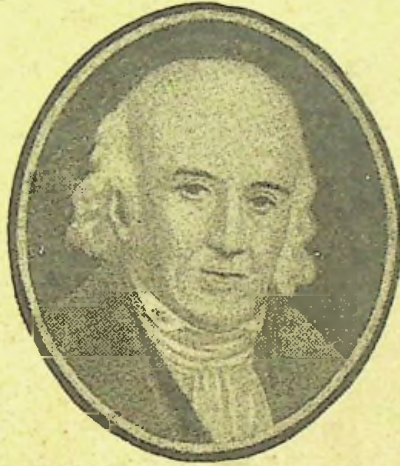


The

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The HOMŒOPATHIC HERALD

EDITOR

Dr. B. K. Sarkar, M. B. (Cal.), D. M. S.

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Editorial**THE STUDY OF HOMŒOPATHIC DURGS FROM THE
STANDPOINT OF ENDCRINOLOGY.**

With the advance in the knowledge of endocrinology we, now know that internal secretions of different ductless glands exert a profound influence over the mental and biological make-up of an individual so that the reactions which individuals make to the problems of life which either confront or which they imagine to confront them—are predetermined to a great extent. One thing has become very evident, that the different glands affect the organism differently, they always seem to act synergistically and in actual clinical conditions it is very difficult to account for the totality of the symptoms with disordered functions of one single gland. Another point to note is that both hyper and hypofunction of the same gland may exist in the same individual at the same time, i. e., majority of clinical picture of glandular affections as due to dysfunction. Further these glands are in intimate relationship with the autonomic nervous system which controls the vegetative functions of the organism. As the autonomic nervous system consists of sympathetic and parasympathetic divisions, exerting antagonistic influences over the organs they supply, the ductless glands also act in two groups in connection with them. Anterior lobe of pituitary, Thyroid, adrenals act synergistically together and stimulate the sympathetic system; the parathyroids and the pancreas act together and influence the para-sympathetics. It is now believed that an individual belongs to one of two classes. In the first, the sympathetic nervous system is dominant, leading to sympathicotonia; in the second the para-

sympathetic or the Vagus is the ruler, leading to vagotonia. By some it is thought that the nervous type is determined by which set of glands is the dominant; what other observers are of the opinion that this is putting "the cart before the horse", and that it would be more true to say that the particular set of glands are in the ascendent because the individuals pass a dominant sympathetic or vagus as the case may be. But these controversies should cease if we always keep in mind that in life a multitude of cells have been brought together under a larger unit, not through aggregation but through a marvellous quality of complex, self adjusting inter-relationship maintaining a perfect co-ordination of functions. This is the creative principle of unity which baffles all analysis. That is why, although physiology has revealed the workings of glands and of the autonomic nervous system, this faulty notion of cause and effect, has hampered the therapeutic efficacy of the old school except in cases where substitution therapy is indicated. Whereas in Homœopathy we get the clinical pictures of the dysfunction of glands reflected in the proving of drugs and we use them on the symptom-similarity basis without taking into account as to whether the glandular dysfunctions or the nervous disturbances are the primary trouble.

To go into the details of the functions of the ductless glands which they exert over nutrition, growth, mental development and evolution of sexual characters, would be quite beyond the limited scope of this article. Herein is presented broad outlines of personalities of thyroid type, adrenal type, pituitary type, thymus and gonadal type; and comparison of these pictures with those presented by several important drugs to bring out the similarity between them.

(1) Thyroid Personalities.

There are three types of Thyroid personalities: one where outstanding features are due to definite deficiency; the second, when thyroid is over-active in comparison with control exercised by other endocrine glands; and a third type, which shows dysfunction of thyroid leading to unstable equilibrium of its secretion and manifesting lesser degrees of hypothyroidism.

Dealing with the first type the characteristics are plain. In

the extreme type, we find "cretin" but here we are not concerned with him because he falls into the definitely abnormal. Rather we are dealing with the normal individual who is sufficient in thyroid secretion to stand out as a definite thyroid personality. Such a child presents a coarse appearance; the hair is dry and straight, the nose is broad, skin is rough and dry, and he retains many babyish characteristics beyond infancy to childhood. Bed-wetting is common in this type. He develops thickening in various parts of the body. This is the child who is likely to suffer with adenoids and enlarged tonsils. He is dull mentally and heavy physically; slow in development, requiring a great deal of sleep and a long time in which to wake up. It is, however, when puberty is reached that the deficiency in thyroid makes itself more noticeably felt; there is delay in the establishment of sexual function. It is possible, however, with the appearance of sexual secretions a natural stimulus arises which makes good the stigmata of thyroid deficiency. All the bodily processes seem to be energised by this change and the sluggish, slow child develops into a restless, excitable adolescent. As middle age is reached an increasing girth points to the deficiency of thyroid and the consequent lack of stimulus to pituitary and adrenals, corpulence develops. Deficiency is noted beneath the eyes, thick neck appears. Opacity of the lens of the eyes; in middle life these individuals take to glasses before their fellows.

Whereas we get an opposite picture with dominant thyroid. In childhood the type is easily recognised; he is the excitable child; quick in the uptake, resistant to infection and generally healthy. They learn well; they are easily influenced, enthusiastic keen on new ideas and usually artistic. Adolescence means for them a time of stress. They are attractive to look upon, their features are characterised by narrow, thin noses, sharply marked eyebrows and fair complexion. In this type of people there is no tendency to obesity. His sexual life is an active one and continues in advancing years.

The third group which is marked by lesser degrees of hypothyroidism manifest obesity, roughness of skin, chilliness

due to lowered basal metabolism, susceptibility to cold, constipation (due to vagotonia) easy fatigability, etc. In the state so-called "thyroid instability" a condition happens when associated with thyroid inadequacy, these syndromes are clinical expressions of hyperthyroidism, which are in themselves, the reactionary manifestations of the fundamental sub-thyroidic condition. They are : migraines, ophthalmic migraines, asthma, attacks of chronic rheumatism and gout, mucons enteritis, urticaria and other skin affections, mental symptoms etc.

From the above descriptions it will be evident that in provings of Calcarea, Baryta salts, Graphitis, etc., sub-thyroid conditions manifest, we can understand the relation between, obesity and chilliness, and susceptibility to cold we remember thyroid being a katabolic gland in association the sympathetic nervous system, hypothyroidism leads to lower metabolic rate resulting in obesity, and generation of less vital heat which makes the individual chilly and susceptible to cold, constipation associated with these conditions may be explained relatively dominant vagus tone producing spastic condition of intestinal musculature. The predominance of skin symptoms may as well be accounted for as thyroid secretion exerts of profound trophic influence over the skin cells ; hypothyroidism produces unhealthy condition of the skin infection as a constitutional signal. We can thus explain the correlation of key-note symptoms of Graphitis e.g. fatty, chilly, and constive.

