cured, the skin being soft and healthy, the only remains of the eruption being slight signs of old fissures on the fingers.

The case of eczema I wish to detail by contrast with the foregoing has proved much more intractable. Since the patient was discharged from the hospital I have learned that the eruption has appeared again on both face and popliteal regions in a slight degree, accompanied by intervals of irritation lasting an hour or two and then passing off. The notes are my own and partly the daily record of the hospital course.

W. J., a girl, aged 4, was admitted into Barton Ward on August 27, 1908. Both parents are healthy, and they do not attribute the chronic eczema to any special cause. An aunt of the child died from consumption; another aunt suffered from an eruption which was not termed eczema. The child was vaccinated when 5 weeks old, which did not "take," and again three weeks later, from which the vesicles were very small. Convulsions followed, and at eleven weeks eczema began in the head, which continued until eighteenth month, when it got well, but has recurred off and on since.

The eruption does not appear syphilitic nor the general aspect of the child tuberculous. She has acute redness of the cheeks, chin, and upper lip, with occasional serous exudation and subsequent desquamation, also patches of eczema in the popliteal regions and inner sides of both knees in various stages of development. There is much irritation, and all through the child's stay in the hospital the eruption was much aggravated by friction.

The child received merc. s. 3x., t.d.s., and then mezereum 30 bis die without any effect. On September 4 I began giving graphites 30 one dose, and this was followed by improvement. She did not receive any more medicine until the 10th, when another was given, another again on the 12th, and on the 14th one dose of the 200th, each dose being repeated if no manifest improvement was observable. The cheeks and chin were much better and the legs drier, although small patches of fresh moist eruption kept reappearing. She now received viola tricolor 30 in single doses after the same manner as graphites, single doses being given on September 9, 15, 16, 22, 25, 29, and on October 2 and 5. On October 6 she received one dose of sulphur 200, on the 13th graphites 30, one dose, which was repeated on the 19th. On the 26th she developed an acute manifestation of the eruption behind the ears, for which I ordered croton tiglium 30, one dose as required. On November 13 this condition had not much improved, and moist places still continued to appear on the legs.

There was more exudation behind the ears than at either of the other situations where eruption had appeared, and as this was with difficulty kept from forming crusts, some local application appeared necessary. An ointment of the yellow oxide of mercury 5 per cent. in *adepts lanæ* was accordingly ordered to be applied to moist places only. This was very effectual in clearing the skin, and healing went on rapidly behind the ears, but slowly elsewhere. I had not tried *thuja* in this case, so now gave a dose of the thirtieth as required. She received single doses on November 24, 30, December 3, 10, 13, 15, 21, and 24, with little manifest improvement. *Rhus tox.* was then tried, and afterwards *mercurius vivus*. The ears and face were well, but the legs kept showing slight fresh patches. On January 18 *graphites 200* was resorted to again with the use of the ointment if required, and the legs were to be protected by light bandages. These measures now seemed effectual, and the child was sent home free from eruption on February 18 this year. The protection afforded by the bandages may have had some influence in promoting the healing process, especially as already stated some fresh eruption has appeared since.

These cases, gentlemen, I fear have been presented to you in wearisome detail, and of detail there is far too much to ask for a discussion upon except at the discretion of the Chairman. I am also afraid I could not always defend my selection of the medicine, at least as being the *similimum*. I made no attempt to sit down and laboriously work out the cases by repertories, but trusted to experience and memory to afford the drug at the moment. As stated at the beginning the cases are not brought forward for the purpose of a discussion of these points, but rather to suggest the unreliability of inference from dosage of a certain stated quantitative value or potency on paper. The latter are relatively arbitrary methods for the guidance of the pharmacist rather than the physician. The attitude of the physician to a case, it seems to me, relative to previous knowledge and experience, must be that of regard for every case as in some sense a new problem. Not only is caution needed in attributing cures to certain medicines, but more so before arriving at the inference that because one form of dose and frequency of repetition have proved beneficial in

some cases, the same form and frequency will be sure to have the same effect in the future for the same cases, or in similar other ones. Proof of value is a fact of experience after the event and only relatively for prognosis.

General rules remain general without being certainly finally applicable to particular cases. A particular case may prove the rule or it may remain particular and exceptional, and if a particular case is found to prove the rule the rule may not be found applicable to future particular cases. The rule remains ideal, and can never be absolutely asserted to overtake the real.

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Dr. STONHAM (in the chair) said that the paper was one of great interest. It dealt with a subject about which, although they were always discussing it, they never came to any real decision. All that they could do at present was to bring forward illustrative cases and gradually accumulate a bulk of knowledge, from which they might in future make deductions. There was not only the question of dose but of the repetition of doses, and the two questions complicated one another. In many of Dr. Goldsbrough's cases it seemed very plausible that subsequent doses interfered with the action of the first dose. He did not think that they would come to any definite conclusion with regard to the repetition, or with regard to the efficacy of any particular dilution, until they adopted the method which he began to adopt in the last case; that is to say, giving a single dose and waiting till the effect had worn off. The early part of the paper touched upon a point of great interest, and suggested that in cases of neuralgia the body might assume a habit of pain through which the pain would continue, although the real cause of the neuralgia had gone. That was probably very true. He (Dr. Stonham) had in his mind the case of an old lady, aged 80, who had complained for eight or nine years of a constant pain in the lower part of the back, although there was no local cause to be found. In that case drugs and everything had been tried, without the slightest avail. He believed that when the body had formed a habit of pain, no drugs were likely to remove the pain. In his own case of facial paralysis, to which Dr. Goldsbrough had referred, the causticum which he used was causticum cm. They did not know what the cm. potencies really were. They



were prepared by the fluxion method, and nobody knew exactly how much of the drug there was present in the dose.

Dr. SPEIRS ALEXANDER congratulated Dr. Goldsbrough on the paper. It was quite refreshing to have a good homœopathic paper. The paper would appeal to them all in a practical way, and ought both to help and to encourage them. It would be indeed of supreme value if they could have a rule as to doses and their repetition, and as to when they should use the lower dilutions and when they should use the higher. As Dr. Goldsbrough had indicated, it was difficult to generalize on such a subject. Every case had to be judged on its own merits. It might be true, as had been suggested by some, that they ought to treat acute diseases with the lower, and chronic diseases with the higher dilutions, and yet it would be found that in some of the acute cases the higher dilutions acted most successfully. As an illustration, he might refer to the dread disease, diphtheria. The treatment of this disease with antitoxin had been much vaunted of late years; but he believed that if homœopathic practitioners were always true to their colours and had more faith in the method which they professed, they might render themselves entirely independent of antitoxin. Within the last few weeks he had had two cases of diphtheria, in both of which the indicated remedy was cyanide of mercury. In the earlier days of his practice he gave this remedy in the 3x and 6th dilution. He was never quite satisfied with its action, and in later years had given the 30th. In the two cases which he had mentioned he gave the latter potency, and the result in both cases was remarkable. It seemed as though the membrane gently melted away, and did not peel off in patches, leaving a raw surface below. He repeated the dose about every two or three hours. It seemed to him that in a general way if a drug was very clearly indicated they could safely go as high as they liked, and that the less frequently they repeated the better. He agreed with the Chairman that as long as improvement continued the drug need not be repeated; but when the improvement came to an end, another dose might be given. Many years ago a friend of his, an officer in the Indian Medical Service, returned home from Burma with malarial fever. On the voyage home the fever gave place to obstinate neuralgia. He came to stay with him (Dr. Alexander) at Plymouth. The first night he was there he had no sleep, on account of intense neuralgic pain, referred to the left supraorbital region. The pain always came on at the same time—11 o'clock; the clocklike regularity of its occurrence suggested cedron as the remedy, and he

(Dr. Alexander) gave his friend a dose of it on his tongue—the 1m dilution. The next night the patient slept “like a top,” and from that time he had been free from both neuralgia and malarial fever. He (Dr. Alexander) had again and again had cases of that kind, in which the most characteristic symptom was the periodical return of the pain, and in such circumstances had always had satisfactory results from the administration of cedron in high attenuation. With regard to the causticum cases, they were examples of the drug being accurately indicated, and, therefore, they might with great boldness go up to the highest dilutions. He seldom gave causticum lower than 200, and in several cases of facial neuralgia or peripheral paralysis of the seventh nerve it had been successful. In the case of very old people, he had found it necessary to give a gentle faradic current to stimulate the nerve. In some cases a unit dose of the 1,000th dilution would cure a patient, while in another Dr. Cooper would tell them that a unit dose of the matrix tincture would do so. This constituted a difficult problem, and again raised the question, when to give the one, and when to give the other. The case of chronic neuralgia mentioned by Dr. Goldsbrough, called to his (Dr. Alexander’s) mind a case which illustrated the point that people could get into the habit of neuralgia after the local cause had passed away. In his case the patient suffered from pain referred to the dental nerve of the lower jaw, though she had long lost all her teeth. Staphisagria had given relief in that case. With regard to acute nephritis, he believed that it was in the experience of most of them that cantharis answered well where indicated. When there was blood in the urine, he had generally found terebinth. to be the indicated remedy. After that, when the blood had passed away, arsenicum seemed to answer best. As to eczema, he had never seen a case get well with a unit dose. He had always had to repeat the dose. Petroleum was a remedy well worthy of attention. He had always had to give it in a high dilution from 12 to 30, and sometimes the 200th, and always had to repeat it. The late Dr. Skinner was in the habit of repeating, in certain cases, but he did not think that that altered the great principle by which they should all be guided—if they had courage to be guided by it—especially in chronic cases, namely, not to repeat as long as improvement continued with the first dose.

Dr. COOPER considered the cases which Dr. Goldsbrough had so ably described of the greatest value, and remarked on the fact that several of them demonstrated the efficacy of remedies when given in unit dose at intervals of several days. Dr. Alexander



had referred to the problem which underlay the potency in which remedies should be given. He (Dr. Cooper) did not consider that the essential factor which made for success lay so much in the potency of the remedies employed as in the frequency of repetition of the doses. Given the fact that the remedy was well indicated and that sufficient time was allowed for each dose to act, the question of potency became to his mind of quite secondary importance. Dr. Alexander had also stated that he had never found any good result follow a single dose in eczema. This had not been his (Dr. Cooper's) experience, or that of his late father, for they had both obtained excellent results from the administration of potentized and unpotentized remedies, when given in this way. He mentioned the case of an elderly gentleman, of gouty disposition, suffering from hitherto intractable eczema of the leg. Specialists and others of the old school had tried various forms of treatment without success, yet arbutus androchre cleared the eruption completely away. It was found, however, that the trouble returned each spring, but a unit dose of the same remedy never failed to render the patient quite free for the rest of the year. Shortly after the late Dr. Robert T. Cooper's decease, the patient came to the speaker in despair, because the spring had come and with it the eczema, and he feared that he would have it for the rest of his life. He received a unit dose of urtica urens, and the eczema not only cleared away, but did not return next spring, and with one exception, when there was a very trivial sign of return which immediately answered to the same remedy, there had been no trouble from the eczema since. Later on, the wife of this same patient developed an acute irritating eruption affecting the face, the eyelids being more or less swollen. It was of a dry character and bright red colour, and was accompanied by a sensation *as though strong brine had been rubbed over the skin*. Urtica urens was given in frequent doses with only temporary slight improvement; other remedies failed to touch it in any way, so the urtica urens was again resorted to, but this time with directions that *it was to be stopped directly any relief was felt*. This cleared up the trouble for some months, and did so again each time it returned, which happened at longer and longer intervals. It was now some years since there had been any recurrence. The strength of the remedy employed was a single drop of the mother tincture in a glass of water, two teaspoonsful being taken at four-hourly intervals. In no case were more than two or three doses required. He could fully confirm, from personal experience, the power of thuja over the constitutional effects of

vaccination, and related a case in point of a gentleman suffering from a chronic suppurative condition affecting the lower part of the neck on the right side. Numerous sinuses were present, as were bridges of tissue, under which a probe passed easily. Allopathic measures, which included constant scrapings and the local applications of various remedies, had been tried for years without avail. The result was that his life was miserable from having to always go about with dressings round his neck in place of a collar. Investigation brought out the fact that the trouble had appeared about two months after vaccination. Thuja was given in unit doses at long intervals, and in a few months all the sinuses healed up, leaving nothing but a scar to mark the spot. Another case showing the profound dynamic action of remedies administered in this way was that of a gentleman suffering from continually recurring attacks of influenza. They came with remarkable regularity every month, it being rare for a month to pass without one. They were characterized by catarrhal symptoms, rise of temperature, body and limb pains, and gastric disturbance. As in the other cases, allopathy, as practised by some of the best known men in London, but failed to prevent the recurrence of these attacks. He (Dr. Cooper) treated the patient during the attacks, which were said to be of much less severity and of shorter duration than under the former treatment. Nevertheless they continued to return, and he then decided to give a unit dose of influenzinum 30 at a time when no signs of an attack were present. The result was startling in the extreme, for the patient came next day and gave a vivid description of an attack of intense hunger which had assailed him a few hours after the dose. He said there was such a fearful gnawing at his stomach that he could not wait to return home to dinner, although he was within a short distance of home, and he was forced to enter the first restaurant he came to. Other doses of various kinds had been given him before, but nothing like this had been experienced, so "imagination" was out of the question. From that day he was entirely free from the attacks for certainly more than a year, and had only once had an attack of influenza since.

Dr. EADIE said that formerly he used to use the lower dilutions. He afterwards tried the higher potencies, and he imagined they gave him much more satisfactory results. Recently he had been trying the lower potencies again to see how they compared with the higher, but he must say that he preferred the higher. He did not agree with Dr. Alexander in his statement as to the repetition of doses; even in cases of diphtheria he gave a

single dose and watched the case. As to eczema, he was quite sure that it could be cured with a single dose, and cited a case. The case which Dr. Stonham had mentioned, illustrated that one could give drugs too often, but the frequency was a very difficult point to settle. In a cancer of breast case, which he (Dr. Eadie) had had, the patient used to suffer excruciating pain, and he unavailingly tried many drugs. At last he tried silica 30, a dose of which relieved the pain in about a quarter of an hour and would leave the patient free for two or three days, when it required repeating.

Dr. ELLWOOD said that he was afraid that the paper would not give them information or real help, from the clinical point of view, with regard to high dilutions or low dilutions. The discussion had followed very much on the same line. Whether they came there high dilutionists or low dilutionists they would go away the same. The interpreted results with regard to any of the dilutions must be taken, he thought, *cum grano salis*. The old text-books on *materia medica* used to state that the greatest tonic was *hope*; now it is said that that must be supplemented by the patient with *faith*. Certainly if a patient lost his faith in the doctor he did not seem to get on very well. He was rather afraid that many of the old school of practitioners, when they studied their *materia medica*, must come to the conclusion that they were faith-healers. He had found with regard to high dilutions and low dilutions, and to unit doses and frequently repeated doses, that what would do good in one instance would fail to do good in another which seemed to be almost identical. He could not understand why this should be. He had known of a neurotic case which had attended the hospital for some time, and was under Dr. Goldsbrough. He (Dr. Ellwood) found that the only thing which did the patient good was a dose of sulphur, the dose being repeated when the effect had gone off. This was a case in which he was sure the unit dose was doing good. With regard to facial neuralgia, he had a patient who had been under all kinds of treatment for that disease. He had nearly all his teeth taken out. The patient told him that what relieved him most was to take a tablespoonful of cod-liver oil, and hold it in his mouth. The patient had tried olive oil and almond oil, but they had done no good at all. He (Dr. Ellwood) considered if there was a specific in the cod-liver oil it must be due to one of the ingredients in the oil. Was it the phosphorus, or was it the iodine? He tried the phosphorus first in the low dilution, and then as high as 30, but the phosphorus brought no relief whatever. He then gave him

phosphide of zinc rather high, and for the first week there was no return of the pain. The patient was delighted, but in a little time the symptoms returned almost as acutely as ever. He then tried the iodine. He found that by giving iodine 3 and phosphorus 30 in alternations, he got rid of the neuralgia entirely. In influenza he had found that guaiacum 5 had been very useful.

Dr. WHEELER said that he was interested to hear Dr. Alexander's experience of the cyanide of mercury. He remembered Dr. Clarke telling him that Dr. von Villers had said that it ought not to be given below the 30th dilution, and now Dr. Alexander had come to the conclusion that the 30th was the best. The question of the dose was always present with them. He fancied that the whole question, both of the high and of the low dilutions, and of the repetition of the dose, would be found to be like the choice of a remedy, and depend on the definite condition to which each patient would respond. But to say this might, perhaps, seem to be adding a new terror to medical practice. There would always be an individual rule and no other; but he did not despair that in the future their successors would be able to say not only, "this patient wants such and such a drug," but "this patient wants the drug in such and such a dilution," and would be able to say whether the dose should be repeated or given as a unit dose. He was sure that the results of the action of a medicine varied between a high dilution and a low dilution, and also that there was a definite range of variation among dilutions themselves. Suppose the case of a particular patient who was suffering from gastritis demanded the use of arsenic. It was quite possible that the patient might respond favourably to arsenic if given, say, in the 3x dilution, or in the 30th, and yet the 12th or the 6th might have no effect upon him at all. That might account for those experiences which were so common to all of them, in which they found that the low would cure when the high had failed, and *vice versa*. He had been put upon this track by some experiments which he had been conducting with regard to the effect of dilute solutions upon the growth of simple plant life. He found that the effects on plant life depended upon a definite relation between the drug and the particular plant. This might be the first shadowing forth of a principle that they would have in the future to consider. He hoped that they might in time be able to say that a particular patient would want some particular dilution as well as some particular remedy.

Dr. HEY said he did not know whether Dr. Ellwood gave

horses, dogs and cows credit for having faith and hope; but both Dr. Eadie and he (Dr. Hey) had proved that neither in animals nor in men was faith or hope required to obtain a cure. Facial neuralgia or dental neuralgia had been discussed. He had in hand the case of a patient who had suffered for eight years with that ailment, and she had had almost all her teeth removed. She had been to some of the greatest specialists of the day, and the last one told her that there were only two remedies, either morphia or the major operation (*i.e.*, removal of Gasserian ganglion). She was now better, as the result of homœopathic treatment, than she had been for eight years. First he went to work, on the ground of experience, with a few drugs, in the somewhat haphazard way, but got no results. He then took the trouble to repertorize the case, and worked it out to three drugs. Probably if he had gone a little further he would have got it down to one drug. He was certain that if they had time to repertorize their difficult cases they would not have so many failures in treatment as they had. A reference had been made by Dr. Alexander to Dr. Skinner. He (Dr. Hey) took the opportunity of having a little conference with Dr. Skinner on the question of high dilutions, and Dr. Skinner assured him that, in dealing with the higher potencies, the *cm.*'s, &c., he never repeated them in less than twelve hours, and then never more than three times, and he then waited for results. That was his practice shortly before he died. He (Dr. Hey) had met several of Dr. Skinner's patients since his death, and they all spoke with the highest possible respect of the one or two doses of the very high dilutions. Dr. Cooper, and also Dr. Eadie, in speaking of the unit dose in eczema, brought to his mind his own case. Every spring he got eczema on his right hand. It used to be bilateral and symmetrical. Dr. Ham relieved him some time ago, but the disease had not been cured. He believed that he took five drops of the mother tincture of *urtica urens* in hot water once or twice a week. With regard to the use of *influenzinum*, Dr. Goldsbrough seemed to have got a marked aggravation of his case. In a case in which he had used it he had got an aggravation with the 30th. In an acute attack he had invariably found that the 30th produced aggravation. With regard to the cyanide of mercury in diphtheria he had had no personal experience. Although he had been in medical practice for eight or nine years he had never had to treat a single case of that disease. He believed Dr. Ham had a great deal of experience of it in Reading twelve months ago, and he found

that in bad cases he had to repeat the 30th every hour. The unit dose did not give him the desired results.

