INFECTIOUS DISEASES AND THEIR NOSODES

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The kind of cases with which this paper is concerned form within the general structure of Homœopathy an unique group, standing by itself and having, both from the theoretical and practical points of view, its own peculiar problems. We have at our disposal to-day over two hundred nosodes, any one of which can be used over a large variety of different diseases. In this paper, however, we are considering only those cases where the remedy and the disease are linked together by the sharing of a common origin, as, for example, where *Morbillinum* is used to confer immunity against measles, or *Influenzinum* is given to banish the dregs of 'flu. It is this close relationship between remedy and disease that gives to such cases a special importance, and separates the group from all other instances of homœopathic treatment. For when a nosode is used against that disease from which it originally sprang it seems to me to reach a degree of homœopathicity which may present dangers as well as advantages. One virtue of this paper, perhaps its only one, may prove to be its capacity to provoke lively controversy. For not only will it be found to contain a view of my own which runs counter to one of our traditional conceptions, but, in addition, the subject itself presents one or two very debatable problems. It is my hope that these may lead to a really worthwhile discussion.

Of such problems one, which has provoked argument from the time of Hahnemann himself, is the question whether a nosode used against its parent disease is truly homœopathic. So far as I can find our literature provides no satisfactorily conclusive answer to this question. Hahnemann's view is expressed in the first volume of his *Chronic Diseases.* "In the subsequent list of antipsoric remedies", he wrote, "no *isopathic* remedies are mentioned, for the reason that their effects upon the healthy organism have not been sufficiently ascertained. Even the itch

miasm in its various degrees of potency comes under this objection. I call *Psorinum* a *homœopathic* antipsoric, because if the preparation of *Psorinum* did not alter its nature to that of a homœopathic remedy it never could have any effect upon an organism tainted with the same identical virus. The psoric virus, by undergoing the processes of trituration and shaking, becomes just as much altered in its nature as gold does, the homœopathic preparations of which are not inert substances in the animal economy, but powerful acting agents".

In this argument Hahnemann is surely begging the question. What in effect he is saying is, this nosode works, therefore it must be homœopathic ; an induction which is not legitimate unless it has been first established that an isopathic remedy is incapable of promoting a curative reaction.

Both Swan and Burnett agreed with and echoed Hahnemann's view that an isopathic substance becomes homœopathic by potentization. Swan quoted Hahnemann's argument, but Burnett brought forward another line of reasoning. "If", he wrote, "you alter somewhat two things which are identically the same, you reduce identity to similarity." On the face of it this argument seems unanswerable. As a general statement it is self-evident that changing something makes it different, but it is quite valueless when applied to any *particular* case unless it is known what especial *kind* of change has been brought about. White arsenic can be altered somewhat in a variety of ways without its chemical qualities being affected in the least. It can be changed in appearance by a drop of cochineal or by dissolving it in a little water. In both cases it has been somewhat altered but it still remains a lethal weapon in the hands of a poisoner. We can certainly agree that potentizing changes a morbific substance but it does not follow that the change is of that particular kind that is necessary to make it homœopathic to its progenitor. If Burnett's reasoning were sound, then the smallest degree of simple dilution would be sufficient to change idem to similimum and, indeed, such a change would create a closer degree of similarity than would potentizing.

It must not be assumed, however, that because the reasoning of these great pioneers was faulty that their intuition there-

fore was unsound. It seems to me that their belief found confirmation in the work of that other pioneer and scientific genius, Dr. W. E. Boyd. For Boyd noted that potentizing, in addition to liberating potency energy, also affected that energy's emanometer tuning. This effect indicates a tiny change in the quality of an energy, which, we have good reason for believing, is the active principle of our remedies. And so, what to Hahnemann and his followers had been—in spite of their attempts to rationalize it—a simple act of intuitive faith would seem now to rest on experimental fact.

Turning from these theoretical questions to the practical uses of the nosodes, let us first consider that of prophylaxis. Samuel Swan would seem to have been the first to use them in this way. His account, originally published in the *Homœopathic World* in April 1882, is well worth quoting, not only as an example of successful immunization, but also because it describes what surely must be the most remarkable group of provings ever recorded. Here, then, is an abbreviated quotation of what Swan wrote :

"For some time I have not vaccinated, but given *Variolinum* internally as a prophylactic..."

"At an institution where I attend professionally there are 200 inmates ; these are mostly waifs and strays from the streets. ...The Lady Manager informed me that the Board of Health was going to vaccinate. I told her that I should prefer to give it internally. She acquiesced, and I gave each inmate two tablets medicated with *Var. cmm.* (Swan), one to be taken at night and the other in the morning (Feb. 18th and 19th).