In phosphorus we picture of hyperthyroidism

In our next editorial issue, we will discuss Adrenal Personality, pituitary personalities and Sex-gland personalities.

B. K. SARKAR.

THE HYPO-ADRENOCORTICAL STATE. RECOGNITION DIAGNOSTIC CRITERIA, TINTERA'S CONCEPTS, PSYCHODYNAMICS AND MANAGEMENT.

JUAN WILSON, M.D.

On May 14, 1969, Dr. W. W. Shreeve, Senior Scientist of the Brookhaven National Laboratories on Long Island, remarked after a 90-minute dissertation on carbohydrate metabolism and the endocrine system, "We have to keep in mind that most of these mechanisms were developed in early primeval periods of evolution when conditions were quite different from today. One might turn this around and say that our ways of present day living and eating are not exactly appropriate to these mechanisms which have been developed in early evolutionary times." Now realize, this is not the statement of a philosopher or health faddist but of a national research scientist.

In Williams' Endocrinology we read: "Under stress cortisone output increases up to ten-fold. Thus many patients who appear healthy in every day life may actually have a very limited adrenocortical reserve." This can suggest that the patient who is not sick but never feels well may represent a most common form of hypoadrenocorticism.

In Pathologic Physiology, by Sodeman and Sodeman, we find these statements: "1. Pathologic physiology may accompany or result from anatomical defects but they frequently occur in the absence of any pathologic anatomic change, for "biochemical lesions" may be expressions of cellular dysfunction before the process is severe enough, or has been present long enough to cause damage detectable grossly or microscopically. 2. The knowledge of the sequence of events in the normal physiology of the endocrine glands is still confusing and incomplete."

We have come to recognize that there is an endocrine component to all disorders. The endocrinologist of today is the internist, the general practitioner, or the specialist in any field who evaluates the role that the glands of internal secretions

play in the pathologic physiology of each of his patients and utilizes hormone preparations in his diagnostic and therapeutic armamentarium. When applied to clinical medicine, disorders of adaptation suggest that there is an endocrine component in the manifestation of all diseases.

We believe that a hypoadrenocortical state is responsible for a major portion of the patho-physiology of many illnesses including Meniere's Syndrome, allergies, schizophrenia, narcotic addiction, alcoholism, the non-neurotic anxiety neurosis, and etc. Even a "nervous breakdown" is an expression of maladaptation and includes some degree of adrenocortical dysfunction.

This position is consistent with Dr. Sely's concept of the diseases of adaptation.

One must keep in mind that classifications of adrenocortical dysfunctions are not teleological but are artificial creations of man's mind which strives to fit things into his limited knowledge. I believe that the variety of adrenocortical imbalances are innumerable.

Alexis Carrell really put it on the line when he said: "Our mind has a natural tendency to reject things that do not fit into the frame of the scientific or philosophical beliefs of our time. After all, scientists are only men, They willingly believe that facts that cannot be explained by current theories do not exist.

Every in vivo test for adrenal function is performed on a stressed animal, therefore inadequate to tell us what is normal.

Although we are familiar with innumerable metabolic changes related to adrenal steroids, the mechanism of their action remains as yet unknown.

(Eisstenstein, et al). Who can therefore make absolute statements about what and how much is necessary for a hypoadrenocortical state?

Consider a latent insufficiency in any patient with T. B. chronic gastrointestinal disorders, unexplained lymphadenopathy, those with a small heart, women with no axillary hair,

those with exaggerated sensory responses, in all cases of chronic fatigue, syncope, convulsions.

When we read in *The Adrenal Cortex*, edited by Eissenstein, that only a few of the adrenal steroids are biologically significant, most of them being precursors or merely intracellular intermediates, we must be conscious that this is a human-scientist concept and not a pronouncement of God or of evolution.

The concepts we can identify with Dr. Tintera are:

1. The adrenal cortex is a Gestalt organ. The use of isolated glucocorticoides is unnatural and should be restricted to severe emergencies.

2. In many illness is a disturbance in the hormonal adaptation mechanism, particularly involving the adrenal cortex.

3. These patients often show a disturbance in carbohydrate metabolism which is causally related to many of their symptoms.

4. Treatment of these diseases should always include a correction of the hypoadrenocortical state and any other ancillary endocrine, disorders.

5. A high protein, moderate fat, low carbohydrate diet with frequent feedings is essential for stabilizing blood glucose levels.

6. The response of hypoglycemia to the administration of the adrenal steroids is not equalled by the simple administration of glucose.

7. The action of ACE is greater than that of the sum of the known isolated hormones.

8. The importance of ACE is that it contains all of the cortex's secretions, known and unknown, in a complimentary relationship of synergistic and antagonistic action which represent an intrinsic check and balance system of homeostasis,

The present ubiquitous use of synthetic, altered, isolated is done without any provisions of their consequences. So it comes as no surprise that a majority of heart transplant patients have developed severe psychosis thought to be related to the use of large doses of prednisone.

Alexis Carrell said it best of all, "We are not free to modify, according to our fancy our own environment or ourselves."

Isolated glucocorticoids are not similar to the adrenocortical extracts.

Cortisone is catabolic, ACE is anabolic.

Cortisone increases water retention and creates abnormal fat deposits, ACE does not.

Cortisone increases intra-ocular pressure in glaucoma, ACE relieves it.

Cortisone leads to thinning of the epiphysial plate and interrupts growth in the young, ACE does not.

Cortisone destroys the ground substance of most cells. ACE enhances its integrity.

Cortisone produces a "diabetic" curve in the GTT. while ACE will lower the peak and bring about a rise in the hypoglycemic level of the GTT of a delayed hyperinsulinism.

Cortisone can produce psychiatric disorders, ACE helps to relieve them.

Symptoms of the hypoarenocortical state are related to the psyche, the intellect, the nervous and somatic system.

Physical examination can reveal a variety of body habitus from the asthenic to one of girdle obesity. The skin is often dry, with calluses over the knuckles and elbows. Patients usually show multiple keratoses. The hands may be mottled or show a rubor the thenar and hypothenar eminences.

The second finger is frequently longer than the fourth. In men there is a decrease from the normal hirsuteness, especially on the extremities. There is often a hypertrophy of cervical glands. The thyroid is often enlarged (perhaps a permissive compensation?). The lower incisors are generally crowded. Multiple fillings are usually present. The liver is often palpable and tender. The back is usually tense with varying degrees of rigidity and instability. There is usually poor balance or an unsteady gait.