Dr. GOLDSBROUGH, in reply, said that in the main the discussion seemed to have substantiated his conclusion that in their present state of knowledge there was no finality on the question of the dose. That seemed to be proved, and to prove this by comparison with some of the dogmatic statements which were made was really the reason why he brought the subject forward. Some of the remarks which had been made were in the nature of a criticism on what he had written. As to using in acute disease dilutions different from what would be used in chronic disease, and with regard to the repetition of the dose, he used to hold the theory that the lower dilutions were the more useful in acute disease, but he had given up that theory because he believed that it misled. But in acute disease as well as in chronic, in the light of freedom from preconceived notions, they ought to consider the whole range of doses, and the frequency of the repetition, and try simply to deal with every new case on its merits. The question of cyanide of mercury was one which interested them all. It interested him personally because his first attempt at reading a paper in the Society was on diphtheria in the year 1881. He then brought forward some cases in which he had used cyanide of mercury in the 6th dilution. The veterans present who discussed the paper gave him a setting down because they said that he ought to have followed Dr. von Viller's plan. He had since that time used cyanide in the 30th dilution, but was still of the opinion that one case did not give a clue to what should be done in another case, the principle being that if improvement took place they should not repeat the dose until the improvement had ceased. With regard to cedron and staphisagria in neuralgia, they were excellent medicines. Dr. Eadie had not quite understood him with reference to the exhaustion theory. He still thought that pain in a nerve was possible from exhaustion simply, in addition to the habit of pain; and if they could get rid of the exhaustion by any means other than a homœopathic remedy they were justified in doing so, as by the use of electricity. They were justified in stimulating the nutrition of the nerve trunk or the nerve sphere, so that their remedies might have a better chance. He (Dr. Goldsbrough) could not see where faith and hope came in in any of his cases. Some of the cases were those of children who knew nothing about faith and hope, unless they were always hopeful. As to the case of chronic neuralgia, the old lady who was a patient was fast losing



faith in her doctor until he gave her something that relieved her pretty quickly. He was rather interested in the case of facial paralysis which Dr. Wheeler published some time ago, where silica was instrumental in relieving the symptoms and curing the patient. In that case there was a suppurative process going on. They had to consider, of course, the totality of the condition, and form a correct diagnosis before arriving at their medicine. He thought that it was in the simple cases of facial paralysis they were likely to get the benefit of causticum.

## MINUTES OF THE SOCIETY MEETINGS.

THE SEVENTH MEETING of the Session 1908-9 was held on April 1, 1909, at the London Homœopathic Hospital at 8 o'clock; Dr. Stonham (Vice-President) in the chair. There were also present Dr. Speirs Alexander, Dr. Cronin, Dr. Rober-son Day, Dr. Goldsbrough, Dr. Ham, Mr. Granville Hey, Dr. McCulloch, Dr. Byres Moir, Dr. Neatby, Mr. Knox Shaw, Mr. Wynne Thomas, Dr. Wheeler and Mr. Dudley Wright. The President (Dr. Cash Reed) and Dr. Dyce Brown sent apologies for absence. Dr. Marriott, Dr. Broomhall and Dr. Brodie were announced as visitors.

## OBITUARY.

The death was announced of Dr. Samuel Henry Ramsbotham, of Harrogate, a highly respected member of the Society, elected in 1894. A vote of condolence with Mrs. Ramsbotham and the family of the late member was passed on the resolution of the Chairman, seconded by Mr. Knox Shaw.

## NEW MEMBER.

Arthur H. Gregson, M.B., Ch.B., of 86, Lower Audley Street, Blackburn, was elected a member of the Society.

## SECTION OF MEDICINE AND PATHOLOGY.

A paper was read by Dr. McCulloch, of London, entitled "The Significance, Pathogenesis and Sequelæ of Fibrositis and the Rationale of Resolution by Electrolytic and Actinic Methods," which was followed by a discussion. This paper, with the discussion, appears on pp. 227-238 of the current issue of the Journal.

The EIGHTH MEETING of the Session was held on May 6, 1909, at the London Homœopathic Hospital, at 8 p.m.; Dr. Stonham (Vice-President) in the chair. There were also present Dr. Speirs Alexander, Dr. Cooper, Mr. Eadie, Dr. Ellwood, Dr. Goldsbrough, Mr. Granville Hey, Dr. McCandlish, Dr. T. E. Purdom, Dr. W. P. Purdom, Dr. Storar, Mr. Wynne Thomas, Dr. Wheeler, and Mr. Wilkinson. Letters of apology

for absence were received from the President (Dr. Cash Reed), Dr. Dyce Brown, Dr. Burford, Dr. Roberson Day and Dr. Neatby; Dr. Marriott and Dr. Weir, were announced as visitors.

#### SECTION OF MATERIA MEDICA AND THERAPEUTICS.

Under the auspices of this Section Dr. Goldsbrough, of London, read a paper entitled "Cases Illustrating the Problem of Dosage." A discussion followed, which with the paper appears on pp. 242-262 of the current issue of the Journal.

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The NINTH MEETING of the Session was held at the London Homœopathic Hospital, on June 3, 1909, at 8 o'clock, Dr. Cash Reed (President) in the chair. There were also present Dr. Burford, Dr. Roberson Day, Mr. Eadie, Dr. Ellwood, Dr. Ham, Mr. Granville Hey, Dr. Jagielski, Dr. Johnstone, Dr. McCandlish, Dr. Byres Moir, Dr. Neatby, Dr. Pincott, Dr. Percy Purdom, Dr. Stonham, Mr. Wynne Thomas, and Mr. Dudley Wright. Dr. Marriott was announced as a visitor.

#### NEW MEMBER.

Arthur Stoddart Kennedy, L.R.C.S., L.R.C.P.Ed., of 64, Leinster Square, was elected a member of the Society.

#### SECTION OF SURGERY AND GYNÆCOLOGY.

A paper was read by Mr. Wynne Thomas, of Bromley, entitled "Notes of Two Cases of Tubal Gestation," which was discussed by the President, Dr. Neatby, Dr. Burford, Mr. Eadie, Dr. Johnstone, Dr. Purdom, and Mr. Wynne Thomas in reply. This paper, with the discussion, will appear in the October number of the Journal.

SUMMARY OF PHARMACODYNAMICS AND  
THERAPEUTICS.

*Extracted from Exchange and other Journals by the Editor in  
collaboration with J. Galley Blackley, M.B.*

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**Quinine.** *A Proving.*—In a paper read before the Hughes Medical Club, Dr. Walter Wesselhoeft gives the following account of some unusual effects of quinine. The words are those of the patient herself. “The first time quinine poisoning happened with me was in 1885, when I was three years old, and was caused by the external application of an ointment containing quinine and lard. A red rash came on after three weeks’ application. I was having bronchitis and whooping-cough, and the eruption caused the whooping-cough to cease. The second time was in 1886. Hypophosphites had been prescribed, and I was given half a teaspoonful at 7 p.m. By nine I had great restlessness and feverishness. In the morning I had a slight eruption. Not knowing what caused it, I took another dose, making in all  $\frac{1}{4}$  gr. of quinine. The eruption increased gradually and spread all over the body and lasted a week. There was great irritation, itching and restlessness. Temperature not taken. Mother says I am of a very eruptive nature—for example, in measles, chicken-pox and moth poison. In June, 1904, I had tonsillitis, was feverish, but not ill enough to go to bed. At 5 p.m. a doctor gave me rhinitis tablets, of which I had taken four by 9.30, containing in all about  $\frac{1}{2}$  gr. of quinine. About 9 p.m. I began to have a chill with chattering teeth and was obliged to go to bed; was obliged to hold on to the bed and could not speak. I found an eruption on my back (bright pink) which made me suspect quinine. Temperature 102° F. The chill continued until sleep came. At 12 I awoke in a perspiration and had a confused idea that I must change my gown. I crossed the room and did so. On the way back my strength gave way and I fell on the floor and probably fainted. I could not move for five minutes, then crawled back to bed. Temperature 101° F. in the morning, throat better and the next day well. The eruption spread gradually all over the body, a new place each day until every inch was covered; dark red-like beads and blotches of plain

colour. The doctor said there were four kinds of eruption. Itching not bad until eruption began to go down, which it did in one place at a time in the order in which it appeared. The eruption was almost hæmorrhagic just above my knees after standing for a few minutes. The colour then was a dark purple all over my legs. The eruption lasted five days, when the treatment was changed. I was almost over it in two days. The fever was gone in two days from taking the tablets. I peeled as if I had scarlet fever. In December the hairdresser rubbed some tonic containing a little guaiacum on the back of my head—this was in the morning. By night I had a tremendous itching on my head. I felt as if the skin had been cooked, and I felt gritty particles there. Next morning I found an eruption on my face just as in the summer, but not so severe. It was checked, I think, by the X-rays. Temperature not taken. In a few days the eruption was gone. Two doctors saw me when I had the quinine poisoning last summer. They had never seen anything like it. At first they did not think it was quinine poisoning, but afterwards admitted that it must be in a very severe form, and if I had taken an ordinary dose, which was 20 gr., in Cincinnati, where I was at the time, they thought it might have been the end of me." (*New England Medical Gazette*, June, 1909, p. 249.)—ED.

**Apis Mellifica.** *Summary of Pathogenesis. General Symptoms and Therapeutics.*—Subacute inflammations of serous membranes with effusions; inflammation of the tubuli uriniferi, giving as a result scanty urination, albuminous urine, and tube casts. Mentally there is either drowsiness or irritability, with awkward movements and jealous or silly disposition. Nervous restlessness alternating with drowsy lethargy. Thirstlessness, 4 to 6 p.m. aggravation. Local rosy-pink inflammation of skin and cellular tissue, quickly becoming œdematous, with burning, stinging pains. *Therapeutics.*—The chief indications for the drug are found in dropsies, beginning under the eyes in all œdemas with inflammation. Dropsies of serous membranes after bryonia; meninges, pleura, pericardium, tunica vaginalis, articulations. Physical depression and muscular tremors characteristic of animal drugs always present. (Dr. A. L. Munroe in *The Hahnemann Monthly*, May, 1909, p. 349.)—ED.

**Carboneum Sulphuratum.**—In a long paper on this drug, by Dr. James Tyler Kent, are to be found detailed in schema form all the symptoms produced by it, intermingled with the morbid

states in which it has been found useful. This drug evidently has a very deep and disorganizing action, and an immense range over all the systems and anatomical spheres of the body. Its nearest analogue is tuberculinum, but there is a more predominating affection of the mind and nervous system than with tuberculous states generally. Dr. Kent says it is the most useful remedy in patients broken down by the long use of alcoholic stimulants. Persons affected by it are very sensitive, much aggravated by cold, their muscles waste, and there is anæsthesia of the skin and mucous membranes. Very variable states of mind are produced—chiefly irritable states—but also with dulness and depression, pains of various kinds all over the head, electric shocks through the head, œdematous and catarrhal states of the mucous membranes, ulceration of the lips, anæsthesia of the mouth and tongue. Irritable states of internal organs, rheumatic affections of the limbs with weakness and anæsthesia are also found. There is deep morning sleep, with anxious, vexatious dreams. Fever during the night, sweating after sleep; anæsthesia and septic states of the skin. In a discussion which followed Dr. Kent's paper, Dr. Fahnestock pointed out that carbon disulphide had a special affinity for the eyes, causing myopia, asthenopia, and a- and dis-chromatopsia, cloudiness and atrophy of the optic disc, and central scotoma for light and colours. The arteries and veins are congested. Dr. H. C. Allen (the late) drew attention to the strong vital reaction characteristic of carbon disulphide, in this case allied to X-rays and radium. Dr. C. E. Walton referred to its use as local application in facial neuralgia, sciatica, &c. It produces intense heat, without vesiculation. (*Journal of the American Institute of Homœopathy*, May, p. 196.)—ED.

**Electricity in Diseases of the Stomach.**—In a paper to the Society of Physical Therapeutics, Dr. Mackay Lyon records his experience with electricity in diseases of the stomach. Galvanism will usually benefit gastralgia, a daily course for two weeks of 20 ma. to 30 ma. applied by sponge electrodes the negative pole over the stomach. Leucodescent light is an aid in this disease for relieving soreness following a severe paroxysm. Ulcer is greatly relieved by the latter agent, ten to fifteen-minute exposures being given daily for several days, using the blue screen. Nervous dyspepsia is improved by galvanism, a current of 5 to 8 ma. for from three to five minutes at a time. Chronic gastritis is improved best by faradism, first by a low-tension current moved freely over the stomach wall, and then a high-tension current

through from the back. (*Journal of the American Institute of Homœopathy*, April, 1909, p. 158.)—ED.

**Radium as a Cure for Birth Marks.**—In the course of a paper on "Radium," Dr. W. H. Dieffenbach referred to its use for the removal of birth marks, and showed two cases under treatment which were slowly improving, the fiery red colour on the face having nearly disappeared in one of them. He pointed out that care was required in remitting the treatment for a week or two when any signs of contraction appeared. In children it is better not to repeat the dose under thirty days. (*The Chironian*, May, p. 421.)—ED.

**Radium in Inoperable Tumour.**—Dr. W. H. Dieffenbach also reports the following case of the use of radium in inoperable tumour. Mr. E. C. H., aged 59, had a tumour 6 in. in diameter in the right inguinal region which could be palpated through the rectum. The X-ray was utilized for its inhibitive action, the tumour being rayed through a chamois filter in all directions, the dose being regulated so as to avoid dermatitis, but still to 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. Impressed with the great value of radium in superficial malignant states, it was suggested that if it could be brought into contact with this tumour some good might result. It was suggested to the patient that the experiment might prove fatal, but he consented to have an operation performed, and that before a class of students, so that the technique could be explained to them. Dr. William Tod Helmuth did the surgical part of the work. The preparation of radium used was 40 mgm. of a weak strength of radium bromide (25,000 activity) mixed with 1 oz. of sterile gelatine. The 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 the abdomen was opened over the central point of the tumour; a small portion was excised for pathological examination. The diagnosis arrived at by pathologists was that of round and spindle-shaped alveolar sarcoma with hæmorrhagic extravasations. The growth was inaccessible to the knife. By

means of a medium-sized aspirator,  $1\frac{1}{2}$  dr. of the fluid radium gelatine were injected into each of three 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 at the lower aspect of the incision. The reaction of the patient was severe. He suffered much from hiccough. In two days the edges of the wound showed marked granulations of an abnormal type, so that it was decided 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. From this point the patient made an uneventful recovery. He was operated on on February 9, and on April 5 the tumour was found to consist of merely a small nodular mass about the size of a horse chestnut, apparently of fibrous connective tissue. (*The Chironian*, May, p. 407.)—ED.

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*All communications and exchanges to be sent to*

DR. GOLDSBROUGH, 82, *Wimpole Street, London, W.*

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NOTES OF TWO CASES OF TUBAL GESTATION.<sup>1</sup>

BY HAROLD WYNNE THOMAS, M.R.C.S.ENG., L.R.C.P.LOND.

*Surgeon to the Phillips Memorial Hospital, Bromley, Kent.*

MR. CHAIRMAN AND GENTLEMEN, — When your energetic Secretary buttonholed me the other evening in the coffee-room and would not take No for an answer, in thinking of what I could say to you that would be of practical value as well as of general interest, it struck me that an account of some personal experience might be helpful under similar conditions to my own. As far as I am aware, the subject of tubal pregnancy has not occupied the attention of the members of this Society before.

Of the frequency of ruptured tubal gestations we require no more proof than the current literature of our profession, which abounds with instances, and there are few men of experience in general practice who cannot call to mind one or more examples of this ghastly catastrophe. Before relating in detail the two cases I wish to bring before you to-night allow me to say a few words on ectopic gestation.

<sup>1</sup> Presented to the Section of Surgery and Gynæcology, June 3, 1909.

The uterus alone is the seat of normal conception, and as soon as the ovum is affected by the spermatozoon it adheres to the mucous surface of the uterus. The function of the ciliated lining of the Fallopian tubes is to prevent spermatozoa entering them, and to facilitate the progress of the ovum into the proper nest.

That being so, it is easy to understand the cause of tubal pregnancy when we remember that desquamative salpingitis could at once put the mucous lining of the tube into a condition exactly similar to that of the uterus, and in that condition access of spermatozoa would be possible, retardation of the ovum in the tube would be inevitable, and its immediate adhesion to the tube wall after impregnation would be as easy and as likely as its occurrence in the uterus.

Some of the modern writers say that impregnation of the ovum normally takes place in the tube or ovary, and that some days elapse, during which segmentation is taking place and the ovum rapidly growing in size, before it reaches the uterus, and that on arriving there, instead of adhering to the inner folds of the uterus it bores itself into the wall of the womb, or if prevented from reaching the uterus it burrows into the walls of the tube and makes for itself a nest, so to speak.

Virchow long ago drew attention to the fact that at *post-mortem* examinations of cases of ectopic gestation ending fatally at the period of rupture, traces of previous pelvic peritonitis were often found, and nothing is more common than to find a record of such attacks in the history of cases that come under clinical investigation. Indeed, there is one fact about these cases which is very notable in the relation that a very large proportion of them have a history of prolonged sterility and menstrual suffering, showing that their procreative machinery was out of gear.

Thus we often have the history common to tubal mischief, that after a first labour there was an illness with marked symptoms of pelvic trouble, then a long period of sterility, then the ectopic gestation ending in rupture. The history in suspected cases of tubal pregnancy is of great value. Parry impresses this by saying that

“women who have become pregnant with a child outside the uterine cavity frequently show a previous ineptitude for conception. The interval between marriage and the first impregnation is frequently long. If the woman has borne children a period of sterility frequently precedes the extra-uterine pregnancy.”

Gestation having taken place in the Fallopian tube, as the ovum enlarges the tube is distended till it finally bursts. This may take place at any time between the fourth and twelfth week. As usually happens, the rupture opens into the peritoneal cavity and hæmorrhage goes on till death takes place, unless something is done to stop the bleeding; more rarely the rupture takes place downward between the layers of the broad ligament. With the latter class I have nothing to say in this paper. It is also possible for the gestation sac to rupture into the tube itself, and hæmorrhage to take place into the peritoneal cavity by way of the fimbriated end of the tube; an interesting case of this kind is reported in the present issue of the *Practitioner*.

Previous to 1881 cases of this accident were almost always fatal, and if diagnosed no attempt was made to save the patient's life. In the summer of that year Mr. Hallwright, of Birmingham, asked Lawson Tait to see with him a case which he had diagnosed as probably hæmorrhage into the peritoneal cavity from a ruptured tubal pregnancy.

The patient was blanched and collapsed, and the uterus was fixed by a doughy mass in the pelvis, and there was clearly a considerable amount of effusion in the peritoneum with no distinct tumour to be felt above. Lawson Tait agreed with the diagnosis. Mr. Hallwright suggested that the abdomen be opened and the ruptured tube removed, but this Tait refused to do. The patient died and the *post mortem* confirmed the diagnosis.

Lawson Tait was called to his next case in June, 1883, by Dr. Spackman, of Wolverhampton. There was no doubt as to the nature of the case, and as the patient was clearly dying of hæmorrhage, laparotomy was performed and a foetus about the twelfth week was found lying amongst masses of clots and coils of intestine, and to these

latter the partially extruded placenta had obtained new attachments; these he cautiously separated and occasioned fast and copious bleeding. He wasted so much time in trying to stop the hæmorrhage that by the time the operation was finished the patient was practically moribund. She died shortly after being got back to bed.