"By the 23rd all the 200 except forty were ill. All had the preliminary symptoms of smallpox, commencing with dullness of head, severe pains in back and limbs, which became quite numb ; most of them had chills, followed by high fever ; violent headaches ; with nausea and vomiting, mostly of greenish water ; in many cases profuse diarrhœa. In some there was despondency. Twenty-two were in bed two days. Some of these who were affected by the *Variolinum* had vaccine marks on the arm, others had not.

"On the 28th I found that twenty-four had smallpox pus-

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tules on different parts of the body, mostly on abdomen and back. The pustules were perfectly formed, some umbilicated, some purulent. They passed away leaving no scars."

When we reflect on this extraordinary mass proving evoked, remember, by two doses of an extremely high potency, we may be forgiven for wondering whether so alarming a reaction did not raise in Swan's mind some passing doubt as to whether potentizing really *had* reduced the morbific product from identity to similarity !

In the meantime let me describe an experience of my own. It occurred many years ago but the salient details are still clear in my mind.

A case of diphtheria occurred in a children's Holiday Home to which I am the appointed medical officer. The exact number of children in the Home at the time escapes my memory, but I do remember that it was over forty. The child was given *Merc. cyan.,* I think in the thirtieth potency, and a swab was taken. All the other children, the Matron and staff received *Diphtherinum* 200. The swab proved positive. On the third day the boy was clinically well. The throat which had had a definite membrane was now perfectly clear, so that the M.O.H. who saw him then for the first time said that but for the swab he could not have believed it had been diphtheria. By the sixth day a swab was negative as were two other succeeding ones. Two other cases occurred in the Home. Each was given *Merc. cyan.* and each ran a precisely similar course to the first case.

At the time these results seemed eminently satisfactory, but a later experience of quite a different kind made me less sure. The case that raised doubts in my mind was one where the parents of a girl desired that she should be immunized, but not, if possible, by inoculation. I Schick-tested her and found she was positive. She was given a single dose of *Diphtherinum* 200. About ten days after she was still Schick positive, but a fortnight later a negative reaction showed that immunity had been achieved.

Here we have an instance, I think, where an isolated case can give positive information of some practical value. It is possible that nosode immunity develops more rapidly in some

and less rapidly in others. The fact that in one patient it took a fortnight or more to appear suggests that this type of immunizing should be reserved for cases in which early exposure to infection is unlikely to occur. Where immediate or rapid immunization is necessary I feel the wiser course would be to use the acute remedy. And the question which my experience raised was whether; had I given all the contacts in the Home *Merc cyan.* instead of *Diphtherinum,* might I have saved the two subsequent cases from developing the illness? I personally think that the acute remedy probably induces a rapidly developing but transient protection, whereas the nosode may act more slowly but its effect will probably last much longer.

When we speak of immunity duration, however, we are, of course, on very uncertain ground. There can be no doubt that protection can be given by nosodes, but which of us can say how permanent it is? In the case of *Diphtherinum* an answer could be found by recording a sufficiently large number of cases followed up by periodic Schick tests. It is, however, extremely doubtful whether sufficient volunteers could be found, especially since they would have to be recruited from Schick positives who, in these days of mass inoculation, must be rapidly dwindling in numbers!

Before leaving the question of prophylaxis it might be worthwhile to remember the link between German measles and congenital abnormalities, and to suggest the advisability of giving *Rubella* as a routine measure to all healthy expectant mothers during the earlier months of pregnancy.

Coming now to consider the nosode in relation to the primary or acute phase of its own disease, we enter what is, to my mind at least, extremely debatable ground. There is no doubt whatever that in all writings on nosode therapy, the subacute and chronic sequelae take first place with prophylaxis a fair second. It is equally true, however, that references to and examples of acute work in this sphere are by no means lacking. Thus Clarke, in his *Prescriber,* under each infectious disease, lists among other remedies the specific nosode for the acute illness. And again, describing *Diphtherinum* in his *Dictionary*

of the Materia Medica, he says, "It should be more efficacious in the potencies against diphtheria, both as prophylactic and cure, than the serum injections."

Discussing this same nosode, Allen in his *Keynotes* describes many symptoms typical of acute diphtheria, some of which indicate a desperate condition of the patient, and then declares, "The above are cured symptoms, verifications which the author has found guiding and reliable for twenty-five years." In the same section also he claims that *Diphtherinum* will cure in every case that crude antitoxin will.

Again, in the *Dictionary* under *Tuberculinum bovinum,* Clarke writes : "In 1892 B.S. Anulphy . . . began giving *Tub.* 6*x* and 8*x* trituration internally in tubercular cases, acute and chronic, and with encouraging success, but with at times undesired aggravations ; with 12*x* and 30*x* these were avoided". Burnett's experience, however, with *Bacillinum* would seem to have been less satisfactory, for he declared : "When the consumptive process is in full blast the virus is unavailing." On this statement Dr. Margaret Tyler commented : ". . . and such is, I believe, the general opinion. In fact one has come to think that *Tuberculinum* is more useful in 'consumptiveness', and in cases where structures other than lungs are affected."