Laboratory examinations will reveal a flat GTT curve or a reactive hypoglycemia. Williams states that the lowering of the blood sugar level in most instances is relatively small and

that there is a decrease in the threshold at which symptoms become manifest, in the hypoglycemia of hypoadrenocorticism. Kauvan and Goldner, have reported that the "hypoglycemia syndrome" May occur with an elevated blood sugar.

A low normal PBI or T4 is an expression of low total metabolism. Oncasionally one finds a high cholesterol and uric acid. A relative lymphocytosis (35-50%), some eosinophilia, 3-5%, and a mild anemia are added findings. Urinary assays will show changes in the 17 keto and hydroxy ketosteroids. A salt loading test often shows a tendency to "waste salt." Females frequently show a poor vaginal cytological index. Dr. J. Hill, a cardiologist, states that 80-90% of patients will show an rsr With inverted T in V 1, and V 2 on the EKG, a pattern consistent with anoxia.

Treatment includes diet, supplementary vitamins and minerals, ACE, an autonomic N.S. stabilizer, such as Bellergal, and psychological counselling regarding the decreased tolerance for stress and the characterological attitudes which are developed in responses to having the disease.

If we are to insure a new state of balance—health—it is essential that we put the hypoadrenal states into a proper perspective.

Nothing will happen to the human condition unless it perceives a stimulus from its environment. It may be a microbe, a pollen or an emotional experience.

In the latter situation the higher cerebral centers perceive the stimulus which is then carried by the A.N.S. to the adrenal medulla, the vegetative connection.

The release of catecholamines will prime somatic structures. They will also stimulate the hypothalamus which, through neuro-humoral pathways will induce the pituitary to stimulate, not only the adrenal cortex, but the thyroid, pancreas and gonads.

The main reasons for their involvement will be to guarantee adequate amounts of energy materials and to promote their utilization by the cells.

The oxidation of these products will provide energy for peripheral muscle action with which the individual can react

to the environment with a response that is appropriate, relevant gratifying. Symptoms can derive from an incompetency anywhere along this line of physiological action.

Other symptoms can be created through the individual's efforts to adapt to his physiological deficiencies. The hypocrines motto can very well be "The spirit is willing but the flesh is weak." It is not difficult to understand his characteristic attitudes of self criticism, perfectionism, compulsion and determinism, which are not real but contrived feelings.

When feelings have been stimulated the A.N.S. and endocrine systems are activated to mobilize the body, Where the patient psychologically immobilizes his real feelings, it will force immobilization of the physical self. Included are a wide range of feelings from mild anxiety to stark terror, from slight annoyance to blind rage.

When feelings are blocked the organ and muscle responses to A.N.S. and endocrine stimulation become disturbed. The resulting changes are sensed as anxiety which may be found even with depression. Anxiety may well be more descriptively spelled ANSI-ety.

Our goals, therefore, should not be limited to the manipulation of biochemical values or biological assays, but should involve getting the whole individual to relate more successfully to his total environment.

Returning to the role of adrenal steroids, Dr. Eugene Yates, remonstrates: "I acknowledge the pertinence of one of Robert Frost's poems to reviewers in the adrenocortical field:

"We dance round in a ring and suppose,

But the Secret sits in the middle and knows."

As a member of the Medical Board of the Adrenal Metabolic Research Society, who had the pleasure of knowing Jack, I can readily visualize Dr. Tintera joining me with his genial smile to say:

"and the only way we'll solve the riddle is in using ACE. which contains the middle."

Journal of the A. I. H. July, August, September, 1969



HOMŒOPATHIC REMEDIES IN A GERIATRIC UNIT

A. E. GIBBS, M.A., M.B., B CH., F.R. H.S.

After twenty years in hospital practice I am convinced that no drug is necessarily good because it is new, nor is it necessarily bad because it is old.

The virtual absence of toxic effects and the valuable results obtained by homœopathic remedies mean that this branch of medicine is well worth while in the management of the multiple diseases to which elderly people are susceptible. A few case histories may be of interest.

Case No. 1

An elderly lady of 82 who had spent twenty years in India as a hospital matron was admitted with extreme apathy, lethargy, angina pectoris, anorexia and diarrhœa.

The diarrhœa settled quickly with one powder of Dys. Co. 30. However, she still remained anxious, depressed and had repeated vomiting attacks. From her conversation she was meticulous as to details, so I decided that the only drug to fit the whole picture was Arsenicum 30. That was given in a dose of drachm i bd for three days, and she began to eat a light diet, the vomiting ceased and the associated precordial pain improved. An ECG showed changes suggestive of an anterior infarct.

The patient was given the allopathic drug Sustac, gr. 1/10 bd, and this helped considerably, but she collapsed in an unconscious state two weeks later. A male nurse administered 4 cc of coramine, but when I saw her she was still in a comatose state and vomiting black fluid. I gave her Arsenicum 10M, drachm i tds for three days, and within two weeks she was reading a novel a day and was ambulant without help. She is soon to be transferred to a Welfare Home.

Case No. 2

A man of 69 was admitted in a desperately ill condition due to coronary thrombosis and pneumonia. He was put on anti-coagulant drugs (warfarin sodium, 5 mg daily), but this had no

effect on his severe precordial pain. As I was determined not to give morphine in this case he was given *Carbo vegetabilis* 10M tds for two days, followed by *Lycopodium* tds for a further two days, and then *Cactus* 10M for seven days. Recovery was quite satisfactory and he was discharged home about five weeks after admission.

Case No. 3

A man of 78 was admitted in a deep coma during the beginning of an influenza epidemic. He was plethoric, icy cold and intensely cyanosed: His own doctor said, "I do not think he will live more than a few hours." The blood pressure was unobtainable and there were coarse crepitations at the bases of both lungs. I administered *Carbo vegetabilis* 10M, one teaspoonful every hour for eight doses, then every four hours. Thirty-six hours after admission there was flickering of the eyelids and he was able to take sips of fluid by mouth. The treatment was then changed to *Lycopodium* 10M, drachms i 4-hourly, and a slow but gradual recovery ensued. He also had penicillin in large doses for legal reasons, but tetracycline therapy before admission had not helped.

He was discharged home two months after being admitted.

Case No. 4

A man of 46 was transferred from another geriatric unit with an indwelling catheter for urinary incontinence. This was due to disseminated sclerosis. The catheter treatment was a necessary evil as he had a large pressure area on one hip and an extensive superficial area of loss of skin off the sacrum.