This naturally was a bitter disappointment to Tait. Instead of achieving a great triumph he had only a failure, but on thinking over the case he soon came to the conclusion that the true method of operating in such a case was to separate adhesion, rapidly, make at once for the source of bleeding, the broad ligament, tie it at its base, and then remove the ovum, *débris* and clots at leisure. During the next five years he operated on forty-two cases with one death, and this treatment is now universally adopted.

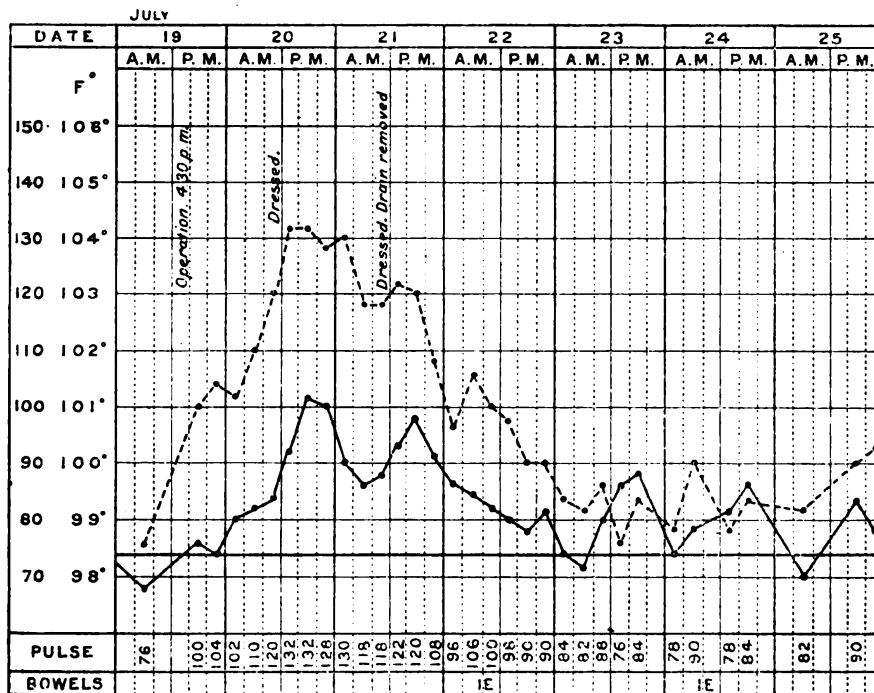
Now to come to my own cases; the first case was clearly the result of inflammatory trouble, most likely of gonorrhœal nature; the second may owe its origin, I am inclined to think, to damage done by an attack of appendicitis.

Mrs. E., wife of a labourer, married at 19. First child a girl, born three months after marriage in October, 1899, at full term, alive at present time. Second child, born twelve months later, premature, lived fourteen days. Third child born dead (about six months) the following year, 1901. Fourth child still-born (about six months) in October, 1902. In December, 1902, was admitted under my late colleague, Dr. Madden, curetted, and the torn cervix repaired in January, 1903, by Dr. Burford. Fifth pregnancy terminated prematurely at six months, dead twins being born in the following July. Sixth child, born in October, 1904, still living.

On July 1, 1907, the patient was seen by Dr. Madden. She was complaining of great pain in hypogastrium through to loins, with difficulty in sitting up in bed. Briefly, the history was, that she had been regular till May, the last menstrual period ending May 9; the June period had been missed. A "miscarriage" had taken place on July 6; she had passed a membranous skin and some clots. On July 11 a brownish discharge commenced with severe aching in the right side. She was admitted to the Phillips Memorial Hospital, a note on her card being to the effect that the right ovary was hard, very tender, and prolapsed. Rest in bed, hot douching, &c., gave some relief,

but suddenly during the morning of July 19 she complained of awful pain in the abdomen and became collapsed.

I saw the patient at midday with Dr. Madden, and we agreed that internal hæmorrhage was going on, and telephoned to Dr. Burford to come down and operate without delay. This he did early in the afternoon, by which time the patient was blanched to a degree; she was conscious and able to answer questions, but no radial pulse could be felt. Before opening the abdomen intra-venous saline transfusion was begun, this was continued during the operative procedure and 4½ pints were thus introduced into the



circulation. On opening the abdomen a gush of blood occurred and a large quantity of clots was removed from the peritoneal cavity. The broad ligaments were examined and the source of hæmorrhage found to be a ruptured tubal swelling on the right side. This was ligatured and removed, leaving the ovary intact; the pelvis was well sponged of clot and the peritoneal cavity washed out with sterile water, and the abdomen closed in the usual way. At the conclusion of the operation the radial pulse was of normal volume and of regular rhythm, beating 98 to the minute; so by the aid of transfusion the radial pulse, completely wanting before operation, had been fully restored,

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and the patient enabled to go through a critical operation which would otherwise most likely have proved fatal. The patient made a perfect recovery, and though the temperature and pulse-rate rose the following day they soon came down, and the patient was walking about within a month.

On examination of the parts removed they were found to consist of the Fallopian tube, distended near its uterine end to the size of a walnut, distended with clot and containing a small embryo; the gestation sac had ruptured, which was the cause of the extravasated blood (*vide* specimen exhibited).

It might be noted how small the gestation sac was, and therefore how early a tubal pregnancy is capable of endangering the life of the woman. This patient had only missed one period. A second point of importance is the history of a miscarriage, a missed period, a brownish discharge and the passage of some shreds of membrane. These, together with pain are the common characters of an ordinary abortion, and yet in this case this was not so, and reliance on the history very misleading. It is interesting subsequent history that the patient became pregnant again last year for the eighth time, and was delivered of a stillborn child at about the sixth month in September. I saw her a few days ago and she expressed herself as being in better health than she ever remembers.

Mrs. C. M. W., aged 39.

*Previous History.*—At 18 years was in bed for four to six weeks with “neuralgia all over,” pain most acute in abdomen about the umbilicus. At 36 was operated upon in Aberdeen and the appendix removed. Married 1907. I first saw the patient in *June*, 1908. She said she had got chilled, pains in back and shoulders, some nausea; menstruation regular, a few days early.

*November 3.*—Some nausea half-hour after meals, some aching and discomfort in lower abdomen. Since *June* menstruation getting less, five to six weeks between last period, very scanty.

*November 6.*—Menstruation came on naturally, stopped next day.

*November 8.*—Dark brown discharge lasting twenty-four hours.

*November 9.*—Went to Hindhead.

*November 11.*—During evening had abdominal pain while trying for an action of the bowels.

*November 12.*—Went out for a good walk.

*November 13.*—Again severe pains while straining at stool, vomited and almost fainted. A local doctor was called in and said she was pregnant, but attributed the pain to fissure of the rectum.

*November 16.*—She returned home by rail and I saw her the following day. I passed my finger easily into the bowel without any pain to the patient. The uterus seemed normal in size, but somewhat pushed over to the left side, and on the right side an indefinite swelling the same side as the former operation. Next day the bowels acted well by enema; there was some slight tenderness in the right flank, but the lady was up and about the house.

*November 20.*—At 6 a.m. a brownish discharge came away from the vagina, followed by severe colicky pains, vomiting several times, rather worse as the day advanced, increased by enema and aggravated by lying on the left side, but towards evening she felt much better and passed a fairly good night. By morning the pain was much less and she could turn in bed without much discomfort. Temperature 99° F.; pulse 80.

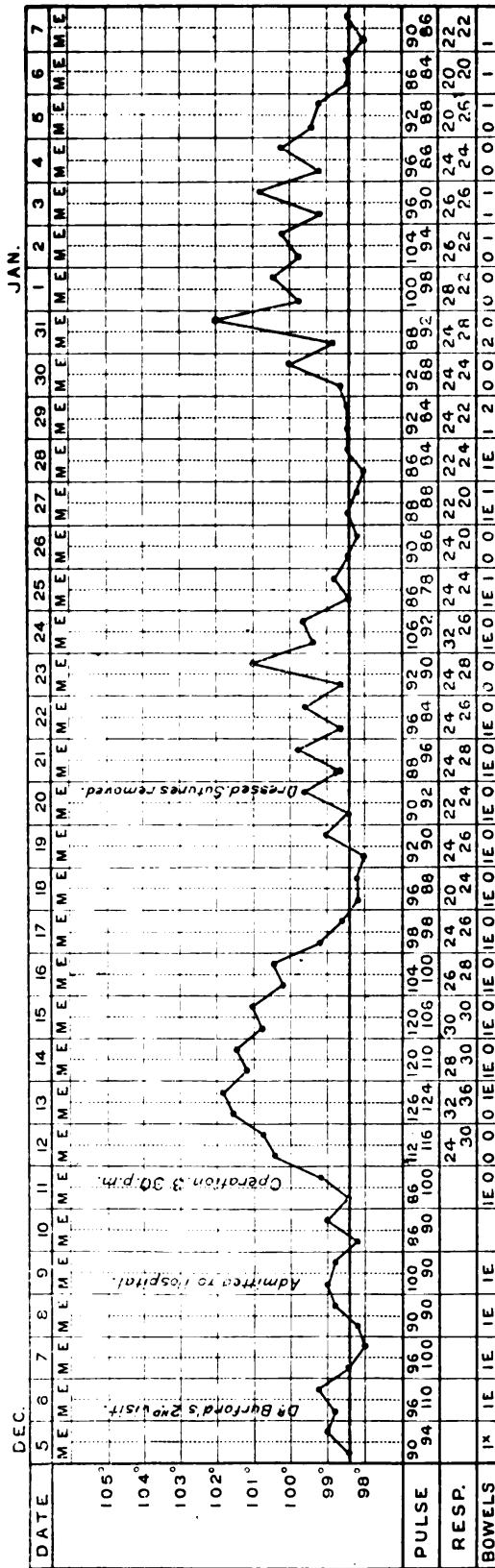
*November 22.*—Chilly sweat in early morning, rather more pain increased by micturition; some sickness.

*November 23.*—Dr. Burford came and saw the lady with me, and I cannot do better than give you in his wording what he found. The temperature 99.2° F.; the evening before pulse 78. "Abdomen was sensitive to touch and pressure but not distended, the uterus was displaced to the left side, bimanually was obviously empty and of average dimensions. The pelvic floor was rigid, indicating plastic effusion. The tender abdomen, the stiffened pelvic floor, the nulliparity of the patient, rendered detailed physical examination without anæsthetic a matter of special and peculiar difficulty. Strict rest in bed was enjoined, and a tubal swelling as a nucleus of the pelvic enlargement diagnosed."

*November 25.*—Patient continued much the same, the pain and tenderness extending to the opposite side.

*November 29.*—Had an attack of severe pain, seemed collapsed and pale; pulse 80, weak; pain shooting down inner side of both thighs and into vulva.

*December 5.*—Menstruation, due yesterday, began this morning early. About 8 a.m. another attack of pain, more collapsed than before; pulse hardly countable, about 120 per minute, vomiting several times. I gave hypodermically  $\frac{1}{4}$  grain of morphia, and as the vomiting was persistent began rectal feeding.





As the patient was getting steadily worse than better, the attacks of pain becoming more frequent and more severe, I again asked Dr. Burford to come down and see if he did not think surgical interference advisable. He came down the following day, and the necessity of an abdominal operation was impressed on the patient and friends. The next few days were utilized in preparation for the operation. Rectal feeding every second hour, small quantities of champagne by the mouth and the use of strychnine improved the condition of the patient markedly, so that on December 9 she was conveyed in a St. John's ambulance to the Phillips Memorial Hospital, a distance of 3 miles. She stood the journey well, and the next day, December 11, seemed decidedly better; sickness had stopped, and a much better night was passed. On December 11 the operation was performed. About an hour before the arrival of Dr. Burford and Dr. Johnstone, three shreds of membrane were passed for the first time from the vagina. On opening the abdomen an extra-uterine gestation was found entirely roofed over by omental adhesions. The adherent tissues were separated, the fœtus and blood-clot removed, the tubal sac separated and ligatured, the abdominal cavity was irrigated with sterilized water, and the abdomen closed without any drain. No transfusion was required. For a few days the temperature and pulse were rather high and quick, but not for long. The greatest trouble was insomnia, a difficulty which had followed the earlier operation for the removal of the appendix, but the higher potencies of gels., acon. and ars. gave much better results than chloral, trional, &c. Nutrient injections were continued with diminishing frequency for four or five days and then stopped. A few days later an acute desquamative dermatitis set in, large pieces of skin, 3 and 4 in. in length, peeling off: this prolonged her stay in hospital, but she returned home the second week in January of the present year. On her return from a visit to the seaside she resumed the ordinary routine of life and keeps well at the present time.

This case at the time presented many difficulties and caused not a little anxiety. The fact that the catamenia had never stopped obscured the possibility of pregnancy. Although the question of ectopic gestation was raised and discussed at our first consultation, yet the signs and symptoms were too inconclusive to warrant an exploratory operation until late in the history of the case.

I think this is a good illustration, in comparison with the first one, how one should have one's mind open to the possibility of such a serious condition being present, and yet most of the classical signs and symptoms of the textbooks be absent.

I believe it is a good rule, that when in doubt "assume that a woman is pregnant until it is proved that she is not." To which I would add, "In case of sudden pelvic pain assume the probability of tubal pregnancy until the possibility of that is excluded."

When I was asked to write this paper I was told it should occupy fifteen to twenty minutes in reading, and when I prepared it I was under the impression that another paper would occupy your attention this evening, but on receiving the notice of this meeting I found I was expected to keep the ball rolling all the time. I trust you will therefore be lenient with me and forgive the scrappy nature of this paper. It was only intended to be what it was entitled, "Notes of Two Cases of Tubal Pregnancy," but I have little doubt that those two pegs will be sufficient to start the discussion, and that others better qualified than I am will give us the result of their experiences. I then shall feel that I shall have achieved what I intended, namely, a good discussion, which I consider is the chief interest of these meetings.

Dr. BURFORD said that, as Dr. Thomas had justly remarked, to Lawson Tait belonged the credit of demonstrating that extra-uterine gestation was practically always tubal gestation: and the proper treatment at once indicated itself—tie the bleeding vessels and remove the ruptured mass. Before this discovery, the lives of millions of women had been sacrificed for lack of this definite knowledge and that consequent procedure. The clinical history of so many of these cases had been studied, and a certain sequence of symptoms obtained, that the diagnosis tended to become cut and dried and but little account was taken of the atypical cases not on the lines of use and wont. Such an one was that so accurately described by Dr. Thomas, where the precise interpretation of the syndrome was in doubt until abdominal section gave the direct evidence necessary. The condition of the patient so obviously required operation that this course was followed as a

remedial measure: the precise determination of the diagnosis coming as an accessory.

He (Dr. Burford) had had other atypical cases of tubal gestation in his experience, notably one of extraordinary rarity, where the pregnancy was bilateral and synchronous. Another was an uncommon case where in conjunction with Dr. Wheeler the condition had been diagnosed and operation successfully carried out before rupture—thus enormously adding to the safety of the patient. Another case was that of a lady of his acquaintance who had not missed a period, did not know she was pregnant, rose in the morning as usual, suddenly became collapsed, was hurriedly operated on for internal hæmorrhage, due to tubal gestation, and died the same evening before he (Dr. Burford) could be communicated with.

The thanks of the Society were due to Dr. Thomas for the narration of his cases.

Dr. CASH REED (in the chair) said that in the first case mentioned in Dr. Thomas's exceedingly interesting and lucid paper he spoke of hæmorrhage going on until death occurred. Hæmorrhage might not be extreme enough necessarily to induce death. It had always been a puzzle to him why, in the case of extra-uterine gestation, one sometimes got hæmorrhage into the abdomen and sometimes through the vagina. It appeared to him that the explanation was that the blood flowed naturally in the line of least resistance, and that it got into the vagina when it could not get into the peritoneum. He would like to ask whether it was the custom of his colleagues to operate immediately after bleeding was known to have occurred? He asked that question with some hesitancy, because it was not the practice of all gynecologists to do so. Some preferred to wait until there was recovery from the shock, or possibly longer, and until another hæmorrhage had made the condition more obvious, and until the shock of the second hæmorrhage even had passed away. There might be cases in which the delay was too long. The collapse which occurred when hæmorrhage had taken place into the peritoneum was quite out of proportion to the amount of the bleeding. The bleeding might be extremely slight and the collapse might be very great. The vomiting and the pulse and the facial expression might lead one to think that the condition was almost beyond aid, though the hæmorrhage had not been enormous. This might be due partly to the temperament of the patient and partly to previous illnesses. He should like to ask what was the amount of bleeding in the first case mentioned in the paper? The cure of that case was extremely

gratifying. The writer also spoke of the uterus being found of abnormal size, accompanied by a lump in the fornix. One should not pay too much attention to the size of the uterus for diagnostic purposes, because in ectopic gestation the uterus was often greatly enlarged in sympathy with the gestation which was going on in its immediate vicinity. Mention had been made of strychnine. He had a belief in strychnine, but in some cases digitalin might do more good in conjunction with saline transfusion into the rectum or into the veins. What they did in Liverpool when they saw a case presenting, broadly speaking, the features which had been referred to, was to take it into the hospital and wait events. When there was a tender lump in either fornix, and a "missed period" and subsequent hæmorrhage, there was an obvious doubt as to whether one was dealing with extra-uterine pregnancy or not. A case of that kind was taken to our hospital to-day, and will be watched.<sup>1</sup> In two or three cases in which the abdomen had been opened, though a positive diagnosis had not been made, it had turned out that there was such a condition as they had been dealing with that evening. Reference had been made to pain in the Fallopian tube, and it had been said to be due to contraction of the tube. He could not help thinking that it was much more probably due to the fact that a localized peritonitis had been set up, and not to colic of the Fallopian tube. There was a case on record relating to the wife of one of their colleagues, who had an extra-uterine gestation and who declined to be operated upon. The sac ruptured and the foetus was extruded, and the patient had a most terrible illness, but she recovered. Two or three years after the occurrence the husband was frightened that the same condition had occurred again. There was a "missed period" and a lump in the right fornix, irregular in outline, and with a great many adhesions, and, apparently, rupture of the sac. He (the President) was telegraphed for, and he told the husband that he did not think that it was a repetition of what had occurred previously, but that he believed that if certain measures were adopted the period would recur. Two or three days afterwards the report came that the lady was well again. He did not doubt that the physical signs in the second illness were really what remained of the former event.

Dr. EADIE referred to Dr. Thomas's recommendation "When in doubt assume pregnancy." A case which he had had was that of an unmarried woman who had had one child and was suddenly

<sup>1</sup>This turned out as anticipated, "an ectopic" was operated on, and has made an excellent recovery.

taken ill with abdominal pains and vomiting. The patient became more and more collapsed, and was admitted to the hospital. Her medical man was under the impression that she had a gastric ulcer; she had suffered from dyspepsia. Dr. Ham and he suspected ectopic pregnancy, and they made very careful enquiry whether there was a possibility of it, but the woman denied it. Dr. Ham and he (Dr. Eadie) then thought that there might be gastric ulcer, and they operated for it, but they found that ectopic pregnancy was the real condition. This was a condition which it was difficult to diagnose, and he believed that he had seen more cases of it wrongly diagnosed than diagnosed correctly.