Three months after admission the patient developed complete anuria as a result of ascending pyelonephritis. Conventional allopathic treatment with intravenous 4.3 per cent. sodium sulphate (in the absence of a kidney machine) produced a diuresis of exactly one ounce of urine in twelve hours. I administered *Stramonium* 30, 1 teaspoonful tds for 48 hours. A normal urinary flow was produced within 8 hours and the treatment was continued once or twice daily for a further three weeks. *Silicea* 30 helped to keep the pressure areas healthy until death occurred three months later.

Case No. 5

A pleasant, obese, diffident lady of 63 was lethargy and difficulty in walking. She had been diagnosed a few weeks previously at a general hospital as having multiple myelomatosis of the spine. Hb=62 per cent. Blood urea 30 mg/dl. ESR=77 mm in one hour.

She was treated with Iscador Mali c. Hg or Ag, 1 cc twice weekly. After six weeks she was able to go home. Nine months later she remains well except for mild chronic congestive cardiac failure. The Hb varies from 60 per cent. to 70 per cent. at different times. In previous years two other patients with this dread disease treated with purely allopathic drugs and blood transfusions both died within a few weeks.

This particular patient had also undergone the severe operation of vulvectomy at a London hospital some years ago for kraurosis vulvac. On three separate occasions she was unable to pass urine, but each time this responded quickly to *Silicea* 30, one dose, probably because this remedy is able to break down periurethral scar tissue.

Case No. 6

A female patient of 82 was admitted with an extensive septic ulcer 8×6 in. on the anterior aspect of the right leg. The ulcer was one of those deep lesions with exposure of the tibialis anterior at the ankle joint.

She was given conventional treatment with Eusol dressings, tulle gras, antibiotics and vasodilator drugs. She was also given *Silicea* 30, drachms i bd, for periods of 7-10 days, *Sulphur* 30, *Hepar sulph.* and occasional doses of *Graphites* 200. The consultant geriatrician said "this patient will require a skin graft from a plastic surgeon". However, perseverance with local dressings and the homœopathic remedies has resulted in healing the ulcer except for an area 2×1 in. only 1 mm in thickness. She has recently been discharged home.

Case No. 7

A professional man aged 78, a retired dentist, was transferred from another geriatric unit after being treated for congestive cardiac failure. The œdema and the dyspnœa had

been relieved, but he was apathetic, looked extremely dirty and his "diet" consisted entirely of Sherry 1 oz every hour as he was a known alcoholic. He was so constipated that at the other hospital he was treated with enemas twice a week. *Nux vomica* 6 failed to help, but *Sulphur* 30, given twice daily for a week, gave him a regular bowel action once a week; his appetite returned and within five weeks he was discharged home. At no time were enemas or purgatives required. The patient stopped his sherry, but he was given beer in order to maintain his morale and prevent delirium tremens.

Case No. 8

A frail exhausted ex-nursing sister aged 60 was admitted with broncho-pneumonia and cerebral thrombosis. The most striking clinical feature, however, was an intermittent choreiform movement of her tongue, i.e. it popped in and out every second, or at least 360 times an hour. A general hospital had failed to relieve this.

Having just heard a lecture in London in which Dr. M. Blackie described the cure of a facial tic with *Lycopodium*, I prescribed *Lycopodium* 6, one powder tds for a week. Within three days the abnormal tongue movements had ceased:

I am quite sure that allopathic medicine could not have helped these patients to the same extent as the homœopathic remedies. In a National Health Service hospital where the physicians are not believers in Homœopathic remedies it is not possible to prescribe the remedies alone. I have, however, realized without any doubt that once the doctor begins to use homœopathic remedies he enters a new world of interest and delight.

The British Homœopathic Journal, April, 1969.

SOME EXPERIENCES OF HOMŒOPATHY

DR. J. D. S. WILSON

Mme. Chairman, Ladies and Gentleman,

Lycopodium is one of several remedies which has terrors of anticipation and also has the certain knowledge that he will make a mess of his forthcoming public performance. When the time comes he stands up and excels himself and as Dr. Tyler puts it in her *Drug Pictures* "all was joy and fluency"—I leave it to you to judge whether a dose of *Lycopodium* would have helped me—I rather doubt it.

My first experience of Homœopathy was attending the course three months ago at the end of February which you will recall had PAIN as its theme. I went away completely punchdrunk, my head in a whirl, but somewhat stimulated by the new approach of treating patients as individuals rather than concentrating on the particular disease process that afflicts them. Three months is not very long to even scratch at the surface of the art of Homœopathy and I was very surprised to see my name included on the agenda for this meeting, but being one of the nation's youth required to do National Service I am used to obeying orders without question and, Mme Chairman, as you know, we have a most persuasive Dean,

Two cases of herpes zoster presented themselves to me on the first day back at work after the course. The first came into surgery—a 45-year-old officer of the local council. He had had a pain in his right buttock and thigh for almost a week and a rash was just appearing. There was a patch of blisters on his buttock and a few early blisters on his thigh. His discomfort made him restless and heat relieved—I gave him *Rhus tox.* 10M two-hourly \times six.

The second case was a good friend of mine, a 56-year-old bank manager, who is a patient of my brother's. While I had been on the course he had developed an acute pain in his right chest, and had even been to the chest clinic to exclude a spontaneously fractured rib. Two days before I saw him his rash had developed involving about six intercostal

spaces right round his right hemithorax and understandably he was very ill. We discovered by using a hot flannel that heat relieved him and clearly he had difficulty in getting comfortable so I gave him *Rhus tox.* 10m x six two-hourly.

In both these cases the lividity of the rash showed a marked change in two days and the blisters, instead of being glistening and fresh, looked very sorry for themselves. Case I developed one or two small bisters on the thigh and complained of an area of tenderness above the knee but no rash developed there. It is possible that this area would have progressed to overt shingles without treatment. He was back at work in two weeks and when I saw him last week had had no pain since.

Case 2 I am not so happy about—the *Rhns* I'm sure had some effect on the rash as I have described, but he was away from work for two months and still has areas of extreme tenderness though I don't think much of neuralgia. I did give him *Variolinum* 30, 200 and M, one table of each on three successive days, whereas three doses of each, I since discovered, would have been more appropriate. He was, I understand, rather depressed before his illness and this state persists and clearly his constitutional remedy requires working out to complete his recovery.

Another case presented itself two weeks ago in a 45-year-old Electricity Board linesman, involving two intercostal spaces on the right. Here again the rash had only just appeared and suited *Rhns tox.* as he had found relief from a hot water bottle and he was restless. The rash was anterolateral and not extensive, He was very sore over his scapula but had no rash. The rash followed the same pattern as in the others, i.e. loss of redness and dull blisters and no more developed. I have given him *Variolinum* which very quickly made him feel better and got rid of the pain in his scapula—I am hopeful that I can sign him off tomorrow, total time off work three weeks.

Shingles, as we all know, is most variable in its severity and evaluation of treatment is difficult—I would hope that I had helped at least two of the above to minimize their attacks

and I think I helped the third a little--and there is still hope ! The important message from this small series is that the best effect is achieved when treatment is instituted as early as possible.

DR. D. F. SMALLBONE

1 *Woman aged 45, married, two children*

Diabetic, controlled by diet only, with diabetic mother. Occasionally smokes, does not drink. Main history is inability to go out alone and fear of crowds. Duration of this is from childhood. At present has a gnawing fear in the epigastrium gradually getting worse until she develops a physical inability to move. This situation is excited by the thought of having to meet people, particularly strangers. Generals and mentals are liking of warmth but not of heat, she dislikes the cold, dislikes damp and dislikes changes. She is full of phobias, hates thunder fears the dark and fears heights. The sea holds a fatal fascination for her, but none the less she hates it. This applies to all broad expanses of water. She loves to feel and hear the wind but she covers her head when she goes out. She used to have a very sweet tooth but recently has started to dislike sugars. This I think is probably, because of her diabetic diet. She does not eat fats but only eats a normal amount of salt. The only real aversion in food that she has, in fact, is fish. She is not a thirsty person. Her bowels are quite normal. No urinary symptoms and still has her periods which are fairly regular. She worries a lot over the future and other people. She is very tidy and is rather irritable but conceals this. She is very possessive over her only son who is not yet married. She tends to bottle things up, but occasionally lets herself go and cries. This makes her feel better. She has a great fear of not pleasing people, yet really puts herself out to accommodate them, even to the extent of going out in a crowd although it petrifies her. She is very prone to crying. She likes people and needs company. She has no self-confidence. Although she says she does not like consolation she is much better if consoled when ill. She talks a lot and she is apprehensive of almost every situation,

particularly strangers, any new undertaking, the dark, hospitals and failure. Her memory is rather poor. She has a peculiar religious conviction that she must look after her son religiously either until she dies or he marries. This appears to be a very deep conviction with her and causes her a lot of alarm. I gave her three doses of *Pulsatilla* 10m and sat back and waited. Three weeks later I had a letter from her in which she stated that she had had a very bad headache lasting until about soon each day, passing off and then returning in the evening. This was accompanied by aching shoulders and heaviness in the head. She had lost a lot of her self-pity and she was not depressed or miserable as she had been. Everyone had told her that she looked bright and in fact she felt brigher. Two days later I went to see her and the headache had in fact gone and she looked much better. She has since been able to go out and meet people with much less apprehension than before although there are still some remaining defects. I have, however, not prescribed further for the time being as I feel improvement is still being maintainèd.

2 *Man, aged 50, owner of a chain of funeral directors*

This case is really a treatment of an acute condition with reference to known past history. I have known the man for several years and have treated him in the past allopathically. I was approached by relatives, namely his wife and son, as he was becoming very deranged in his behaviour. He had periods of mania when he was obsessed and violent. He was thrown into a rage very easily by any small domestic argument. He had, in fact, threatened and attacked members of his family, and had half heartedly attempted suicide. His previous history included a periop of virtual alcoholism and he had had two bouts of acute hepatitis. Eight years previously he had had an acute nervous break-down. Eight months prior to my seeing him his marriage had almost collapsed because of his moods and tempers but reconciliation had been effected. I told his wife that if these moods persisted and he refused treatment the only other recourse would be to have him certified. Things had obviously reached a head when this was contemplated by the family, but they persuaded him to come and see me.

He was still a moderately heavy drinker although he could now do without alcohol. He complained periodically of stomach upsets of a general nature. There were no food specialities except fat upset his tummy as did quite a lot of other foods. Consequently he avoided these. I treated him with three doses of *Nux vom.* 10m, as it was a matter of doing something or getting him certified. Two days later he had what appears to have been a violent reaction to the *Nux vom.* although at the time I did not realize this. I was called to see him at home. His marriage was on the rocks and his wife could tolerate no more. He had threatened her and his son with terrible consequences. Eventually he blamed his wife for all the faults and said that he would leave her. In the mood he was in I thought it was probably wiser to acquiesce and I took him to a hotel for the night. Two weeks later he came to my surgery saying that he was well. He was back home and felt better. He had touched very little alcohol and was much more amiable. He agreed that the domestic crisis I had seen two weeks before was truly his fault in that he became easily aggravated. He said that "they" the family were much easier to live with. After this interview I rang his wife and she confirmed that everything he said was true. He was much more rational, but she was still waiting for another outburst. He had remained more normal for a longer period than she was used to for some little while. The measure of effectiveness of the treatment I think is borne out by the fact that his wife said following his treatment she was much better also. I have seen him on two occasions since then and the improvement has been maintained. He is now so much more improved that he approached me concerning his wife's mild anæmia saying that he was worried that because of the last few months she had been neglecting herself. I have not as yet repeated the *Nux vom.* but feel that it will probably be necessary in the future.

DR. K. R. WALLACE

Mrs. F. M., aged 38 years

Family history: Mother suffers from chronic rheumatism. Father died in 1959—cause of death, anæmia. There are two

brothers alive and well and one aunt and uncle on her mother's side died of T. B.

Patient's background : She is Irish and lived in Ireland until she married a doctor and came to live in this country about five years ago. She has a vivacious and intelligent personality.

Previous history : A polypus was removed from the nose four years ago. Subsequently she had attacks of bronchitis and immediately before the onset on the present complaint, one acute asthmatic attack.

Present complaint : About one year ago she noticed a painful swelling of the index finger of the left hand mostly in the region the metacarpo-phalangeal joint. The pain and swelling has subsequently been in the same joint in her right hand, to a lesser extent in both wrists with more involvement of the left wrist, and in the left shoulder joint. The small joints of both feet, but especially the left, were involved for several months but are now quiescent.

Nodalities . There is considerable relief of symptoms from rest but this causes increasing stiffness. Moderate activity relieve the stiffness but the affected joints become more painful and swollen as a result. There is no definite relief from either heat or cold nor in any particular sort of weather.

Generals : Dislikes any extremes of temperature. Hates windy weather ; has intense, almost phobic dislike of heights which she has really only noticed in the last two or three years. As a child she was absolutely terrified of the dark ; she has an almost phobic anxiety of being lost while she is on a car journey. This is because she has no sense of location at all. She is very intolerant of rudeness or meanness, when she becomes extremely angry and says she shows this quite clearly in such circumstances. She believes she is critical of other people, impatient, of a tidy outlook, will nurse resentment especially against people who have shown either rudeness or meanness. She likes people in small numbers and gets on well with them provided she feels she has something in common, She does not like people on masse and is not self-confident unless she is sure of a sympathetic reaction from

people she meets. She has a very poor memory for dates and places, particularly in the keeping of appointments. Her sleep is good. There have been two normal pregnancies and menstruation is normal. Appetite generally good. She has an aversion to hare which she will never eat, and dislikes spinach and sprouts. She has no strong preference for either sweet or savoury foods in general.