Dr. JOHNSTONE congratulated Dr. Thomas on his interesting contribution. He said that perhaps those medical men who did not operate, and who looked into the abdomen for the first time and saw a quart or two of blood, did not appreciate the situation. But it was a matter of extreme gratification to the surgeon to find a case of tubal gestation when he opened the abdomen. There was an enormous quantity of blood, and the subsequent operation went on satisfactorily. The difficulty of the case was, of course, the diagnosis. Nowadays the abdomen could be opened without any risk. The existence of previous sterility had long been held to be a symptom common to many cases of ectopic gestation. He knew several cases in his own experience in which that symptom applied. A case of his own had one child shortly after marriage, and, about ten years afterwards, no child having been born in the meantime, she complained of abdominal pains. Those were overlooked, but in a week or two they returned. She was put to bed, and had a severe collapse, owing to severe hæmorrhage. A surgeon was called in, and he diagnosed extra-uterine pregnancy. This happened twelve years ago, when, unfortunately, there was a vogue for sparing women from mutilation by an abdominal incision; and, therefore, the surgeon determined to operate *per vaginam*. The fœtus was removed and the tube was removed, but the lady died twenty-four hours after the operation of secondary hæmorrhage. The vaginal operation was a very difficult matter in any case, because the surgeon would not find the numerous adhesions, and there was great difficulty in securing the main vessels unless they could be seen. It was almost impossible to get at large vessels which could not be seen. The abdominal route was the most useful one to adopt. The President had remarked that a great amount of shock did not necessarily denote great loss of blood. In a case which he had twelve years ago the patient had repeated shocks, a total collapse, loss of blood, and blanched

appearance. Each shock was of the same intensity, and in each case she recovered after a few hours. This occurred four or five times, and at last the decidual membrane was passed *per vaginam*. In that case the bleeding had been very extensive and had been going on for a fortnight. Great clots of blood were found about the liver and the spleen and the stomach. Gore drains were put in to ensure the rapid elimination of the blood. The woman had since had a child, and she was now well.

Dr. NEATBY said that Dr. Thomas had brought before them a very important subject. It dealt with a situation with which any of them might be brought face to face in a moment. It was of extreme importance that they should be able to recognize the condition. The early cases had of late years attracted considerable attention. It was of these cases that the most certainty of success could be predicated if they could be diagnosed. In Dr. Thomas's first case the treatment would be "plain sailing" after the diagnosis had been made. Mr. Hastings Gifford had written several interesting papers, which appeared in the *Lancet* on the occurrence of early rupture in extra-uterine gestation, and those papers first drew his (Dr. Neatby's) attention to the subject. He thought that they might now say that the date of the extra-uterine gestation and the amount of hæmorrhage were not by any means proportionate or parallel. The explanation was that the growing chorionic villi penetrated into the tissues. The ovum burrowed and became embedded, and there was actual erosion taking place. When he was studying the subject of chorio-epithelioma, on which he had read a paper before the Society, that point came very conspicuously before his mind, and it also came before his eyes in one or two excellent slides which he happened to possess. In those slides one could see the villi eating their way to the very surface of the tubal wall, and, in some cases, the actual peritoneal membrane had given way before the erosive action of the villi; so that in some cases it was an erosion and not a rupture which took place. The question of waiting had been alluded to. He thought that in the second case which Dr. Thomas had detailed it was an entirely justifiable procedure to wait, not necessarily because one had any doubt as to the diagnosis, but because it had been shown that many of the cases, instead of terminating fatally, ended in spontaneous recovery. Of course, the difficulty was to decide in any given case whether it was a case in which waiting was justifiable or not. It would be difficult to lay down any definite rule. Dr. Champneys had described a great many cases of pelvic hæmatocele which were

undoubtedly due to extra-uterine gestation, and in which recovery took place. Operators had no doubt seen cases in which, when the abdomen had been opened for other reasons, they had found signs of there having been extra-uterine pregnancy which had been recovered from without operation. The explanation was that they had a tubal mole, and that rupture might take place from the sac that had been formed from the wall of the tube into the lumen of the tube, and hæmorrhage had taken place at the unclosed extremity of the tube. The President had alluded to the use of drugs in shock. In such cases, he (Dr. Neatby) was not inclined to rely upon drugs at all, and he should not think that there was much to choose between strychnine and digitalin. He thought that ergot was a better drug, and opium better still. He thought, however, that a saline infusion or transfusion was to be relied upon mainly in such cases. As to the proportion between the degree of shock and the amount of hæmorrhage, they had all seen cases of bad shock with little hæmorrhage; but he knew of a case where there was very little shock and very much hæmorrhage. In the operation it was found that the hæmorrhage was in the broad ligament. The hæmorrhage was so considerable that it appeared to fill the pelvis and extend a considerable way into the abdomen. It was diagnosed before operation as being a very large pelvic hæmatocele. The patient was in a great deal of pain, but not in a condition of shock. An interesting feature which he had noticed was the association of ovarian cyst with extra-uterine pregnancy. He had noticed this on two occasions, and Dr. Thomas's paper gave another example of it. In one case he found the ovarian cyst on the opposite side, or, as one might say, on the wrong side. In the other case the ovarian cyst and the extra-uterine gestation were on the same side. He thought that the history of the patient in cases of extra-uterine gestation was of less importance than had once been supposed. The cases in which there was definite evidence of previous salpingitis were in a very small proportion. They really did not know what was the cause of the ovum being arrested in the tube.

Dr. PERCY PURDOM said that just before he left Guy's he saw the case of a woman who came to the hospital with symptoms of acute abdominal pain, in which the question of tubal pregnancy was discussed and was put out of court by the staff; but the abdomen was opened, and it was found to be a case of ruptured tubal pregnancy after all. She had had three children within five years, so that the question of sterility was not present; and the menstrual periods had been perfectly regular up to the time

of admission. Hence there was an absence of all the classical symptoms of ruptured tubal pregnancy. He had also met with a case of ruptured tubal pregnancy in which the uterus—examined *post mortem*—was of the size of a five months' pregnancy, although it is generally stated that in ectopic pregnancy the uterus does not grow to more than the size of a three months' pregnancy.

Dr. WYNNE THOMAS, in replying to the discussion, thanked the speakers for the kind remarks which they had made upon his paper. The President had doubted the advisability of operating very soon after hæmorrhage. He (Dr. Thomas) thought that the operation which he had described in his paper in connection with one of the cases did not take place at all too soon. If he had allowed the patient to go on many more hours it would have been too late to operate. He agreed that it was difficult to decide the point at which the operation should take place—one could not tell the size of the vessel that was bleeding. Of course, the larger the vessel the greater would be the hæmorrhage and the sooner would the patient die if left alone. It was only by carefully watching the patient and the amount of collapse that one could come to a conclusion as to the time to operate. Perhaps the injection of  $\frac{1}{4}$  grain of morphia might be useful in some cases in helping one to come to the conclusion whether the shock was due entirely to hæmorrhage or was out of proportion to the hæmorrhage. A saline infusion—not into the veins directly, but injected into the rectum—might be useful in temporizing. Dr. Neatby had discredited a history of sterility as being of any use in helping the doctor to come to the conclusion as to whether a patient was subject to ectopic gestation or not. He believed that ectopic pregnancy was very, much more frequent than was formerly supposed to be the case; but he thought that the case of which he spoke, where the woman was repeatedly having miscarriages, would weigh down the balance in favour of tubal pregnancy. Dr. Johnstone had spoken of a case in which a woman had repeated hæmorrhages for fourteen days. The amount of blood which a woman might lose in the abdominal cavity without dying was extraordinary. He believed that in many cases of tubal pregnancy there were only slight hæmorrhages which cleared up without going any further, and that the foetus became absorbed. He (Dr. Thomas) thought in that case the hæmorrhages were at no time very profuse.

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A MEDICAL MISCELLANY.<sup>1</sup>

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

*Physician to the Hahnemann Hospital, Liverpool.*

ON March 17 last a meeting was held in the Mansion House, London, to inaugurate a fund which it is hoped will be liberally subscribed to throughout the length and breadth of the country, and will be administered on an equally broad and comprehensive basis for the promotion, academically and practically, of homœopathy. This meeting was the outcome of the activities of the British Homœopathic Association, and was rendered possible through the interest and countenance which Alderman Sir George Wyatt Truscott, the present Lord Mayor, has taken in homœopathy and in the work of the British Homœopathic Association. I think that this meeting deserves more than a merely passing notice at our hands, and that it is desirable that we should decide what attitude we are to adopt towards it. I imagine it is possible that some of us, whilst in sympathy with the avowed object of the meeting, may nevertheless be inclined to the view that it will tend rather to hinder than to promote the best interests of homœopathy; that the financial support which it is hoped will be obtained by this means will be more than balanced by the umbrage and affront with which the orthodox section of the medical fraternity will regard such propagandist efforts. There is no doubt that the meeting will cause a considerable stir in the medical world, and it is probable that the flood-gates of editorial wrath and scorn will once more be flung open, and much more or less unmeasured contempt poured out upon what is to the average editor a discredited, if not discreditable, heresy. It will be interesting to see the literary output which will result, and how the critics will regard this evidence of vitality and vigour in a system the decease of which Oliver Wendell Holmes long

<sup>1</sup> Presented to the Liverpool Branch, April 8, 1909.

since foretold. But I doubt whether the merits of the question will receive the calm, judicial examination which one would imagine the importance of the subject fully warrants. Instead, I fear emphasis will be laid upon the sectarian character of the meeting, and probably some very hard things will be said of the action of the British Homœopathic Association, or rather of the medical men associated with that body, in countenancing a movement which has for its object an appeal to the public on behalf of a system which is under the ban of professional ethics, and the practice of which is still officially regarded as a breach of professional conduct. Apart, however, from the merits of the "pathy" advocated, the principal indictment which will be brought against the medical promoters and abettors of the meeting is this: that the purpose of the meeting is propagandist. This means, bluntly speaking, that the medical men attending the meeting are thereby advertising their own wares, so to speak, in a way which is discreditable to them and derogatory in a professional sense. There is, of course, no combating the element of propagandism which is present, but that element should not be emphasized apart from the context of the movement, the saving clauses in which are, firstly, that the "pathy" which is to be promoted, though openly avowed by a comparatively select body of medical men, and practised more or less by all, is not in any sense a secret method; and secondly, that one of the main planks—in fact, the main plank—in the propagandist programme is the further diffusion of an intelligent knowledge and appreciation of the method amongst the rank and file of the profession, many of whom already practise it, though unwittingly. To my mind, attendance at this meeting was no more derogatory in a professional sense than attendance at a meeting promoted by the Cancer Research Fund or the National Society for the Study and Prevention of Tuberculosis. I think I am correct in saying that meetings have, within the last year or two, been held at the Mansion House in furtherance of the work of these two societies. I do not recall that there was any

outcry against the experts who have made and are making these special diseases their life-study for attending these meetings and addressing them, though the appeals which were then made to the general public were for funds to carry out further researches in these diseases, from the treatment of which the speakers themselves derived probably the larger portion of their professional income. Such actions on the part of the foremost members of the profession pass muster without comment, though the element of notoriety and possible financial return attaching thereto might very well be construed by carping critics as constituting unethical self-advertisement. What is permissible to the leaders of the profession may, I hold, be permitted to the rank and file, even though, as in this instance, the financial benefit may seem to bulk more largely. Personally, I hold that such meetings, allopathic and homœopathic, have a legitimate sphere in medical polity, and I consider that we should not withhold our support, in this instance, if we honestly believe that homœopathy is capable of rendering great benefit not only in cancer and tuberculosis, but also in all the ailments that flesh is heir to.

I have already pointed out that one of the principal objects to which the Fund which is being inaugurated is to be applied is that of helping, by various means, to increase the number of avowed adherents of homœopathy amongst medical men. The ranks of homœopathy sadly want recruits; a fact that is very plainly evidenced in the difficulty which obtains in securing adequate staffs for our hospitals and dispensaries. I have often wondered, not so much at this difficulty as at the fact that recruits are forthcoming at all. Students come and graduates go, but from first to last of his curriculum the average student never hears of homœopathy. He graduates for the most part ignorant of the term, not to mention the principle for which it stands. It is only through fortuitous circumstance that attention is, in a few scattered instances, drawn to the fact of the existence of a principle in therapeutics, and it is still more seldom that the circumstance is strong enough to arouse sufficient practical interest to determine a course of

study and investigation of what is, in the mind of the profession generally, an object of suspicion and derision. This is a condition of things which it is hoped may, as the result of the meeting, be gradually done away with. Whatever may be thought of the various schemes propounded for so doing, none can deny the advisability of making the attempt to alter the present order of things. The method which I think ought to be utilized is to secure for our philosophy of cure a wider circle of acquaintance. For this purpose I would suggest that a short summary of Hahnemann's "Organon of Medicine," couched in the language of the day, should be drawn up and published and brought to the notice of the allopathic section of the profession.

The question of how to bring about this introduction is one which primarily concerns us. I should say that it is in this department of the forward movement that we medical men can render our most efficient service, through individual effort to interest those of our fellow-practitioners of the opposite persuasion whom we think would be likely to be open to investigate the subject if thus laid before them. I was pleased to see that this plan for disseminating a knowledge of Hahnemann's tenets was one which had commended itself to the British Homœopathic Association. This is evidenced by the announcement, in this month's journals, of a course of four lectures on Hahnemann's "Organon of Medicine," to be given by Dr. J. H. Clarke, at Chalmers House, London. I imagine that comparatively little practical benefit will attend the delivery of this series because, no matter how good they may be, they will, in all probability, be delivered to audiences composed in the main, if not entirely, of homœopaths. But if, as I hope will be the case, they are published and made available for distribution, probably by medical men amongst their allopathic *confrères*, then I think that they should play a very important part, not only in propagating a knowledge of homœopathy and what it claims to do, but also in securing a large accession of those recruits which at present we stand so much in need of.

I should like to point out what are some of the main points which such a treatise, to fulfil its function as a proselytizing agency, should contain. You notice the adjectival phrase employed and will not, therefore, anticipate anything like a full and detailed statement of homœopathic philosophy in what is to come.

In the first place, I should lay special emphasis upon Hahnemann's contention that in every individual patient the totality of the symptoms—by which is meant all the changes in the health of the body and of the mind, whether felt by the patient, remarked by those around him or observed by the physician—constitute the disease in its whole extent, and that the removal of this totality of symptoms constitutes the cure of the patient, which, as Hahnemann pertinently remarks, is the one and only mission which the physician has to fulfil. I must admit parenthetically that this definition is not one which is calculated at first sight to commend itself very favourably to men who have hitherto failed to grasp the significance which the individuality of the patient imparts to the disease from which he is suffering, and who have in consequence come to regard the physical signs and symptoms as constituting the disease in its entire extent. Nevertheless, this doctrine of the totality of the symptoms must be insisted upon, as it lies at the foundation of any homœopathy worth the name.

In the second place, attention must be drawn to Hahnemann's method of determining the properties of the remedial agents to be used in the curing of disease. His method was that of provings; he held that the only efficient way of determining the curative properties of any drug was to test it experimentally on healthy people, the results of the experiments conducted on a large scale exhibiting the potentialities of the drug under observation. This method was a novel and strikingly original one in Hahnemann's day, but it has now become recognized by some of the foremost authorities of orthodox medicine as being *par excellence* the correct one.

Lastly, the problem which Hahnemann discusses at

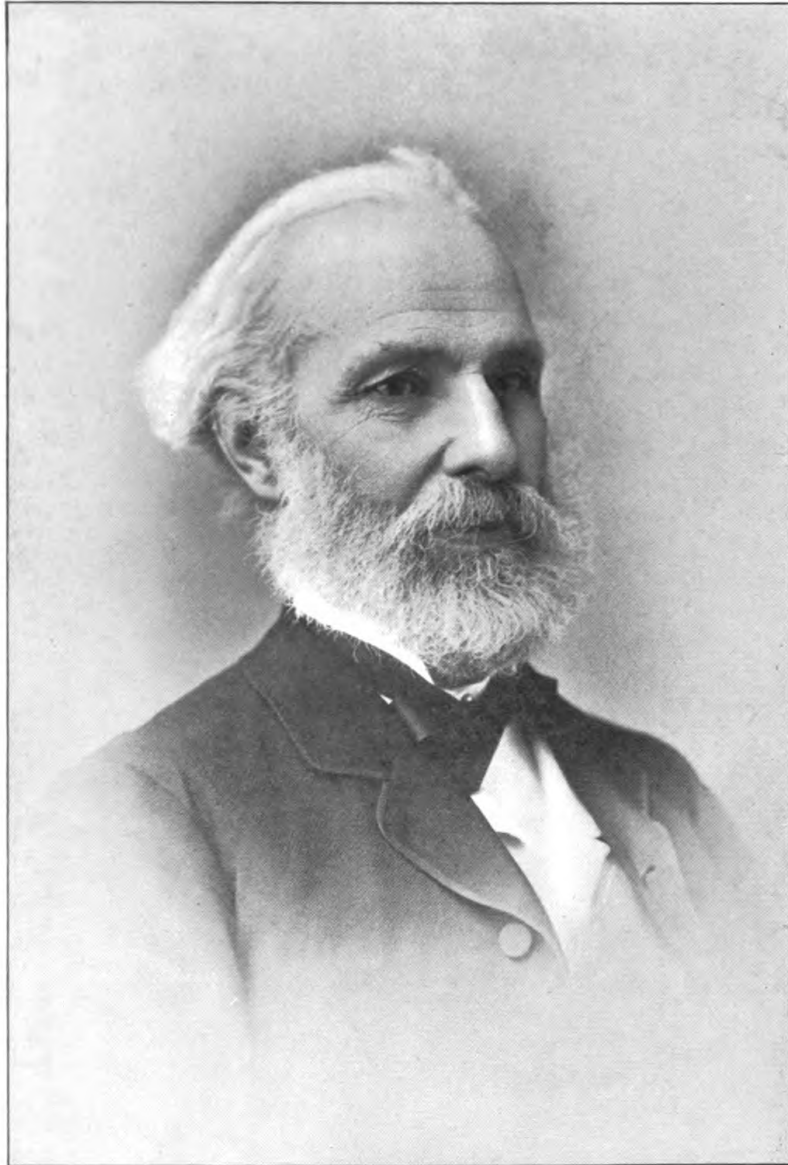
length, of how to apply what is known of the curative properties of drugs to individual cases of disease, would necessarily bulk largely in any synopsis of Hahnemann's "Organon."

In this connection it is interesting to note that quite a number of leading allopathic authorities can now be quoted in favour of Hahnemann's contention of over a hundred years ago. It is true that these men, as, for example, Pasteur and von Behring, only recognize the truth of the maxim *similia similibus curantur* in certain isolated instances, but such confirmative discoveries are of the utmost value in furtherance of homœopathy.

One other point to which I would draw attention is that of dose. To my mind the important element to emphasize in connection with the question of the dose would be this: that the evolution of the small dose, so long a stumbling block and subject for derision, was the product not of Hahnemann's diseased imagination, but of hard experimental and clinical investigation. Here, again, modern medicine offers an illustration exactly analogous. I refer to the evolution which tuberculin as a remedy in allopathic hands has passed through. The editorial in the *Homœopathic Review* for February, referring to Dr. Burnett's prediction regarding the allopathic use of this remedy, is worth quoting: "Koch and his world-famed remedy have come and gone; but they will return again anon and . . . remain, only the dose will get smaller and smaller until the long-condemned homœopathic dilutions will acquire the rights of citizenship in the universities of the world." Such was Dr. Burnett's prediction in 1891, and the truth of it has been substantiated in a recent paper appearing in the *Lancet*.