(Continued)

SECALE CORNUTUM, A STUDY

D. M. GIBBSON, M.B., B.S. (LOND.), F.R.C.S. (EDIN.), F.F.HOM.

Pharmacognosy

The remedy is prepared from ergot, *Secale cornutum*, the dark purplish cylindroid sclerotium formed in the ear of rye by the fungus *Claviceps purpurea*. When fully developed this is a flattened, crescent-shaped body about 5 mm. in diameter and 4-5 cm. in length. A number of such may be found in the ripened ear of rye, or of wheat or barley as the case may be.

This plant-parasite has a most interesting history medically as its inadvertent ingestion in contaminated flour has caused outbreaks of serious disease to which the same ergotism has been applied. The history is a long one. An assyrian tablet of 600 B. C. refers to a noxious pustule found on ears of ears of grain, and a sacred book of the Parsees (400-300 B.C.) speaks of noxious grasses that caused pregnant women to "drop the womb and die in childbed". In France epidemics of ergotism can be traced back as far as A. D. 857 and in the tenth to the thirteenth century there were numerous outbreaks in that country. It was in the eleventh century that the affliction began to be known as St. Anthony's fire from the custom which had grown up of sufferers from the disease making pilgrimages to the shrine of St. Anthony located "near Vienne, in Daiphine," in the hope of cure. One of the symptoms is a sensation as if ants were running about under the skin, associated with a generalized erythema and much burning.

In addition to prominent symptoms such as convulsions and

gangrene of the limbs, the condition was often accompanied by hallucinations, delirium, mania or mental feebleness. A number of alkaloids are present in the sclerotium—ergonovine, the oxytoxic principle, ergotoxine, ergotamine, ergotinine. A further constituent is lysergie acid which is probably responsible for the psychotic effects. Amongst other ingredients are histamine and acetylcholine. The mother Tincture is prepared from fresh spurs gathered just before harvest.

Pharmacology

There is an affinity with the neuromuscular system, inducing violent spasm of muscle, especially plain muscle in the walls of the arterioles, and the muscle of the gravid uterus. The prolonged use of ergot preparations, for instance in the treatment of migraine, carries a serious risk of circulatory disturbance in the extremities or even in the mesentery, where gangrene of the intestine may supervene as the result of vasospasm.

Affinity with the nervous system leads to varying degrees of paraesthesia or anæsthesia of the skin. Symptoms of mental deterioration, ataxia, rombergism, lightning pains, and convulsions may also occur.

Vasospasm is, of course, followed by a rebound vasodilatation; this may account for the tendency to hæmorrhage of passive type. Moreover the blood is lacking in coagulability which results in persistent oozing and may involve serious loss of blood.

Physiognomy

The face appears pale and drawn. Pupils are large, Facial muscles may show twitching. Skin looks dry, shrivelled, sallow. The picture may be one of collapse with sunken eyes, blue rings around the orbits, lips pale or blue, and cold extremities.

The gate if up and about is trembling and staggering.

Foetor oris is present; discharges have a putrid odour.

Psychology

There is an air of timidity, sadness, and discouragement, even anguish. Anxiety may progress to actual fear of death.

Semi-stupor may occur, or a maniacal state with an urge to bite.

The sufferer may complain of sensations of numbness or formication, which is relieved by rubbing.

Physiology

A feature is marked coldness to touch over the whole surface of the body. In contrast to this objective coldness the patient complains of burning sparks were falling on the skin. This produces a great aversion from being covered and a desire for cool.

Appetite is often ravenous with aversion from fat and meat.

Thirst is unquenchable with a craving for lemon or acid drinks.

Sleep can be deep and prolpnged, but in drug addicts and alcoholics insomnia is more common.

Profuse cold clammy sweats involve the whole body, especially above the waist line.

Modalities. There is aggravation from being warmly covered, in fact from heat in any form; also from touch, exertion, round about 3 a. m., and both before and during menstruation.

Relief is obtained in cool air, by uncovering, when lying doubled up in bed, by being rubbed.

Pathology

General. Pains are described as burning in character and are made much worse by heat.

Hæmorrhage is a prominent symptom, from mucous surfaces, ulcers, even from small wounds. The bleeding is of the oozing type with dark non-coagulating blood, accompanied by burning pains and chilliness. It may be persistent to the point of causing collapse.

Head. A confused feeling in the head is associated with vertigo and a tendency for the head to sway from side to side like a pendulum. This is worse when moving about.

A burning violent pain in the forehead spreads over the vertex to the occipital region.

Eyes. Eye symptoms are various and often accompanied

by headache and vertigo. Mentioned are squint, double vision, sparks before the eyes, incipient cataract.

Ears. Quite slight noises may re-echo in the head and cause alarm. Roaring and humming tinnitus may be present.

Respiratory system. The nose feels stuffed up, but a watery discharge flows from the nostrils. Severe epistaxis occurs with dark blood which does not coagulate; the bleeding may be difficult to stay, with resulting prostration and thready pulse.

The voice may become weak and aphonic. Breathing may be shallow with a feeling of oppression in the chest and diaphragmatic cramp. Spitting of blood may occur with or without cough. A boring pain may be felt in the chest.

Alimentary system. Trismus may occur. Gums may bleed easily. The tongue becomes dry, fissured and coated brown or black, and may exude inky blood. It feels stiff and tingles at the tip.

Nausea is very persistent and made worse by taking food. It may be accompanied by much retching and vomiting. Bleeding may occur with coffee-ground vomit. The abdomen becomes distended like a drum, with cutting and tearing pain.

Profuse watery diarrhœa occurs, with olive green foul-smelling stools expelled like a jet; this is accompanied by great prostration and icy coldness, but the sufferer wants cold and throws off the covers. Stools may be involuntary with patulous anus. Melaena may be present.

Cardiovascular system. Anxiety, even pain, may be felt in the præcordial region, associated with tenderness on pressure.

The pulse may be small, rapid and intermittent.

Involvement of the circulation may give rise to such conditions as Raynand's disease, intermittent claudication, erythromelalgia, dry gangrene.

Urinary system. There may be much ineffectual urging to urinate. Incontinence may also be present, or retention with distension and overflow. Hæmaturia may be a symptom.