The fact that allopathy is in many such instances re-discovering the truths and practices of homœopathy by methods of its own devising, necessitate to my mind the need for us to do all we can to make known the underlying principles of it, seeing that much of the work of allopathic investigators is limited in its scope through their inability to clearly recognize the principle of cure which their





**ARTHUR CROWEN CLIFTON, M.D.(Hon.), M.R.C.S.Eng.**  
(Born 1825 ; Died February 16, 1909.)



discoveries involve. What is wanted, therefore, is a concise summary of the main truths upon which *similia similibus curantur* as a law of cure is based. It remains to be seen whether the forthcoming lectures by Dr. J. H. Clarke will provide what is needed. If so, doubtless they will be published by the British Homœopathic Association.

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ARTHUR CROWEN CLIFTON.

A BIOGRAPHICAL MEMOIR, WITH LIST OF PUBLISHED  
ADDRESSES, PAPERS, &C.

BY GEORGE CLIFTON, L.R.C.P., J.P.

ARTHUR CROWEN CLIFTON, M.R.C.S., M.D. (Hon.) New York, was born at Guilsborough, Northamptonshire, December 22, 1825. He was the eldest son of Samuel Clifton, a well-known draper and grazier in Guilsborough, who established the principal business in the village. Samuel Clifton was a staunch Nonconformist who, standing firmly to his religious convictions at a time when a dissenter was anathema, became at that time one of the most respected leaders of the district. Religiously, socially and politically, both churchmen as well as dissenters, parties of all grades of thought, sought his advice and guidance.

He was the principal deacon of the Baptist Church for over half a century, and an intimate friend of the leaders of Nonconformity at that period. I remember with what delight he spoke of his connection with Miall, Robert Hall, Mursell Griffiths, Rosevelt Hawkes, the Edmonds and the Baines, of Leicester. These were all cultured men having at that time a great influence on the religious and political world. The father of Dr. Hawkes, of Liverpool, was a minister for some years in the Guilsborough Baptist Church.

From his mother's side—who was the daughter of William Harris, a worthy, well-known Calvinistic Baptist

—Arthur Clifton inherited his strong religious convictions, broadened in later years by his intimate connection with men of large views. Through his mother also he early saw a great deal of sickness and suffering. She was well known in the villages round as the wise woman doctor, ready at all times to apply her leeches or blisters, and did more than many busy physicians in doctoring all the mothers and babies in the district. One could therefore see how in his early life Arthur Clifton became imbued with strong convictions and aspirations which eventually developed into such a wide reputation as a general medical practitioner.

Later in life, Arthur Clifton delighted in telling the tales of his boyhood days; for instance, how he was deputed, when only about 10 years of age, to take his father's pony, early on a Sunday morning, to go half-way or more to Northampton, the County town, to meet the minister who was to preach at the local chapel. When he met the reverend gentleman he climbed down for him to have the saddle, and young Arthur had to sit behind on the crupper. On one of these occasions the minister told him he was going to preach from a favourite text, "Mark, learn, and inwardly digest," and proceeded to give the heads of his discourse. "Mark" came so frequently with "Mark that my boy," that the boy, feeling in his pocket and finding some chalk, whenever the word "mark" came made a cross on the good man's back. This occurred so often that when they arrived at the chapel, and the minister reached *terra firma*, the deputation awaiting him burst into fits of laughter, for his good broad cloth was covered with crosses. Arthur nearly got a good caning on his own back for this joke, but the minister forgave him and the matter ended. This was an early sign of the love of fun and adventure which permeated the web of Arthur Clifton's later life's strenuous nature.

From the dame school in the village he went to the endowed grammar school, where, besides learning the three R's he received a good groundwork in English and Latin, and became a good penman. Between his twelfth and

thirteenth years the village apothecary, needing a boy to wash bottles and go with him to take care of the horse and gig, singled out this lad and took him as an apprentice for five years. Here was laid the foundation of his enthusiasm in medicine, as in the latter part of this apprenticeship he became expert in the usual treatment of bleeding, blistering, inserting setons, and in the mixing of drugs. His master used to send him to visit many of his patients; he relates how he assisted at the amputation of a man's thigh when he was 15 years old, and attended his first midwifery case at 16 years of age. At this time he came in contact with both rich and poor; his master instilled into his mind that in diagnosing a case he should grasp all the idiosyncrasies of his patient, and he emphasized the importance of attaining success in treatment, and the difference between health and disease through knowing the individual. During most of this time the apprentice attended evening classes at the grammar school. His good penmanship showed the character of the young man and was very different from the writing of the medical professor of that time.

After his apprenticeship, his parents not being in a position to send him to study medicine, which he was most anxious to do, Arthur Clifton looked out for a situation in a druggist's shop, and went first to a druggist in Lincolnshire. He tells of how he crossed the country on the outside of the stage coach, arriving cold and starved, to be regaled on cold batter pudding with bacon in it.

From this situation he soon went on to Southampton. Here he nearly lost his life from pneumonia. Having bled others he now had to submit to a fair depletion himself, and from that time he resolved to find a better way of reducing fever. He went from Southampton to Manchester, to one of the leading chemists. Even here he could not abandon his strenuous life, as he had to take down the shutters at 8 a.m. and put them up again at 9 p.m., and worked for a half-day each Sunday. Thence he passed on to London, where he became the chief assistant to a well-known chemist in Holborn. Here he came under the

influence of such men as the Rev. Drs. Binney and Lynch, to whom he often referred with gratitude as having given him a higher and broader knowledge of Divine revelation.

When about 24 years of age he determined to start in life for himself as a chemist and druggist in Northampton, the county town of his village home. He opened a small shop in Bridge Street, where in a few years he worked up a business that began to keep him. Becoming enamoured of a young lady belonging to Northampton, and thinking that it would not cost more to keep two than one, he married his first wife—a Miss Harris: a very happy marriage for both of them. He had one son by this marriage, who is still living at Bedford. His wife died in 1880. After a time he married for his second wife a Miss Read, of Newport, Mon., who still survives him; she was the sister-in-law of the Rev. Arthur Murcell. Soon after Clifton's coming to Northampton, Dr. John Epps, of London, and Dr. Curie contested the Parliamentary seat for the borough in the Liberal interest, but they were both before their day in political and other principles, and were not returned. Dr. Epps was one of the early pioneers of homœopathy, as also was Dr. Curie, the father of Curie, of radium fame. Being a staunch Liberal, Arthur Clifton was brought into contact with Dr. Epps, who first opened his eyes to the truth of the law of similars. Dr. Epps lectured on homœopathy in Northampton, and so convinced the chemist that he later decided to adopt the system of Hahnemann. As the late Dr. Charles Pearce was then starting as a homœopath, Clifton invited him to come to Northampton. Notwithstanding the jeers and vituperation of friends and foes, Clifton removed to the principal part of the town and opened one of the best fitted pharmacies, with a bust of Hahnemann in the window. He was told by all his friends that this step spelt ruin and destruction. With Dr. Charles Pearce as physician, and Arthur Clifton as chemist, homœopathy soon began to revolutionize the neighbourhood; so much so, that both had to engage others to assist them.

After some years as a chemist, with still the early aspiration to become a doctor, Arthur Clifton sold his

business and went to University College Hospital, London, where, after the due course of study and examination, he took the qualification of M.R.C.S.Eng., coming back to Northampton a fully fledged medical practitioner. By Dr. Pearce, Dr. Rigg, and Mr. Clifton, a large homœopathic dispensary was formed, with branches in several of the adjoining towns. During these early years of pioneer work these men had the temerity to break through all orthodox rules of professional custom by bringing out a *Popular Monthly Record* of the progress of homœopathy in the country at large. In this production was described the varied forms of treatment of disease by the different schools of medicine, and with the permission of their patients, the record of cures of disease by homœopathy, which had failed under allopathic treatment, the medicines prescribed being added. When the General Infirmary of the town was in low water for want of funds, Dr. Pearce and Mr. Clifton wrote letters to the Governors, promising to raise funds to clear them from their difficulties if they would allow a proportion of their beds to be used for cases treated by homœopathic remedies. This the orthodox school, as usual, refused. But, not copying their opponents, the homœopaths always admitted the benefits of the infirmary, especially in surgical cases. A few years later, Dr. Pearce's health failing, and requiring a more genial climate than Northampton, he retired to the South of England, and the brunt of carrying on the pioneer work fell on Mr. Clifton for some years. He was ably assisted by Dr. Thomas, who afterwards went into Warwickshire and Chester; Dr. Brown; Dr. Craig, of Hanley; Dr. George Clifton, of Leicester; Dr. Wilkinson, of Northampton; and Dr. Ross. In the nineties, his health failing from an internal complaint—threatened cancer of rectum—he decided then to give up general practice and retired, finding in Dr. Ross a worthy successor.

Although retiring from practice he never lost his enthusiasm for homœopathy, ever being convinced that this system gave most relief in all diseases for suffering humanity.

For the whole of his professional life, whenever he was able, Dr. Clifton attended the meetings of the British Homœopathic Society, the London Homœopathic Hospital, and the annual Homœopathic Congress. His advocacy of the Congress was such that from the first meeting to the last which he attended he believed that these annual meetings were most useful to the cause, and did more to hold the men together than any other means. He had so much faith in the pioneer work of the London Homœopathic Hospital that he endowed a bed as an example to others who acknowledge, but who do not always show, their practical sympathy to the cause by such acts. The new British Homœopathic Association also had his entire sympathy and support.

At the zenith of his professional career he had as his patients very many of the nobility of the neighbourhood, such as Lord Lilford, Sir Charles Isham, Sir Henry Manfeld; and a great number of the leading clergymen of the Church of England, who while disliking the nonconformity of the man, yet loved him as their doctor and friend. The leading men of light and learning of the neighbourhood knew him as one true to the principles he advocated. To the general public he was a comrade in all difficulties, and to the poor and distressed a brother, ready in season and out of season to help to raise and encourage them.

In the religious and philanthropic work of the town of his adoption he was always to the front in his endeavours to raise the weak to strength; a staunch Nonconformist, yet with a great reverence for the Established Church and its ministers.

He was a fervid Liberal in politics. For many years he was the intimate friend of the Rev. John Turland Brown, the noted Baptist minister of College Street Baptist Chapel, and in his early life he was superintendent of a ragged-school branch of that church, and for some years he entirely supported a district mission nurse in the town.

In the homœopathic world of medicine he was a tower of strength. He was honoured by being made a Fellow

of the British Homœopathic Society, and President in 1898. He was also President of the Homœopathic Congress held at Liverpool in the year 1887. On his visiting America in June, 1876, with Dr. Richard Hughes, of Brighton, and Dr. J. W. Hayward, of Liverpool, as delegates to the International Homœopathic Congress, he was made an Hon. M.D. of New York, in testimony to his services in the cause of homœopathy.

Dr. Clifton was a voluminous writer in the *British Journal of Homœopathy*, the *Monthly Homœopathic Review*, the *Homœopathic World* and other periodicals, never failing to give his experience openly and aboveboard, advocating criticism, a bold enemy and a true friend. Many of his writings would bear reprinting; a list of them is appended.

During the last twelve years of his life, having retired from active practice, he took great interest in the welfare of all his old patients, and till the last week of his life was seldom without his pen in correspondence with his old *confrères* and his wide circle of patients and social and political friends.

When not writing he remained a voracious reader of all that was going on in the world. The last few months of his active life told on his advanced age, but ever his cry was, "*Nil desperandum.*" At last he succumbed to an attack of bronchitis, and was laid to rest in the grave of his first wife in the Northampton Cemetery.

At his request the following inscription was placed on the tombstone:—

First his wife's name and time of death.—"Also the husband of the above. Arthur Crowen Clifton, M.R.C.S.Eng., M.D. New York Hon., born December 22, 1825, died February 16, 1909, aged 83 years. Physician and Surgeon of this town for over forty years. 'He lengthened life and shortened suffering after the method of Dr. Samuel Hahnemann, the pioneer of Homœopathic Therapeutics.'"

At the funeral he was followed by a large concourse of his old friends and patients, representatives of the British Homœopathic Society and Association, also representatives of the allopathic medical men of the town, and

of his family by his only son and grandson, his two remaining brothers, and other members of the family.

ADDRESSES AND PAPERS BY DR. A. C. CLIFTON.

*The Homœopathic Record.* Published in Northampton. Conjoint Editor with Dr. Charles Pearce. Approximately from 1850 to 1869.

“On the Therapeutic Changes in General Medicine during the Victorian Era, their Meaning and Lessons to Homœopaths.” The Presidential Address at the British Homœopathic Congress held at Liverpool in 1887. Published in the *Monthly Homœopathic Review*.

“The British Homœopathic Society. Its *Raison d'être*, the Growing of Souls.” The Presidential Address to the Society in 1898-9. *Journal of the British Homœopathic Society*.

“On Agaricus,” and “Criticism of Dr. Sharpe’s Address” (at the British Association held at Nottingham). *Monthly Homœopathic Review*, 1866.

“Notes on certain Homœopathic Remedies, with Cases illustrative of their Action. *Æthusa Cynapium*, *Acalepha*, *Agaricus*, *Ambergris*, *Antimonium Crudum*, *Argentum Nitricum*, *Acidum Benzoicum*, *Baryta Carb.*, *Berberis*, *Borax*, *Causticum*, *Chelidonium*, *Cinnamon*, *Coccus Cacti*, *Croton Tiglium*, *Graphites*, *Kalmia Latifolia*.” *Ibid.*, 1868.

“Indications for the Use of *Chelidonium Magus*, *Kali Bichromicum*, *Hydrastis*, and *Sepia* in *Dyspepsia*.” *Ibid.*, 1873.

“Cases cured by *Elaps Corallinus* when other Remedies had Failed.” *Ibid.*, October, 1873.

“A Glimpse of Homœopathy in the United States.” *Homœopathic World*, 1876.<sup>1</sup>

“On Shingles.” *British Journal of Homœopathy*, 1877.

“How to Advance Homœopathic Therapeutics.” A letter in the *Monthly Homœopathic Review*, 1877.

“Notes from Daily Practice.” Three papers treating of *Magnesia Muriatica*, *Magnesia Carbonica*, *Kalmia*, *Dioscorea*, *Staphisagria*, *Chloral* in *Urticaria*, *Æsculus Hippocastanum* in *Follicular Sore Throat* and *Lumbago*, *Aurum Metallicum* in *Interstitial Keratitis*, *Magnesia Muriatica* in *Liver Disease*, *Capsicum* in *Gonorrhœa*, *Coccus Cacti* in *Pertussis*, *Lachesis* and *Lycopodium* in *Nævus*. *Ibid.*, 1877.

<sup>1</sup> In a footnote to this address Dr. Clifton draws attention to the necessity of homœopathic hospitals in every town in England, thus foreshadowing the work of the British Homœopathic Association.



"Notes and Queries." Two papers containing references to Argentum Nitricum and Liliun Tigrinum in Eye Cases, Morning Diarrhœa and Ovarian Disease, the Treatment of Lumbago, Acute Gout and Tonsillitis. *Ibid.*, 1878.

"On the Antecedent Symptoms (Constitutional or Diathetic) to Local Cancerous Deposit, illustrated by Cases." *Annals of the British Homœopathic Society*, 1878

"A Case of Duchenne's Pseudo-hypertrophic Paralysis Cured." *British Journal of Homœopathy*, 1878.

"On the Superiority of Homœopathic Treatment in Certain Forms of Chronic Disease." *Homœopathic World*, 1879.

"The Therapeutics of Constipation." A Congress paper. *Monthly Homœopathic Review*, 1885.

"Clinical and Therapeutic Notes," referring to Acute Gout, Tonsillitis, Coccygodynia, Hæmorrhoids, Cases of Eczema. *Ibid.*, 1891, 1892.

"A Review of Thirty-seven Years' Practice of Homœopathy," referring especially to the "Two Paths" and "the Dose." *Ibid.*, 1892.

"Characteristics," "Keynotes," "Guiding Symptoms with Clinical Observations." Four papers. *Ibid.*, 1893.

"Retrospect of the Rise, Development and Progress of Homœopathy in Northamptonshire." A pamphlet published after retirement from practice.

In the *Index of Clinical Cases*, published by the British Homœopathic Society in 1907, Dr. Clifton collaborated with the Indexing Committee in searching and recording cases from the *Monthly Homœopathic Review*, from its first publication up to 1896.

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CASES AND SPECIMENS EXHIBITED AT  
VARIOUS MEETINGS.

CASES.

*Paroxysmal Hæmoglobinuria.*<sup>1</sup>

R. L., aged 4; third child in family, one other living, one dead; breast-fed nine months; came as out-patient November 12, 1908.

*History of Illness.*—Four weeks ago had pains round loins, feverish and passed urine like porter; then got clear again.

<sup>1</sup> Exhibited by Dr. ROBERSON DAY, February 4, 1909.

Four days ago 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.

*Present Condition.*—Very anæmic, but no definite physical signs.

November 26.—Four days ago again passed similar urine, a specimen of which was brought with the child and tested by Dr. Watkins. "Faintly alkaline; brown-red colour, with deposit. Hæmoglobin present (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)."

Urine passed at time of visit clear and normal. Was admitted as in-patient to hospital and detained some time, but as he appeared quite well and passed normal urine, he was discharged, but readmitted January 5, 1909, as he had again passed dark-coloured urine, and also at time of admission passed urine of slightly red colour with large quantity of albumin.

January 13.—When up and walking about the ward, suddenly began to cry and could not walk upright. Urine passed a short time after, red colour with albumin.

Since January 17 had pain and swelling in knees, with pyrexia. Very anæmic.

January 29.—Developed keratitis right eye. Knees more swollen and painful.

February 2.—Cries each night with pain in knees. No more coloured urine passed.

It was suggested the condition could be induced by poisons, *e.g.*, chlorate of potash, and the child is taking kali chlor. 3x.

*Pathological Report.—Blood Examination.*

Blood count: red, 5,000,000; white, 10,000; hæmoglobin, 62 per cent. Date, February 2, 1909.

*Urine Examination, First Specimen.*

Specific gravity, 1023; albumin, +; sugar, —; urea, 1.9 per cent.; crystals, calcium oxalate; reaction, slightly acid; blood corpuscles, —; hæmoglobin, +. There was no deposit on centrifugalizing, and no micro-organisms could be seen microscopically or on culture. (J. G. Hare, Pathologist.) Date, February 4, 1909.

*Urine Examination, Second Specimen.*

Specific gravity, 1019; sugar, —; albumin, +; urea, 2.1 per cent.; crystals, calcium oxalate; reaction, slightly acid; blood corpuscles, —; hæmoglobin, —. No deposit on centrifugalizing. (J. G. Hare, Pathologist.) Date, February 4, 1909.

*Tubercular Disease of the Pelvis.<sup>1</sup>*

M. W., aged 5. First came October 12, 1898, with fulness in left iliac region over psoas and iliacus muscles. Movements of left leg are less free than of right side. Hip-joint appears normal. A very anæmic child. She was given hep. s. 3 soon after admission to the London Homœopathic Hospital, and the psoas abscess was opened. She remained there five months and was sent out with a discharging wound. She then continued treatment as an out-patient, taking tuberc., 30, ars. i. 3x, and hep. s. She was quite unable to walk and was confined to her bed at home under most unhygienic conditions. The sinus continued to discharge, but she steadily improved in spite of her surroundings, and the treatment was so successful that on October 3, 1900, (just two years since the first came) she was again able to go out, but could only walk a few steps, and the sinus still discharged.

December 11, 1901.—She could walk much better and the sinus had completely healed.

February 11, 1903.—Scar continues soundly healed and she walks about quite well. She was now sent to the seaside and afterwards attended school.

The result now, after six years, is perfect recovery. The scar remains, but no other sign of disease.

Mr. Knox Shaw, on being asked to speak on this case, said that he had no distinct recollection of the patient, but he felt sure that in all cases of the kind they could ultimately do a great deal to benefit them if the wound did not become septic. He did not think that the child had had anything more than a tuberculous affection.

Dr. Roberson Day said that the wound did not close in the hospital, and the state of the patient was such that she was discharged rather as a forlorn hope. He thought that the case emphasized the importance of the combined surgical and medical treatment of such cases. It was perfectly clear that they must not give up hope in too short a time.

<sup>1</sup> Exhibited by Dr. ROBERSON DAY, April 1, 1909.

*Recent Petit Mal.*<sup>1</sup>

A case of recent petit mal in a girl aged 9. The unusual feature in this case was a severe parieto-occipital headache. There was a fully corrected hypermetropia. The discs were normal. No reflex cause was apparent. Bromides had no effect. The case was submitted to the meeting for diagnosis and treatment.

*Recurrent Facial Erysipelas.*<sup>2</sup>

Mrs. O., aged 56 in 1906. Had been under the same allopathic physician, of good standing, for the past sixteen years.

When I saw her first, in March, 1906, she appeared a querulous old woman and very feeble; much œdema, redness, and tenderness about face, scalp and neck, and with a tongue thickly coated white, and vomiting everything. Temperature, 101° F. Also there was constant severe aching in dorsi-lumbar region. She told me she supposed she had had ninety attacks of erysipelas altogether. Though this was probably an exaggeration, she has had several attacks of this nature every year for the past twelve years, and has seldom been able to go out of the house during the winter months.

I considered that the stomach was the organ primarily at fault, and foresaw that if the gastric symptoms were cured we should see little of the "erysipelas."

Both ears are permanently thickened, and I was told that sometimes a watery discharge came from them, though I did not see this.

I do not remember any blisters forming about the head and face.

The attacks always began at the corner of an eye or the nostrils.

After I had been attending her for a few months she said she never felt so ill in these attacks as under the old *régime*, and they lasted a shorter time, and the vomiting, which was a distressing feature, now seldom occurred.

The following synopsis of the attacks will give an idea of their degree of intensity: 1906—March, ten daily visits; May, five visits; June, seven visits; September, gastric catarrh without erysipelas, four visits; October, erysipelas, six visits. 1907—March, influenza

<sup>1</sup> Exhibited by Dr. EDMUND HUGHES at the Liverpool Branch, May 13, 1909.

<sup>2</sup> Exhibited by Dr. THEODORE GREEN at the Liverpool Branch, May 13 1909.

and gastric catarrh without erysipelas, four visits; November, erysipelas and gastric catarrh, five visits. 1908—February, erysipelas, six visits; May, erysipelas, three visits; August, one visit. She said she feared erysipelas was coming on, but by treating the gastric symptoms it did not appear, nor has it done so to date, February, 1909.

The patient no longer looks and behaves as an invalid old lady, but goes out in all weathers in the winter, and enjoys life better than during the past ten years.

What was the real nature of these recurrent erysipelatoid attacks? I cannot think they were the genuine erysipelas due to its own bacillus that invades wounds or external mucous membrane, but I think toxins must have been absorbed from the inflamed gastric mucous membrane, and the erysipelas was Nature's attempt to get rid of them. Still, the general appearance was that of erysipelas in its point of invasion, its mode of extension, and the œdema, redness, and tenderness of the parts affected.

*Treatment.*—I kept the face, &c., well covered with cornflour. The chief medicine given was rhus 1, also bell. and croctalus. For the ears graph. 6 was given, but I never saw any improvement from this drug. For the gastric catarrh I gave at different times ant. crud. 3x, puls. 1, ipec. 1, kali bich. 3x.

The diet during the attacks was almost *nil* for the first twenty-four to thirty-six hours, and a little animal broth, milk and soda, and sanatogen afterwards.

#### *Epileptic Idiot.*<sup>1</sup>

Epileptic idiot, aged 23. Patient was bright and intelligent until 3½ years old. A fall on head was followed by some months of unconsciousness and blindness, and then by a skin eruption on the head. Fits very violent, < at night. Patient unable to wash and dress herself.

One dose of cicuta 200 followed by improvement in violence and number of fits and by enormous improvement in the mental condition.

#### *Adenoids in a Congenital Syphilitic.*<sup>2</sup>

Ivy W., aged 6. In May, 1908, typical adenoid facies, mouth-breathing, deafness, offensive discharge from ears and nose; restlessness and irritability.

<sup>1</sup> Exhibited by Dr. MARGARET TYLER at the Clinical Evening, June 29, 1909.

<sup>2</sup> Exhibited by Dr. ROBERSON DAY at the Clinical Evening, June 29, 1909.

*Treatment.*—Calc. phos. 12; sulph. 12; merc. viv. 2; syphilinum 30; calc. c. cm.; iod. 3x; merc. bin., kali iod. 3x. Result: cured.

*Sporadic Cretinism.*<sup>1</sup>

A. W., aged 6. Full-term child, delivered normally; third in family. One other child died of tuberculous peritonitis; another is healthy and intelligent.

October 10, 1907.—Height 30 in., weight 26½ lb.; could not walk alone; could only say “mamma, papa,” &c.; thought to be imbecile. Characteristic physiognomy: mouth open, tongue protruded, dribbling, very anæmic; skin always dry, flesh flabby, fatty masses about shoulders.

*Treatment.*—Thyroid extract. Grew 7½ in. in one year. Now goes to school and has the appearance of a normal child.

*Compound Fracture of Ulna and Radius.*<sup>2</sup>

Treated by wiring; followed by good union of radius and fibrous union of ulna, resulting in a strong, useful limb.

(5) *Sarcoma of Thigh.*<sup>3</sup>

A man suffering from sarcoma of thigh undergoing treatment by Coley's fluid.

Dr. Jones asked whether any member had seen good results from the use of Coley's fluid? He would be very glad to hear of any such.

Dr. Weir said that while he was in Glasgow he saw a case of sarcoma of the tonsils, chiefly on the left side, with large glands on the outside, so large that they almost choked the patient. It was outside the reach of surgery, and Coley's fluid was accordingly tried, and he was asked to administer it. Up to 6 minims were given, from which there was much constitutional disturbance; the temperature rose to 104° F. The last dose almost killed the patient. Afterwards there was a decided improvement in the cancerous condition, the tonsils sloughed out, and the breathing was much improved, owing to the marked reduction in the size of the glands. The patient did so well that she went out of the hospital. Then suddenly one night she died, and no one was able to say why, no *post-mortem* examination being allowed. The fluid had to be given tentatively, the dose being increased by ½ minim each time.

<sup>1</sup> Exhibited by Dr. J. JONES and Dr. ROBERSON DAY at the Clinical Evening, June 29, 1909.

<sup>2</sup> Exhibited by Mr. KNOX SHAW at the Clinical Evening, June 29, 1909.

*Xeroderma Pigmentosum.*<sup>1</sup>

H. E., aged 12. Dutch, only child, not vaccinated; no family history of disease except father died of phthisis. Mother vaccinated from a child; when young, ill for two years. Patient had measles at 4 months and at 5 years; varicella and diphtheria.

General health good; appetite good, specially for meat and fish; does not like vegetables; will take fruit. At six weeks had pink spots on the face, then a purplish stain all over, with feverishness lasting twenty-four hours. Was given grey powders.

At 7 months was scaly all over; soon recovered. Well until 2 years old, when a warty growth appeared on one cheek, which was removed. Afterwards stayed at Folkestone, where it was very sunny; child peeled and freckled. From this time the disease steadily progressed, until seen on February 26, 1909, when she presented typical appearance of xeroderma pigmentosum. Patient has been under special treatment for nine years at a London hospital. Since February treatment has been thuja 30, occasional doses, and cinnamon  $\phi$ . Externally fluid extract of thuja to the warty growth and lotio cupr. sulph. 1 in 2,000 in drops for the conjunctivitis.

Mr. Dudley Wright asked, in reference to general cases of xeroderma pigmentosa, whether it had been definitely settled, whether, as the disease appeared only on the parts which were exposed to light, that particular rays of light caused the trouble. Also, had an effort been made to exclude all but the red rays, or all the rays except those of highest wave velocities; and, if so, had those measures had any influence upon the condition? It was suggestive that the malignant degeneration occurred on the hands and face—the parts exposed to light. He had been under the impression that there were retinal changes in the disease also, or choroidal changes. If that were so, it would be another factor pointing to the influence of light in its causation.

Dr. Epps replied that he did not think anything had been done in reference to the different forms of light. Apparently sunlight did not make much difference, as the condition was as bad in winter as in summer. Beyond that, he had no experience of the action of light, and he had seen no reference to it. At the London Hospital the patient had X-ray treatment, and that was the principal treatment which had been carried out, with the removal of the growths as they appeared. At last the removal of the growths was found to be tiring, and some friends of his

<sup>1</sup> Exhibited by Dr. Epps at the Clinical Evening, June 29, 1909.

(Dr. Epps) thought they would like to do something else for the patient. He found that the thuja had done good.

*Sarcoma of Jaw.*<sup>1</sup>

Rapidly growing and extensive, very soft. Superior maxilla removed in September last; recurrence after eight months.

*Irido-cyclitis.*<sup>2</sup>

Recurrent attacks extending over years; usually lasts about two months; present attack, more than five months, most severe of all—pain severe, deep ciliary injection, vision *nil*. After one dose of phos. 200 rapid relief of pain, subsidence of inflammation, and commencing return of sight.

*Case of Rheumatoid Arthritis demonstrating Effect of High Potency of Rhus.*<sup>3</sup>

A woman, aged 30, a widow, was suffering from typical spindle-shaped knuckles, stiffness of fingers, wrist, elbows, and shoulders. Left arm rotated. Creaking and stiffness of jaws; could not feed or wash herself. Severe throbbing pain for eight months. Has had cataphoresis and rhus in low dilution.

After one dose of rhus tox. 200, pain disappeared in ten hours; after three days, stiffness of arms greatly better, and could feed herself and open mouth.

*Locomotor Ataxia.*<sup>3</sup>

G. S., aged 40, male, married, blacksmith by trade, was admitted into the hospital May 27, 1909. Had chancre fifteen years ago. Treated two months; no secondaries. Girdle sensation ten years ago. Began to feel legs strained, especially the right, nine years ago. Could not hurry; legs felt weighted with shooting pains in lumbar and lower limbs. Could walk, but easily tired. Eight years ago felt as if he were walking on carpets. Five years ago had tendency to fall forward when eyes were closed, or when in the dark. He was told then that he had locomotor ataxia. He was able to work, however, until recently, but was quickly tired. Eleven weeks ago he had blue leg, causing him to drag leg for a time. Four weeks ago had griping feeling in lumbar region as if a spring there caused knees to lock. Difficulty in bending the knees, as if tightly bound after certain degree

<sup>1</sup> Exhibited by Mr. HEY at the Clinical Evening, June 29, 1909.

<sup>2</sup> Exhibited by Dr. WEIR at the Clinical Evening, June 29, 1909.

<sup>3</sup> Exhibited by Dr. GOLDSBROUGH at the Clinical Evening, June 29, 1909.



of flexion. Legs apt to cross each other. Has had to use two sticks recently owing to shaking of legs.

*Present Condition.*—*General*: Seems a little anxious in expression; general condition is fairly good. *Mental state*: Soon tires of talking; angry readily over trifles; feels depressed; anxiety as to recovery; aversion to company; excitement causes great weakness, almost collapse; mental restlessness, changing from one subject to another; very sensitive, yet does not show it, and feels worse, like pent-up wrath; sleeps well, yet feels generally worse after sleep, even in daytime. *Sensorium*: Tends to fall when eyes are shut. *Organs of vision*: Pupils react to light, not so well to accommodation.

*Sensory Symptoms.*—*Touch and Pain*: Slightly delayed over the extensors, both thighs and legs, and somewhat altered; can stick pins in him without his feeling. *Heat*: Fairly good. *Cold*: Excessively active. Hot bath leaves him so weak, and he cannot take a cold one; "it puts him out of his mind." In warm bath when water reaches a certain level of abdomen he feels a cutting pain like a knife.

*Muscle sense* normal.

*Motor Symptoms.*—Can stand when eyes are open. Legs feel fairly close together. Gait ataxic and a little spastic, feels legs restrained; cannot turn quickly. Power is fair; weakness of extensors, especially right leg. Co-ordination is very poor.

*Reflexes.*—Knee-jerks gone; no ankle clonus.

*Sphincters.*—Both bladder and bowel good.

*Trophic Condition.*—Muscles of legs very flabby.

*Digestive System.*—Good appetite; no crises. Bowels extremely constipated for years; hard, dry stools in small balls.

*Circulatory and Respiratory Systems.*—Legs feel very cold, like ice.

*Reproductive System.*—No excessive or diminished power.

*Urine.*—Has to strain, stops suddenly at times; must attend in hurry.

A careful selection of the remedy by repertorizing and the numerical method was made by the house physician (Dr. Weir), and the choice fell on sulphur. A dose of the 1m was administered, and the case showed marked improvement in a few days.

Dr. Stonham asked Dr. Weir to say why he chose sulphur in Dr. Goldsbrough's case?

Dr. Weir replied that the condition was worse in wet weather, after bathing, after sleep, and after lying down. He was very excitable, sensitive and restless, and had weakness of the lower

limbs, numbness, and paralysis and stiffness, especially after sitting, and some tingling in the lower limbs, with a tendency to fall forward. The stools were hard and dry, and there was a frequent desire to urinate, which was urgent. Lycopodium and rhus came out very well, but sulphur was higher than the rest. Pulsatilla came next.

Dr. Goldsbrough said he thought the case was hardly one of *tabes dorsalis*, although it had been diagnosed as such elsewhere. In the notes which he had wished to appear on the agenda paper in connection with the case he specified that the case exhibited symptoms suggestive of locomotor ataxy. He believed it to be a case of chronic myelitis, and if that was so they would be more likely to get good results from homœopathic medicines than if there were actual degeneration of the columns of the cord.

*A Cerebral Case for Diagnosis.*<sup>1</sup>

G. C., aged 30, married man, a carpenter, was admitted to the hospital April 29, 1909. Had been ill three years, and previously treated at the National Hospital. Has father and mother living and well. Two brothers quite healthy, one sister in an asylum. Had gonorrhœa; not well conducted, not a drinker. Noticed first vertigo on riding bicycle, and double vision; things appeared one over the other, worse on fatigue. Sensation of pins and needles in the fingers on extension; slow pace. In South African War he had slight dysentery.

*Present Condition.*—Face asymmetrical, right side contracted. Weight, 10 st.; height, 5 ft. 9 in. *Speech*: Normal, except slight delay in utterance. *Mental state*: Slight lapses of memory occasionally. Occasionally depressed. Sleeps well, though heavily, and has no dreams.

*Sensorium.*—No headache. Sways sideways on walking; cannot well look forward. *Organs of vision*: Appearance and sensitiveness quite normal, but sees better in twilight. Slight inclination to nystagmus on moving eyes rapidly.

*Sensory Symptoms.*—Feet and hands get very cold.

*Motor Symptoms.*—Dynamometer, right 200, left 160. Co-ordination, slight weakness of left side in walking. No Romberg. Slight dysphagia on hurried swallowing.

*Reflexes.*—Superficial, all present, but feeble. Deep, knee-jerks, right plus, left diminished; ankle clonus both sides.

*Sphincters.*—If specially occupied, often has to hurry to pass water.

<sup>1</sup> Exhibited by Dr. GOLDSBROUGH at the Clinical Evening, June 29, 1909.

*Diagnosis.*—(?) Slight bulbar lesion on right side above the decussation. Arg. nit. 6 was given.

May 10.—Patient said he was not any better. Confusion and awkwardness on walking. Dynamometer, right 230, left 175. Arg. nit. repeated.

May 27.—Dynamometer, right 220, left 180. Medicine repeated.

June 17.—Patient feels as if he were walking in the air; giddy and sleeps heavily; staggers as if he had been drinking. Arg. nit. 200; one dose.

June 24.—More inco-ordination, especially of vision. Things look differently when opening and shutting lids; worse in cold weather, or if cold. Bowels confined. Gelsem. 30 was given.

*Scirrhus of Right Breast.*<sup>1</sup>

X-rays applied weekly for six months to lymphatic glands in axilla and thorax, with arrest of growth and restoration to health.

*Multiple Epitheliomata of the Tongue.*<sup>1</sup>

Diagnosis confirmed by microscope. Six months ago articulation so bad that patient could not be understood; salivary flow and neuritic symptoms marked. X-rays applied to submaxillary, pre-auricular, and pharyngeal lymphatic glands every week. Arrest of all growth and restoration of function of tongue, and incidentally, cure of deafness in right ear.

Mr. Dudley Wright, discussing the diagnosis of this case said the patient was undoubtedly very much benefited by the treatment. There had been a very large ulcer on the tongue. The patient had been under his own and Mr. Eadie's care for three or four years, and the ulcer could not be got to successfully heal. He (Mr. Wright) never had the impression that it was really epitheliomatous; the long duration of it, the condition of the ulcer and its position on the tongue—in the mid-line, far back—and the absence of deep infiltration, even though it had lasted so long, and the absence of enlarged cervical glands, as far as he could recollect, taken in conjunction with the undoubted history of syphilis and the general condition of the patient, led him to the conclusion that it was gumma. As the condition was not progressing, he referred the case to Dr. McCulloch, and there was no doubt that under the latter's treatment by X-rays the patient had benefited very much indeed, and his

<sup>1</sup> Exhibited by Dr. McCULLOCH at the Clinical Evening, June 29, 1909.

condition was in every way improved. He doubted the diagnosis of epithelioma.

Dr. McCulloch remarked that Mr. Dudley Wright said there was one ulcer at the back of the tongue, but that its situation was not the usual one for epithelioma. On October 14, he (Dr. McCulloch) found a note that the lingual motility in the cheek was affected by paresis of the right half. Later he had a further description of the ulcers being strawberry-like, like epitheliomata. So that, in addition to there being more than one, their situation was not entirely at the back of the tongue. On the same side of the jaw the man had a very suspicious-looking tooth, which was removed by the hospital dentist. The improvement, Dr. McCulloch believed, had gone on owing largely to the causes of the condition having been removed. The patient had had a gargle to keep the mouth as aseptic as possible. In addition to the X-rays he had had an occasional application of zinc ions introduced through the tongue by electrolysis. Kathode rays had sometimes been used when the object was to get a superficial and not a deep action on the glands. With regard to the microscopic examination of the tongue, he hoped more enquiry would be made. His authority for stating that the nature of the lesion was confirmed by the microscope was Mr. Eadie, who assured him that the specimens would be available that evening, but he (Dr. McCulloch) had not seen them.

*Tertiary Ulceration of Vulva.*<sup>1</sup>

Began six years ago; ulceration of left knee for a longer period. Primary and secondary history unobtainable. Potassii iod., gr. iii., twice daily, followed by spots on face; gr. i. bis die, followed by rapid improvement without spots.

*Pernicious Anæmia.*<sup>2</sup>

Man, aged 57, recovering from fourth attack. At worst, red corpuscles 675,000 per c.mm. Liq. arsenicalis only remedy giving good results.

*Cheloid.*<sup>2</sup>

Girl, aged 17, with warty growth developed in cheloid. Prior to onset of menstruation warty growth used to bleed at regular intervals.

<sup>1</sup> Exhibited by Dr. NEATBY at the Clinical Evening, June 29, 1909.

<sup>2</sup> Exhibited by Dr. BLACKLEY at the Clinical Evening, June 29, 1909.