Genital system. Menses profuse, irregular and accompanied by severe bearing-down pains, which are relieved when the flow starts. A persistent loss of thin dark blood may continue till the next period; this is aggravated by the least movement.

The remedy may be indicated in abortion at the third month.

Other uterine symptoms are irregular, weak labour pains, prolonged after pains, offensive, greenish purulent lochia ; puerperal fever ; suppression or non-appearance of lactation.

Nervous system. Twitchings and jerkings begin in the facial muscles and may spread to involve the whole body.

Intermittent tonic spasms affect chiefly extensor muscle ; if the hands are involved, the fingers are spread wide apart.

There are complaints of formication, numbness, and tinglings, especially in fingers and feet.

Locomotor system. Limbs feel heavy, tremulous, even paralytic. There may be associated pallor and icy coldness, but with burning pains and desire for cold.

Violent cramp may occur, especially in the lower extremities.

Skin. Small boils occur which are extremely painful and contain a green core. Gangrenous carbuncle may require the remedy. Large ecchymoses or blood blisters may be present.

Ulcers become black and exude dark blood. Suppuration occurs in nail beds with shedding of nails.

Posology

Hæmorrhagic and uterine complaints provide the main indications for the remedy ; also conditions resulting from vaso-spasm. Psorinum is a complementary remedy.

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THE CARCINOSIN DRUG PICTURE

DR. D. M. FOUBISTER

Physician, Diseases of Children, The Royal London
Hœopathic Hospital

According to homœopathic philosophy, organic disease is an ultimate, the result of preceding changes in the vitality of the patient which are manifested by functional changes and subjective symptoms. It is generally accepted that organic disease may be foreshadowed by functional

changes. It is these symptoms of disordered vitality which have to be matched in selecting a constitutional remedy with the object of correcting the underlying disharmony.

There is perhaps a tendency to regard nosodes representing the ultimates in disease as being comparatively superficial in their action, yet the well-proved nosodes such as *Tuberculinum* and *Medorrhinum* are undoubtedly among the most deeply acting and valuable medicines in the materia medica. It may be that nosodes carry in them in their potentized state something of the nature of the preceding deranged vitality. After six years' study of *Carcinosin* that is my impression, and its profound action may possibly be explained in this way—Kent believed cancer to be the result of suppressed psora and it is of interest to note that in some cases responding to *Carcinosin*, indications for *Psorinum* and other antipsorics not previously evident came to light. In a few cases the symptom of *Psorinum* "feels specially well before an attack" was uncovered only after previous benefit from *carcinosin*.

My interest in *Carcinosin* was aroused by a chance experience: that of having in the out-patient department simultaneously two children born of mothers who were, during the pregnancy, suffering from cancer of the breast (2). These children presented a remarkably similar appearance, having blue sclerotics, a cafe au lait complexion and numerous moles. Both children suffered from insomnia. I had previously been given a given a therapeutic hint that where there was a family history of cancer, *Carcinosin* sometimes cured insomnia, and had used it occasionally in insomnia with success.

I wondered if one could regard these children, having been nourished by cancerous blood, as exhibiting these characteristics on account of the mother's condition, in other words was this a sort of proving of *Carcinosin*, or was it a coincidence.

It would take considerable time to collect a number of such cases, and the immediate course open was to study the antecedents of children, with that appearance to find out whether this appearance was associated with a strong family history of cancer or not. In the out-patient department we began by checking the family history and giving *Carcinosin* to

children with that appearance. During the first few years detailed notes were taken by one of my clinical assistants of 200 cases in which we had tested the remedy with or without success. Gradually the picture of Carcinosis emerged. It did receive a small proving (3), and I proved it myself in the 200th potency.

It is generally accepted that we can utilize the symptoms derived from clinical experience of the therapeutic effects of a remedy and that the drug picture which is the real basis of prescribing is built up from provings plus clinical experience.

It has been noted that only a small proportion of provers are sufficiently sensitive to any substance to bring out anything like its full effects, those presumably having an idiosyncrasy to the drug being tested (4). In studying the therapeutic effects of a homoeopathic remedy one cannot escape the conclusion that anyone benefiting from a drug in high potency must also have been sensitive to it. A more careful study of therapeutic effects would in my view enrich the *materia medica*. Disease in fact tends to increase sensitivity to the appropriate remedy even in the physiological use of drugs (5).

It soon became apparent that children of what we came to regard as the "Carcinosis appearance" did not show the kind of family history we had almost expected to find. In many instances there was a strong family history of cancer, but in others there was a strong family history of tuberculosis, of diabetes and pernicious anaemia, or a combination of all these more strongly represented than in the average family; only occasionally there was no such history. It would, of course, require a great deal of research to prove this.

Gradually we gained the impression that in addition to the "Carcinosis appearance" and a tendency to insomnia even in young children there was a tendency to have an inflammatory illness, usually whooping cough or pneumonia, very early in life, and therefore almost always severely. For instance, whooping cough at five months fits into the Carcinosis picture. If for the sake of argument, we accept McDonagh's concept that there are two basic diseases, inflammation and tumour formation also the teaching of Rudolf Steiner, then it might

not be too far fetched to regard this tendency to inflammation as a reaction against inherited tendencies. A child who had the longest list of severe inflammatory diseases I have ever seen had indications of Carcinosis, and its administration was followed by a remarkable improvement. We gained the impression that after administration of Carcinosis there was considerable likelihood of an inflammatory reaction very difficult to prove also without considerable research. In the children's ward Sister Saver observed that children receiving Carcinosis often had a rise of temperature on the tenth day, and this has been often confirmed.

Alimentary upsets of one kind or another, say a tendency to diarrhoea or constipation or acidosis in childhood, seemed to come into the picture, but this is not certain ; it is so common in childhood. In the provings Dr. Templeton noted the constancy with which Carcinosis produced constipation (6).

In the children's ward we observe the position in which a child sleeps, and in the out-patient department I have for years asked all mothers about this symptom, as it is an unequivocal one. There is a tendency for many infants to sleep in the knee-elbow position up to the last quarter of the first year, then it often disappears. The knee-elbow position is noted in Kent's Repertory only under *Medorrhinum*. but our enquiry has revealed that a number of drugs have it. Carcinosis has this symptom (also a tendency to sleep on the back, hands above head). Other drugs having the knee-elbow position, which is obviously more valuable as a symptom in older children, are *Tuberculinum*, *Phosphorus*, *Sepia*, *Lycopodium* and *Calc. pho's*.

More work is required to elucidate the full picture of mentals and generals of Carcinosis, but clinical studies gradually revealed that Carcinosis is related to some of the most commonly indicated and deeply acting medicines in the materia medica, and the action of Carcinosis is deep and lasting.