SPECIMENS.

*Extra-uterine Pregnancy (a Drawing).<sup>1</sup>*

A drawing by Dr. Lucas Hughes, the son of the well-known artist, of a specimen of a extra-uterine pregnancy. The drawing has been executed under very unfavourable circumstances, the specimen having been considerably hardened and, unfortunately, left too long in spirit.

*Perforated Duodenal Ulcer, from a Woman aged 65.<sup>2</sup>*

*Epithelioma of the Cervix Uteri; Vaginal Hysterectomy; Recovery.<sup>3</sup>*

*Microscopic Slide of the same.<sup>4</sup>*

*Extra-uterine Gestation at about the Third Month; Tubal Rupture; Laparotomy; Recovery.<sup>5</sup>*

*Microscopic Slide of the Uterine Decidua from the above.<sup>5</sup>*

*Double Pyosalpinx, closely incorporated with the Rectum; Laparotomy; Recovery.<sup>6</sup>*

*Carcinoma of Lymphatic Gland.<sup>7</sup>*

Showing commencing of disintegration brought about by X-ray treatment.

*Uterine Curetting.<sup>3</sup>*

Showing alveolar growth infiltrating the myomatous tissue.

*Section of Upper Cervix.<sup>3</sup>*

Showing an infiltration of the myomatous tissue with an alveolar growth.

*Section of Uterine Wall.<sup>3</sup>*

Showing a carcinomatous growth infiltrating the myomatous tissue.

<sup>1</sup> Exhibited by Dr. CASH REED, December 3, 1908.

<sup>2</sup> Exhibited by Dr. WYNNE THOMAS, January 7, 1909.

<sup>3</sup> Exhibited by Dr. BURFORD, January 7, 1909.

<sup>4</sup> Exhibited by Mr. FRANK WATKINS, January 7, 1909.

<sup>5</sup> Exhibited by Dr. H. WYNNE THOMAS and Dr. BURFORD, January 7, 1909.

<sup>6</sup> Exhibited by Dr. MACLACHLAN and Dr. BURFORD, January 7, 1909.

<sup>7</sup> Exhibited by Dr. SANDBERG and Dr. BURFORD, January 7, 1909.

*Curetings from Uterus.*<sup>1</sup>

Showing an epithelial growth into the myomatous tissue. There were some large vessels shown in this specimen.

*Growth Removed from the Iliac Fossa ; Round-celled Sarcoma.*<sup>1</sup>*Dermoid of Ovary.*<sup>2</sup>

Showing bony formation resembling sphenoid from a young girl.

*Soft Myoma simulating Cyst.*<sup>3</sup>

G. S., single, aged 43. Abdominal tumour first noticed six years ago ; growing more the last two years. She had dysmenorrhœa, but no menorrhagia. Heart slightly dilated ; short presystolic thrill and bruit in apex. General inconvenience from weight and size of tumour.

*Physical Signs of Tumour.*—A mass rising abruptly from pelvis and abdomen, not distending flanks, which were resonant. The tumour was dull on percussion, and was believed to yield an obscure thrill. A nodule felt *per vaginam* was thought to be the uterus lying posteriorly. The diagnosis was made of multilocular ovarian cyst with thick walls.

The operation showed it to be a soft semi-fluctuating myoma with no definite cyst. The microscope showed it to be undergoing mucoid degeneration.

Clinically the case presented three unusual features :—

- (1) It was a soft myoma without excessive hæmorrhage.
- (2) There was a well-marked intra-uterine mucous polypus, but no hæmorrhage.
- (3) There was cardiac dilatation, though there had been no bleeding.

*Multiple Uterine Myomata and Ovarian Tumour.*<sup>3</sup>

A. H., married, aged 46. This patient was admitted on January 21. Two years ago she had gastric ulcer, and was in bed two months.

December 11, 1908, she had sickness and diarrhœa and was very ill. She discovered a lump in her side. On examination a lump was found in right iliac region and in Douglas' pouch.

<sup>1</sup> Exhibited by Dr. BURFORD, January 7, 1909.

<sup>2</sup> Exhibited by FRANK H. SHAW and EDWIN A. NEATBY, February 4, 1909.

<sup>3</sup> Exhibited by Dr. E. A. NEATBY, February 4, 1909.

Much enlarged uterus fixed backwards. Peri- and parametritis. Effusion surrounding rectum.

January 23.—Operation. Right ovarian cyst size of a tennis-ball. All organs bound down. Uterus and fibroid removed; also right ovarian cyst; both tubes dilated. Left ovary not removed. Up on fifth day. Smooth recovery.

*Appendix Vermiformis.*<sup>1</sup>

An appendix, 7 in. long, removed by careful dissection from the cæcum, to which it was universally adherent. From a case of chronic appendicitis.

*Uterine Adnexa.*<sup>1</sup>

Tubes and ovaries showing extensive and universal adhesions which required carefully breaking down. The chief interest lay in the fact that the patient had had the Alexander Adams operation performed some time ago in another hospital for prolapse. It had completely cured this, but had not relieved the pain associated with the condition, and the patient requested to have "something further done." The uterus was found beautifully suspended, but the adnexa were in the condition described.

*Ectopic Gestation.*<sup>1</sup>

The parts from a case of ectopic gestation. The right Fallopian tube contained a mole, and in the left ovary a large hæmatoma existed. The sac containing the mole had bled extensively from time to time, forming a more or less recent fibrinous clot. This was removed, and the large area, left, from which blood exuded, was packed with gauze. The latter was allowed to remain *in situ* for forty-eight hours.

*Radiographs of Fracture of Olecranon.*<sup>2</sup>

- (1) Twelve weeks after fracture showing fibrous union.
- (2) Same case five weeks after wiring.

*Forty-two Calculi and Prostate removed Suprapubically.*<sup>2</sup>

Prostate shows marked middle lobe which acted as an obstructing valve, also several false passages.

*Radiographs of Dilated Stomach rendered Visible by Bismuth.*<sup>3</sup>

*Prostate and Calculi removed Suprapubically.*<sup>3</sup>

<sup>1</sup> Exhibited by Dr. CASH REED, Liverpool Branch, May 13, 1909.

<sup>2</sup> Exhibited by Mr. HEY at the Clinical Evening, June 29, 1909.

<sup>3</sup> Exhibited by Mr. WRIGHT at the Clinical Evening, June 29, 1909.

*Perforated Vermiform Appendix removed Post Mortem.*<sup>1</sup>

*Large Mass of Tuberculous Mesenteric Glands.*<sup>1</sup>

*Tuberculous Ulcer of Intestine.*<sup>1</sup>

*Microscopic Sections from above.*<sup>2</sup>

*Microscopic Sections from Nodules in Liver and Lung.*<sup>3</sup>

*Sarcoma of Tibia.*<sup>3</sup>

*Carcinoma of Fundus Uteri removed by Vaginal  
Hysterectomy.*<sup>4</sup>

## BRITISH HOMŒOPATHIC SOCIETY.

### REPORT OF COUNCIL, 1908-9.

THE first meeting of the session 1908-9 was held on Thursday, October 1, 1908, when the President, Dr. Cash Reed, read his introductory address entitled "*Esto vigilans.*" At the invitation of the President the meeting adjourned for supper to the Hôtel Russell.

During the session nine papers have been read before the Society, four on *Materia Medica* and Therapeutics, two on Medicine and Pathology, and three on Surgery and Gynæcology. The average attendance at the meetings has been nineteen. The Section of Medicine and Pathology organized a Clinical Evening for the last meeting of the Session, when cases and specimens were exhibited by several members.

Papers are difficult to obtain, and the new members are slow to come forward. This session has probably been unique in that, with one exception, only one paper was read at each meeting.

As last year, four evenings were devoted to the *Materia Medica* and Therapeutic Section. It is significant that not a single paper was strictly speaking on *Materia Medica* (pharmaco-dynamics), while one of the evenings of the Section was occupied mainly by

<sup>1</sup> Exhibited by Dr. ROBERSON DAY at the Clinical Evening, June 29, 1909.

<sup>2</sup> Exhibited by Drs. HARE and DAY at the Clinical Evening, June 29, 1909.

<sup>3</sup> Exhibited by Mr. KNOX SHAW at the Clinical Evening, June 29, 1909.

<sup>4</sup> Exhibited by Dr. JOHNSTONE at the Clinical Evening, June 29, 1909.



an interesting pathological paper. The retiring Council suggest to future Secretaries of this Section that endeavours should be made to revive an interest in pharmaco-dynamics by obtaining papers on this subject as contrasted with Therapeutics.

No new fellows have been elected, but eight members have joined the Society during the session, among them being Dr. Watts, a former member, who was re-elected after an absence from home of thirty years.

The meetings have been visited at various times by Dr. Melhorn, of Stettin, Dr. Rees, of Ohio, Dr. Hare, Pathologist to the Hospital, Dr. Brodie, and the resident medical officers.

The Society has lost by death three of its well-known members and two corresponding members.

Thomas Hahnemann Hayle, M.B.Lond. B.Sc. Univ. Vict. (Hon.), of Rochdale, died early in November of last year. As his University degrees show, Dr. Hayle was a man of scientific accomplishments, and his speeches at meetings of this Society were always examples of clear reasoning. His mind was of the type which demands ample evidence for its beliefs, but when once satisfied by proofs remains unshaken in its convictions. His career was cut short in the heyday of a too full life.

Arthur Crowen Clifton died at the age of 83. He was a staunch and fearless champion of homœopathy, and one who by his powerful clinical advocacy did more for "the cause" than many more scholarly supporters. Until recent years he was a most regular attendant at the meetings of the Society, and it was only increasing infirmity which kept him away, much to his chagrin. His stooping figure would become erect and his voice regain much of its old vigour under the stimulation of some lively discussion, and he would enforce his views by striking language and emphatic gesture. His venerable presence will be greatly missed from our meetings. At the time of his death he was the second oldest fellow on the Roll, Dr. J. P. Harper being the doyen.

In the year 1905 Dr. Clifton presented to the Society a collection of photographs of members and distinguished foreigners. He was very anxious that a suitable housing should be given to these, and it was decided to invite subscriptions to provide a screen for their protection and display as a memorial to our departed colleague. The screen has been procured and was unveiled on the first meeting of the Annual Assembly. Further contributions to the memorial are asked for, and the presentation of photographs for the extension of the collection by the addition of present members.

THE BRITISH HOMOEOPATHIC SOCIETY.

DR. BALANCE SHEET—SESSION 1908-9. CR.

RECEIPTS.		EXPENDITURE.	
	£ s. d.		£ s. d.
To Balance in Hand ..	4 15 9	By Rent ..	25 0 0
„ Dividends on Consols ..	4 19 4	„ Printing (less advertising) ..	59 6 2
„ Subscriptions ..	201 1 6	„ Reporting ..	16 16 0
„ Sale of Publications ..	6 18 10	„ Honorarium to Editor ..	10 10 0
„ Half cost of Plates ..	2 1 0	„ Library ..	7 0 11
		„ Postage and Stationery ..	6 16 8
		„ Refreshments ..	5 10 0
		„ Petty Cash ..	5 9 0
		„ Interest on overdraft at Bankers ..	0 4 9
			£136 13 6
		„ Balance ..	83 2 11
			£219 16 5

J. C. POWELL, Auditor.

JNO. G. BLACKLEY, Treasurer.

S. H. Ramsbotham, M.D., of Harrogate, formerly of Leeds, had been disabled from practice for many months prior to his death. He was for many years a chief supporter of homœopathy in Yorkshire, and was well known as a musical critic and a missionary enthusiast. He was also an able writer and a pleasant speaker. He will be greatly missed in the North of England and regretted by his *confrères* in London.

During the year Dr. H. C. Allen, of Chicago, Dr. Schepens, of Ghent, and Dr. Windelbandt, corresponding members of the Society, passed away.

The death of Dr. Madden left the Dr. Hughes Memorial Fund with only one trustee, Mr. Hughes. The Council asked Mr. Knox Shaw to accept the position of co-trustee as representing the Society. This he has kindly consented to do.

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## THE PRESIDENT'S VALEDICTORY ADDRESS.

BY WILLIAM CASH REED, M.D. EDIN.

IN taking leave of you, gentlemen, at the close of another session, I do so with a very real sense that I owe an apology for the many occasions upon which I have been absent, and now I am obliged to ask a deputy to read these few words for me.

The fact is, circumstances have been most unkind in prohibiting a fit and proper attendance at the meetings. The distance from Liverpool, too, is, of course, a serious barrier.

However, the loss is mine, and I only am to be commiserated. When we met at the beginning of the session, I ventured to lay before you a certain programme. The date now falls due when it is a fit and proper thing to review this programme, and to enquire during the few minutes at our disposal which, if any, of its items is an accomplished fact or in process of becoming so.

The first had reference to a *Worldwide Conference*, which, though not yet *in esse* is still *in posse*. I am glad to say that within the last few days I have received a letter from a well-known member of our Society, suggesting that the time had arrived for an invitation to be sent to our

German *confrères* to come over and see what we can show them, and for us to have the opportunity to bestow such hospitality as may be possible. It needs no argument to appeal to our Society to assent to this proposal, nor is it necessary to insist upon the present being the psychological moment for such a step to be taken. I throw out the suggestion that a sub-committee be appointed to consider the above.

(2) The hope was expressed that we might widen the base of our hospitals, and show that homœopathy had no limitations. What is the fact? Our hospitals have never been so efficient nor the clamour for admission so importunate and insistent; and to-day has seen the inauguration of a splendid addition to the Metropolitan Hospital.

(3) The endeavour to foster a corporate life amongst our fellows—the keynote being sympathy. Please apply at 43, Russell Square, London, for information concerning this.

There remains, however, much to be done, and I submit that a business committee of commercial men could formulate a working scheme to found here, for provincial members, a club which would pay a fair dividend.

(4) and (5) The next two headings, viz., the enlightenment of the profession and of the laity on the subject of homœopathy, have met with conspicuous fulfilment. There is still, however, much to be done which admits of no cessation, and periods of intermission even should be impossible.

Finally, vigilance was to be shown “by anticipating the cataclysm which must inevitably ensue before long if we hold our hands, for homœopathy will be ‘rediscovered,’ so to say, and called by another name.”

This was no nightmare when the words were written. To-day, however, it has passed into the region of phantasm, for a homœopathy which is either national or territorial is not extinguishable; but a homœopathy which is both is indeed a factor to reckon with.

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## MINUTES OF THE SOCIETY MEETINGS.

THE TENTH MEETING of the Session 1908-9 and first of the Annual Assembly was held at the London Homœopathic Hospital on Tuesday, June 29, 1909, at 8 o'clock, Dr. Stonham, Vice-President, in the chair. There were present, also, Dr. Blackley, Dr. Roberson Day, Dr. Epps, Dr. Goldsbrough, Dr. Vincent Green, Dr. Granville Hey, Dr. Grantham Hill, Dr. Jagielski, Dr. Johnstone, Dr. James Jones, Dr. Kennedy, Dr. McCulloch, Dr. Byres Moir, Dr. Newbery, Dr. Nicholson, Dr. Norman, Dr. Ord, Dr. E. B. Roche, Dr. Margaret Tyler, Mr. Wilkinson, Mr. Dudley Wright, and Dr. E. A. Neatby. Dr. Redpath, of Sunderland, and Drs. Hare and Weir, of the London Homœopathic Hospital, were present as visitors.

## THE CLIFTON MEMORIAL.

As an introduction to the ceremony of unveiling the Clifton Memorial, Dr. Stonham, Vice-President, stated that the establishment of some memorial of the late Dr. Arthur Clifton was desirable. This was now effected in the following manner: Certain photographs which Dr. Clifton presented to the Society some time ago—the result of his collection for a good many years—portraits of members of the profession which were lying in an album not much looked at, were brought together, and those which required it renewed and placed in a suitable receptacle, in the nature of a screen, which had been obtained. Dr. Clifton was never happier than when in the society of his colleagues and friends, and he manifested his feelings by collecting the photographs of those he met. It was due to Dr. Clifton that the Society had such a collection of its old members which it would not otherwise have possessed. For the execution of the memorial the Society was largely indebted to the energy of the Honorary Secretary, Dr. Neatby. Several photographs had been retouched, including one of Dr. Clifton himself, and the photograph of the founder of the Society—Dr. Quin—had been enlarged. He thought the result would be a very suitable memorial to one who all his life was noted for his sociability. Dr. Stonham then unveiled the screen.

Dr. Neatby said it was the hope of the Council that living members would also contribute their photographs, so that the collection might be extended. Room could be found for them by

the provision of additional wings. He hoped those who did not figure in the screen would send their photographs at a convenient date.

#### CLINICAL EVENING.

A selection of cases was shown by various members, particulars of which will be found in the current number of the *JOURNAL*. The cases were illustrated by radiographs, pathological specimens, &c. There were on view, also, collections of surgical and other instruments sent by Messrs. Allen and Hanburys and the Medical Supply Association.

The ELEVENTH MEETING of the Session and the second of the Annual Assembly was held at the London Homœopathic Hospital on Wednesday, June 30, 1909, at 5 p.m., Dr. William Cash Reed, President, in the chair. There were present, also, Dr. Speirs Alexander, Dr. Blackley, Dr. Burford, Dr. Epps, Dr. Gilbert, Dr. Goldsbrough, Dr. Johnstone, Dr. Neatby, Dr. E. B. Roche, Dr. W. Roche, Dr. Stonham, and Dr. Storrar.

#### REPORT OF THE COUNCIL.

The Report of the Council was presented and adopted (see p. 324).

#### TREASURER'S STATEMENT.

The Treasurer's Balance Sheet, audited by Dr. J. C. Powell, was presented and adopted (see p. 326).

#### THE HUGHES MEMORIAL FUND.

Mr. C. Knox Shaw was unanimously elected co-trustee of the Hughes Memorial Fund in the place of the late Dr. E. M. Madden.

#### OFFICERS FOR THE SESSION 1909-10.

*President*.—Dr. David Macnish.

*Vice-Presidents*.—Dr. T. G. Stonham, Dr. E. B. Roche.

*Treasurer*.—Dr. J. Galley Blackley.

*Council* (together with the above and the ex-President).—

*Fellows*: Dr. Burford, Dr. Johnstone, Dr. Byres Moir, Mr. Knox Shaw, and Dr. A. E. Hawkes (Liverpool Branch). *Members*: Dr. R. Le H. Cooper, Dr. C. E. Wheeler.

#### PRESIDENT'S VALEDICTORY ADDRESS.

At the conclusion of the business of the Session the President delivered a valedictory address (see p. 327), and a vote of thanks

was subsequently accorded to him for his conduct in the chair during the Session. The meeting then separated.

— — — — —  
SESSION 1909-10.

OFFICERS OF THE LIVERPOOL BRANCH.

At the meeting of the Liverpool Branch of the British Homœopathic Society, held in May last, the following officers were chosen for the Session 1909-10 :—

*President.*—Dr. John Davey Hayward.

*Vice-President.*—Dr. Douglas Moir.

*Honorary Secretary and Treasurer.*—Dr. Bryan.

*Representative on Council.*—Dr. Alfred E. Hawkes.

OFFICERS ELECTED BY THE COUNCIL.

At a meeting of the Council, held on July 6, 1909, Dr. E. A. Neatby was re-elected Secretary of the Society, Dr. Goldsbrough Editor of the JOURNAL, and Dr. Cooper Librarian. The following were appointed Sectional Secretaries for obtaining of papers or otherwise arranging the proceedings of the Society in conjunction with the General Secretary :—

*Materia Medica and Therapeutics.*—Dr. R. M. Le Hunte Cooper.

*Medicine and Pathology.*—Dr. Miller Neatby.

*Surgery and Gynæcology.*—Mr. James Eadie.

ALLOTMENT OF DATES TO DIFFERENT SECTIONS.

The allotment of dates to different Sections was made as follows :—

1909—October 7, Presidential Address.

November 4, *Materia Medica and Therapeutics.*

December 2, *General Medicine and Pathology.*

1910—January 6, *Materia Medica and Therapeutics.*

February 3, *Surgery and Gynæcology.*

March 3, *Materia Medica and Therapeutics.*

April 7, *General Medicine and Pathology.*

May 5, *Materia Medica and Therapeutics.*

June 2, *Surgery and Gynæcology.*

June 29, *General Medicine and Pathology* (first meeting of Annual Assembly).

June 30, *Business Meeting for Election of Officers, &c.* (second meeting of Annual Assembly).

## SUMMARY OF PHARMACODYNAMICS AND THERAPEUTICS.

*Extracted from Exchange and other Journals.*

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**Bismuth Subnitrate. Toxic Effects.**—Beck states his conclusions as to this subject in the *New York Medical Journal* of January 2, 1909, as follows: In the presence of certain bacteria in the fæces of children bismuth subnitrate will liberate nitrites which will be absorbed by the intestines and liberated by the kidneys, and, if production is faster than elimination, methæmoglobinæmia is the result. In large doses by the mouth it is apt to produce an acute nitrite poisoning, characterized by cyanosis, collapse and methæmoglobinæmia, which may terminate fatally. Rectal injection may cause poisoning more quickly than administration by the mouth, especially in cases of intestinal putrefaction. Characteristic symptoms of poisoning are black borders on the gums, ulcerations of mucous membranes, diarrhœa, and desquamative nephritis. Injection into suppurating sinuses may cause mild symptoms of nitrite intoxication, and the drug may be found in the liver, spleen, muscles and intestines. Acute nitrite poisoning is to be regarded as separate from more chronic bismuth absorption. (*Therapeutic Gazette*, May, p. 355.)—ED.

**Cactus and Cratægus in Mitral Regurgitation.**—A merchant, aged 50, of temperate habits and well nourished, had suffered from cardiac weakness for fifteen years. Mitral regurgitation and myocardial degeneration had been diagnosed, and an unfavourable prognosis given. Under the late Dr. E. R. Snader's care, who prescribed cactus, ten drops of the tincture four times a day, he steadily improved, and within two years the symptoms were got under control and he suffered only from shortness of breath on exertion. Occasional symptoms of cardiac embarrassment were entirely controlled by cactus. In March this year the patient was attacked with influenza, accompanied by a distressing cough. There was a good deal of general prostration, and the pulse became abnormally weak, rapid, and irregular. The attack of influenza subsided in about ten days, but the weak state of the



pulse continued. Cactus was administered, but now without any remedial effect. Dr. G. Harlam Wells, under whose care the patient was at the time, prescribed cratægus. The patient complained of attacks of cardiac palpitation and shortness of breath, especially after coughing, and stated he had a painful sensation of pressure on the left side of the chest below the clavicle < when tired, slight cough and expectoration of grey mucus. Marked mental and physical fatigue after slight exertion. There was irregularity of pulse (100 per minute); moderate hypertrophy of the heart, with a loud systolic murmur, heard best at the apex and transmitted to the axillary region. After two days of cratægus, in doses of five drops four times a day until the symptoms disappeared, the pulse became regular and 70 per minute. The murmur, of course, persisted as before. (*Hahnemannian Monthly*, July, p. 498.)—ED.

**Calcarea Arsenicosa.**—Dr. A. L. Blackwood draws attention to the value of calcarea arsenicosa in patients of a false plethoric type who have kidney disease, especially in women approaching the climacteric, and who suffer from palpitation. The hæmoglobin and red corpuscles are low. This drug should also be useful in affections of the spleen and mesenteric glands, also in certain forms of alcoholism and epilepsy. (*Journal of the American Institute of Homœopathy*, July, p. 302.)—ED.

**Carbon Dioxide in the Treatment of Cutaneous Neoplasms.**—Dr. Ralph Bernstein, of Philadelphia, gives a report of sixty-four cases of neoplasm of the skin treated by solidified carbon dioxide as a freezing agent in preference to liquid air. Full details of the method of application are given, and in sixty-three of the cases the result was successful. The neoplasms included rodent ulcer, chloasma, nævus, papilloma, sebaceous cyst, morphœa, cheloid, tattoo marks, xanthoma, angioma cavernosis, telangiectasis, epithelioma, Paget's disease, and others. The age of the patients varied from 6 years to 76. The number of applications was usually one, and never exceeded five, the latter being a case of epithelioma. The duration of the application varied from five seconds to three minutes, being accompanied by light, medium, or firm pressure. The amount of reaction varied, but the result was almost invariably a smooth white spot, area or scar. (*Hahnemannian Monthly*, September, p. 647.)—ED.

**Caryophyllum.** *Oleum Caryophylli in Profuse Septic Expectoration.*—Dr. H. A. Hare has referred to the use of oil of cloves in advanced cases of pulmonary tuberculosis in his "Text-book of

**Practical Therapeutics.**” Dr. Landis, of the White Haven Sanatorium, and Dr. Hartz, of the Jefferson Hospital, give an account of fifty cases in which this oil was given as a medicine, and the cases in which benefit was received appear to be very clearly defined. These were severe cases of advanced pulmonary tuberculosis in which cavity formations had occurred, and in which severe paroxysms of coughing, accompanied by excessive expectoration, were conspicuous symptoms, and where the cough and expectoration were apparently the cause of loss of weight, exhaustion, sleeplessness, and frequently vomiting at night. The oil of cloves was tried after kreasote and other drugs had failed. Where profuse expectoration was not present it appeared rather to aggravate the patients' symptoms, but proved of great benefit, temporarily of course, where all the symptoms mentioned concurred in their incidence. Care was taken to eliminate suggestion as a factor in noting the effect of the medicine. The oil was administered in doses of three to five minims. It may be taken in milk, or in capsules. Only good effects on the patients were observed from reduction of the amount of expectoration when the oil was given. (*Therapeutic Gazette*, June, p. 385.)—Ed.

**Cina in Convulsive Tic.**—Dr. C. J. Lopez, of New Orleans, records three cases in which cina proved curative where the usual symptoms indicating worms were absent and where none of those parasites were present. They were a lad of 15, a boy of 13, and a girl of 10, who were suffering from choreic movements of the face and hands, without the constant and severe inco-ordination of ordinary chorea. The movements were sufficiently severe, however, to interfere with the use of the hands in writing or musical performance. Cina was administered steadily for two months in the case of the lad, and a few days in the other cases, the dilutions being 6—200. Tarentula and tanacetum had been given previously, but as soon as cina was administered, amelioration began and continued until cure resulted, which has been permanent. (*North American Journal of Homœopathy*, August, p. 532.)—Ed.

**Lecithin.**—In a paper on lecithin, Dr. J. C. Fahnestock gives a *résumé* of the chemistry and physiological effects and therapeutics from old school authorities; also some provings and cases in which this product was given homœopathically. The lecithins are etherial compounds which result from the union of cholin with glycerine—phosphoric acid, in which the two glycerine hydroxyl groups have been replaced by fatty acid radicles. In the yolk of eggs lecithin occurs with vitellin, but is apparently

not closely bound. The lecithins are widely distributed in both the animal and vegetable kingdoms. According to Hoppe Seyer they are found in all cells and bodily fluids. They are specially abundant in nerve tissue and in the eggs and semen of most animals. Dr. Fahnestock states he has been proving lecithin for two years, but he does not give the doses administered, nor the doses employed in patients who received the drug. The symptoms are presented in schema form. The following is a condensed summary: *Mind and sensorium*: forgetfulness and dulness of mind, confusion, irritability, with tendency to hypochondriasis. *Head*: aching and dulness, mostly in the occiput, but also in the temples and eyes. *Eyes*: soreness and sticky sensation in the eyes. *Ears*: pulsation and ringing, with dulness of hearing. *Nose*: rawness and soreness. *Face*: pain in zygoma; pale, looks ill. *Mouth and tongue*: dryness, white coating, some pasty taste. *Appetite*: loss; thirsty, desires wine; belching, nausea, bloatedness of stomach. *Liver and abdomen*: dull pain, with bloatedness, sometimes colic pains. *Stools*: loose, yellow, with flatus. *Urine*: scanty, with phosphates, sugar, or albumin. *Sexual organs*: *male*, power lost or enfeebled; *female*, menses delayed, but flow profuse. *Respiratory organs*: rawness, dyspnoea (from palpitation), dry cough; soreness in lungs. *Heart and pulse*: beats increased. *Neck, back, and limbs*: soreness, aching and tiredness; lack of energy; nervous. *Sleep*: restless, wakes early, hypochondriacal dreams, soreness, and tiredness in the morning. *Fever*: chill followed by fever (temperature 100° F.); thirst and hunger during the chill.

In a case of neurasthenia sexualis in a man, aged 54, lecithin proved curative in about eight or nine weeks. The chief symptoms were weakness all over, sore spot in sacrum, shooting pains in arms and legs; loss of memory; wakes 1 to 2 a.m.; frequent micturition day and night; impotent two years. Dr. Fahnestock reports another case, also of debility, with hypochondriacal feelings, which rapidly improved under lecithin. The patient was a medical man suffering from cough, loss of weight, evening temperature, night sweats, soreness of chest, loss of appetite, sleeplessness, loss of memory, persistent sick headaches, loss of sexual power. In a few weeks all symptoms were much improved. (*Journal of the American Institute of Homœopathy*, July, 1909, p. 289.)—ED.

**Lycopus Virginicus in Cardiac Neuroses.**—A woman, aged 32, married, with two children, formerly a school mistress, of nervous constitution, suffered from fluttering or palpitation at

times, especially at night, increased if she has a hearty meal or coffee. Wakes her out of a sound sleep, and she has to sit up to get relief. Excessive flatulence, decreased by eructations. In daytime annoyed by sensation as if her heart turned over; this symptom being caused by the pulse dropping a beat. Successfully treated by lycopus. (Dr. Roberts Richel in the *Hahnemannian Monthly*, July, p. 496.)—ED.

**Spongia, Aurum, Iodine, in Cardiac Disease.**—In a contribution to a symposium on the homœopathic treatment of cardiac disease. Dr. O. S. Haines draws attention to spongia, iodine, and aurum, as often neglected. He gives the special indications for each. *Spongia*.—In cardiac inflammations, accompanied with almost the same fear and anxiety as aconite, almost resembling the stitches produced by spigelia, and almost the compression of cactus, these symptoms being overshadowed by the patient waking up after midnight with paroxysms of suffocative anxiety and palpitation. He cannot move, is flushed and hot, and frightened to death. Spongia is adapted to cases later than aconite, and it removes pathological changes. *Aurum*.—Dr. Haines considers aurum specially useful in arterio-sclerosis, where there are nightly paroxysms of pain behind the sternum, sleeplessness and epistaxis in the morning. The paroxysms may be relieved by glycerine, but aurum is indicated when there are the following symptoms: Erosion of the nasal mucosa, violent pain behind the sternum on the slightest exertion, symptoms aggravated at night, violent palpitation with rushing of blood to the head, a feeble, weak, irregular pulse, and melancholic despair. *Iodine* is called for in myocarditis, with emaciation and look of degeneration, a weak, thready pulse, accelerated on every exertion, although absence of definite enlargement or murmurs. Painful attacks of compression about the heart. It seems as if the heart were squeezed with an iron band, followed by great weakness and faintness in the region affected. (*Hahnemannian Monthly*, July, p. 481.)—ED.

**Strychnia Phosphorica.** *A Proving.*—Dr. M. A. Royal, of Des Moines, presents a study of strychnia phosphorica based on a proving made by eleven students of the University of Iowa. The method employed was that of the O. O. and L. Society, the potencies used the 30th, 6th, 3rd and 1st, and the time of the proving was from March 19 to April 14, 1908. The symptoms were culled and combined, and ninety-seven are left as representing the effects of the drug. In Dr. Royal's study these are

regrouped under location, sensations, and modalities. The therapeutic applications are given with some cases, and then the symptoms presented in schema form. The following are Dr. Royal's first group : *Location*.—Strych. phos. seems to act through the cerebrospinal nervous system upon the following tissues and organs : (1) Muscles : Twitching, jerking, lack of co-ordination, trembling, stiffness, cramping, soreness, weakness, and even complete loss of power. (2) Mind : Lack of control, silliness and uncontrollable desire to laugh, followed by disinclination and inability to use the brain. (3) Circulatory system : Irregularity of pulse both as to frequency and force, rate varying from 50 to 132, pulse easily accelerated on exercise, the face flushed, the hands cold, with a cold, clammy sweat over the entire body. Pulse tracings are given by Dr. Royal. (4) Thermal centres : Under the 30th and 6th, four provers recorded variation of temperature from 97° to 100° F., while from the 3rd and 1st there was variation from 97·4° to 99·4 F. *Sensations*.—Vertigo, fainting, drawing, soreness, stiffness, trembling, twitching, jerking, cramping. *Modalities*.—All symptoms are markedly aggravated by motion ; vertigo on ascending and descending stairs ; spasmodic action of muscles, aggravated on ascending and descending stairs and rapid motion ; all symptoms are relieved by quiet and in the open air ; stiffness and drawing of the muscles better on gentle continued motion. *The nosological types of disease* to which strychnia phosphorica is applicable are chorea, locomotor ataxia, paralysis agitans, tetanus, hysteria, and acute profound asthenia following acute fevers or pneumonia. A case is cited of the last-named condition where strychn. phos. 3 every two hours was followed by rapid improvement ; also another case of hypertrophied and dilated heart, accompanied by irregular pulse, vertigo, and other symptoms, which were all cleared up except the irregular pulse by the 6th dilution. (*Journal of the American Institute of Homœopathy*, July, 1909, p. 297.)—ED.

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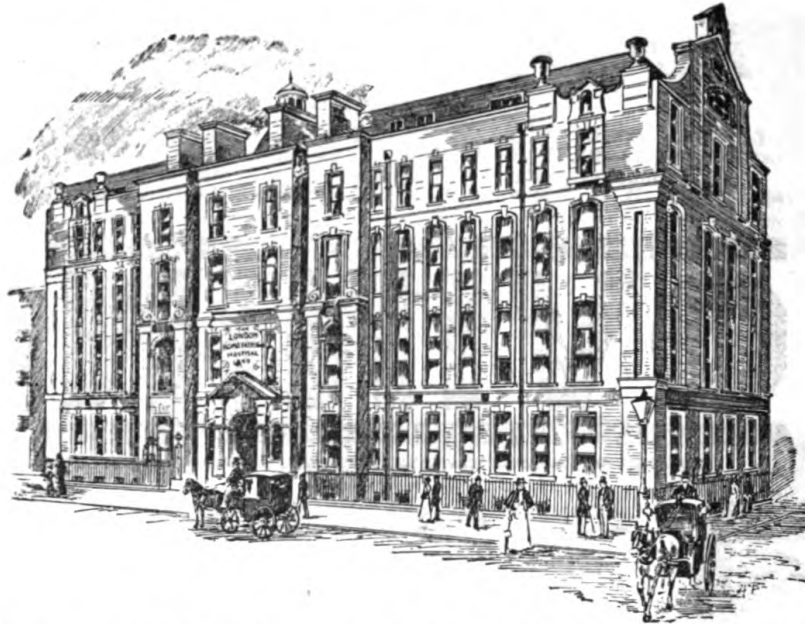
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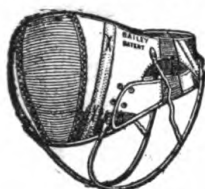
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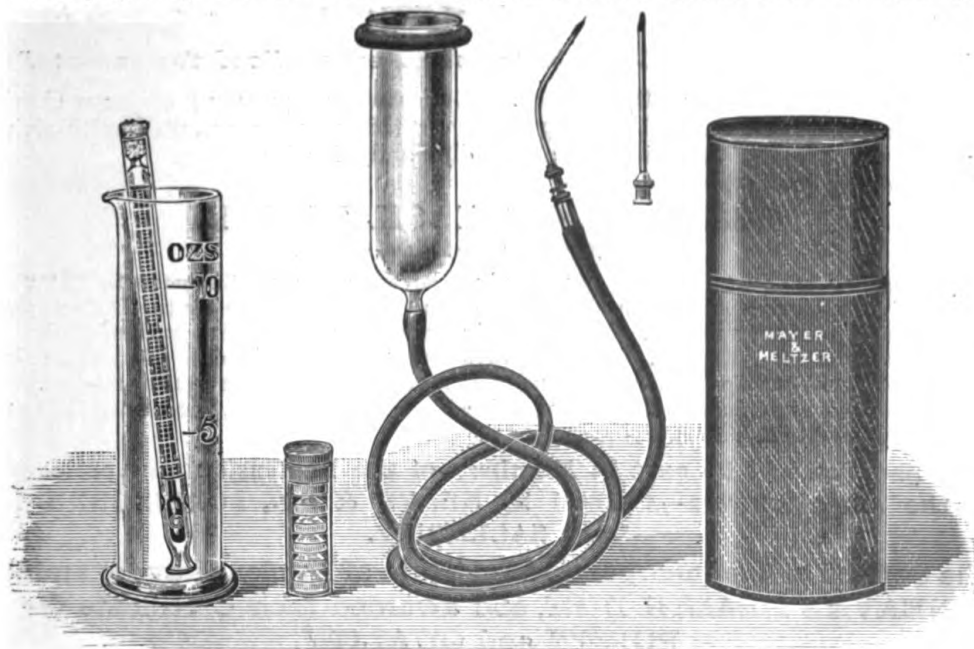
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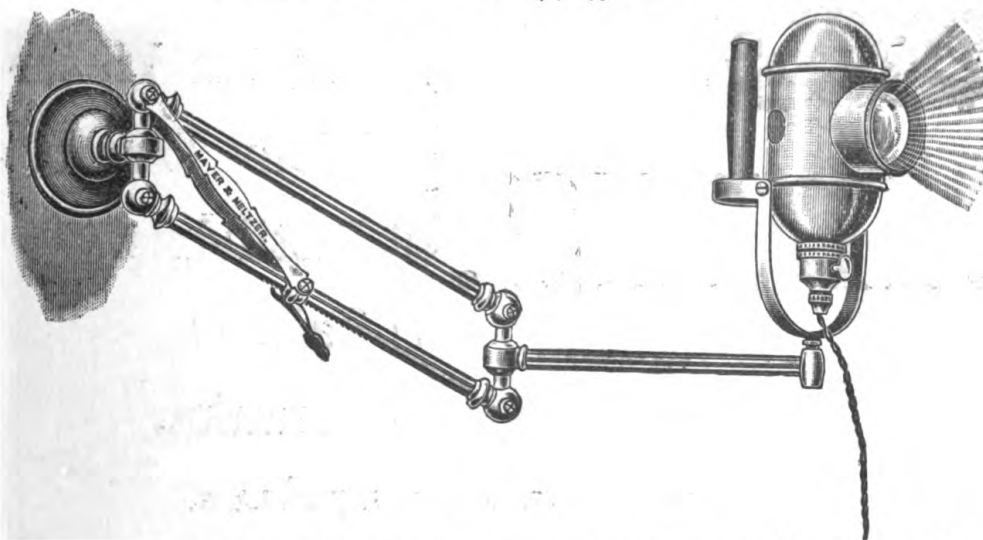
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