The majority of the children in out-patients had been receiving treatment, and it became apparent that many children who were candidates for Carcinosis in other respects had already been helped by one or more of a group of remedies,

the most constant of which are Tuberculinum, Medorrhinum, Nat. mur. and Sepia ; others were Alumina, Ars. alb., Ars. iod., Pulsatilla, Staphisagria, Phos., Calc. phos., Lueticum, Lycopodium, Sulphur, Psorinum, Dysentery co. and Opium. Others may be added as experience grows.

In any patient not responding to one of these remedies, though accurately chosen, it is worth while to see whether Carcinisin may fit the case. Also, when two or more of the related remedies are partially indicated but no one adequately covers the case, Carcinisin should be considered. These indications for Carcinisin have been abundantly confirmed.

Say you have a child with the obstinacy and love of travel of Tub. bov. combined with amelioration by the sea and other symptoms of Medorrhinum, a fairly common combination in my experience, Carcinisin will often cover the case. I have not hesitated to prescribe Carcinisin at the beginning of treatment, it clearly indicated, with excellent results.

(Continued)

DISEASES OF CHILDREN

DR. ABHOYPADA CHATTERJEE

(Continued from page 256)

Third Stage : Period of Pressure on the brain

Increased apathy and eructation. It is only when raising the child and not supporting the head for a few minutes that the patient becomes anxious and restless and tries to rest the head on something.

Increased alteration of the features ; the child lies crooked or on its back, with its legs spread and boring with the head into the pillow ; it stamps with the feet, leg which is drawn up, totters to and fro ; the hand of this side performs unconscious tremulous motions ; the child bores the nose and ears ; all the senses have become dull, except perhaps the hearing ; the children do no longer recognize objects which are held before them ; they miss them in trying to take hold of them ; the pupils one dilated and insensible to the light, except to very

bright light, which still causes a slight vibratory trembling in the pupils. The eyes run, the pulse becomes slower and unequal ; partial sweets break out, the breath becomes foetid. In this stage the children show a greedy desire for something to eat.

Fourth Stage ; Period of Torpid fever :—

Complete stupefaction ; sopor with the eyelids half open ; extinction of the senses, diplopia, blindness, deafness, convulsive distortion of the eyeballs, general or semilateral convulsions, opisthotonos, hemiplegia, generally of the right-side ; the paralysed parts are cooler than the rest of the body ; involuntary discharges of stool and urine, or else distention of the bladder, which is full, the respiration hurried and short, and more and more interrupted by sighing ; difficulty of swallowing ; striking emaciation ; abatement and cessation of the vomiting, accelerations of the pulse, which becomes smaller and smaller, and finally uncountable, with increased fever burning skin, Amid these symptoms the patient dies, with or without convulsions, and sometimes in a comatose state, this stage lasts one or two or three days.

Although this description of the disease is very lucid and accurate, yet the diagnosis is not always easy, for the disease may be complicated with other affections, especially abdominal affections, Gastromalacia, inflammation of the abdominal organs, worm affections, dentition, Croup, bronchitis, Pneumonia, Whooping cough, pulmonary tubercles, measles, Scarlatina, and other diseases which can indeed be recognized by their characteristic symptoms.

The symptoms vary a good deal, and one symptom is not sufficient to reveal the true character of the disease ; It is from totality of the symptoma that this has to be inferred. Delirium, for instance, is not always present, generally only after the seventh year. In some cases it commences when the vomiting ceases, it is not as violent as in the case of full grown persons ; it is generally bland, consisting of incoherent inarticulate words, mingled with unintelligible muttering and motion of the lower jaw as if the child were masticating something : It generally lasts from three to four days during the

irritative stage, is never permanent, alternates with coma from the commencement and is finally superseded by coma entirely. Vomiting is one of the most distinguished and most permanent symptoms of cerebral irritation, and, if accompanied by headache, should always be attended to with due care. The headache is however, a more persistent symptom than the vomiting, and sometimes precedes it for weeks. The vomiting increases by moving the head and is appeased by keeping the head quiet, It may disappear after the delirium has set in, or else, it may recur every now and then until the patient dies. It occurs very rarely in the third stage of the disease, mostly after drinking, containing the beverage which the patient had drunk and a slimy and bilious fluid, Sometimes the tongue is coated white, as othera quits clean, only towards the end of the disease it becomes dry and blackish. The pain in the head is not definite either as to locality or character, it is a tensive aching pain, accompanied by vertigo, intermitting or also continuous, etc, effecting the whole head, forehead, temples or back part of the head ; a characteristic symptom of this headache is to get worse when the head is kept erect. Headache is rarely wanting, and even if children should not complain of it, yet its presence may be inferred from the fact that children grasp at their heads involuntarily. The face of the patient has a peculiar expression of languor and apathy in their eyes. is more particularly from the beginning of the third stage that the face becomes pale, shrivelled, and looks hollow, even if the children should have been ever so fleshy and robust. We do not see any permanent distortion of the mouth or violent convulsions of the facial muscles, but passing grimaces. The shrill piercing, longdrawn shriek which characterizes this disease, has first been described by Loindet ; it occurs periodically, either without any apparent cause, or when the abdomen, or some other part of the body is touched. The peculiar groaning and moaning are frequently accompanied short, hacking cough.

Continueud

HOMŒOPATHIC NEWS

HOMŒOPATHIC MEDICAL RELIEF CENTRES

Homœopathic Medical Relief Centres at Bangladesh Refugee Camps and flood affected areas of North Bengal are being run by the various Homœopathic Associations under the ægis of the *West Bengal State Homœopathic Federation*, depending solely on the benevolence of philanthropic people of India and the leading Homœopathic Pharmacists of West Bengal. Each of these centres are catering medical aid to 200 to 400 patients per day with success in more than 85% cases. Of these we have got glorious report of the following centres upto November 1971—

Murshidabad District Homœopathic Medical

Association—5 Centres.

Nadia Homœopathic Association

—8 Centres.

Kanchrapara Homœopathic Medical Association

(24 Parganas)—2 Centres.

Jalpaiguri District Homœopathic Practitioners'

Association—1 Centre.

In addition to all these the Deshbandhu Charitable Homœopathic Dispensary—opened at Siliguri by Darjeeling District Homœopathic Medical Association (affiliated to W. B. S. H. Federation) at the time of the devastating flood in October 1968, later turned into a permanent charitable dispensary and is still running with creditable efficiency with the aid of local philanthropic people and the Siliguri Municipality, which has lately increased its monthly grant from Rs. 50/- to Rs. 70/-.

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