But although Dr. Tyler in the case of acute T.B. is opposed to the use of the nosode, she had not the same scruples with regard to *Diphtherinum* and *Variolinum.* In *Pointers to the Common Remedies* she includes *Diphtherinum* for acute diphtheria, and for smallpox she places *Variolinum* ahead of all other remedies, describing it as, "Probably the most potent of all, having the complete picture of the disease from which it is prepared." Again in *Homœopathy,* Vol. X, she wrote : "An extended clinical record by competent and reliable observers attests its curative value in variola—simple, confluent and malignant." In the same volume she reprints an article taken from the *Homœopathic Physician* in which Dr. W. L. Bonnell describes the successful treatment of twenty smallpox cases.

Apart from Burnett's and Margaret Tyler's caution against using nosode in phthisis, the only opposition to treating acute diseases with their derivative nosodes that I have been able to

find is contained in Dr. Foubister's paper on nosodes given in 1939. In that address he said, "It is difficult to imagine that better results could be obtained by nosodes in the average case than by an accurately prescribed remedy of high potency.

"The place of importance for nosodes in acute illness seems to be in clearing up lingering cases, as for example, *Tuberculinum* in pneumonia, or where there is a chronic substratum, example *Medorrhinum* in asthma."

Nevertheless, though opposition seems to be small, may there not be some significance in the fact that amongst all the writings on nosodes those dealing with either prophylaxis or sequelae far outweigh the few that advocate using the specific nosode in the acute phase of illness ? Does not this fact indicate that, of homœopathic doctors in general and the pioneers of nosodes in particular, comparatively few have felt happy about applying nosodes in this way ? It would seem, in fact, that Dr. Foubister has not been alone in his opinion and that his reluctance to apply a nosode against its related disease has been shared by many homœopathic doctors in the past.

For my own part I most strongly support this attitude of caution. For while I believe that the nosode can, under certain circumstances, brilliantly wipe out its own acute disease, I believe also that it has extremely harmful potentialities and can excite a variety of different reactions, some of which might be of real danger to the patient. The question seems to me to be one of very great importance. For if it can be shown that the nosode in such cases has no harmful potentialities it would seem that in all acute fevers the appropriate nosode must always and without question be the first choice. To cure the acute disease with some other remedy and then later on have to give the nosode to clear away the dregs is both clumsy and irrational if the disease can be completely eradicated by using the nosode in the first place.

Now there can be no doubt at all that the advocates for using nosodes in this way can find complete support for their view in the traditional Hahnemannian conception of the similimum. For, if potentizing a substance reduces it from identity to similarity, and if the perfect remedy must always be the

similimum, then the related nosode, more than any other remedy should in every case bring about an ideally complete homœopathic cure. And so, if we take the opposite view and contend that such use of a nosode is inadvisable it means that our conception of the similimum must undergo considerable modification.

Leaving aside the question of the nosode for the moment, let us consider the action of potencies in general when applied in acute and in chronic disease. Why is it that, as a rule, response in an acute case takes place in a matter of hours, or, at the most, a day or so, whereas we commonly have to wait for a fortnight or more when we treat a chronic case ? This time difference, as you know, is not a matter of different remedies. A chronic sulphur case must bide his time, while a sulphur pneumonia improves overnight. We say, perhaps, that it is in the nature of acute illness to develop and resolve comparatively quickly, and that chronic disease is inherently long lasting and deep rooted. Then why, we may ask, does the quickly reacting acute patient require repetition of dose, when the more unresponsive chronic will always improve and may completely recover from a single stimulus ? And again, how can we account for the chronic case we occasionally meet which begins to improve almost immediately after the dose is administered ?

To all these questions an answer, I suggest, can be found in Boyd's interference theory. This theory requires only one single assumption, that the energies present in disease and in potencies—energies whose existence has been completely established—are of a vibratory kind. Although this assumption cannot be proved yet, there are many phenomena which point to its being a fact. It can indeed, be claimed that the interference theory is a great deal more than a mere hypothesis. It stands, in fact, on as sound a basis as have many theories which have been accepted in other sciences as reasonable explanations pending further experimental proof.......

It must, of course, be understood that in all cases complete cure demands the optimum potency. For if the potency energy be of less intensity than that of the disease, neutralization

will be only partial and further dosage with either the same or another remedy will be required.

We can see, then, that Boyd's theory offers an explanation of why chronic diseases—though commonly slow—can occasionally achieve rapid cure.

The fact that acute cases need repetition while chronics do not can be explained by the reasonable assumption that in chronic cases the intensity of the disease energy approximately equals that of the potency, while in most acute cases the disease energy is much higher, and the interfering potency wave must therefore be built up by repeated dosage.

In an acute illness the pattern of cure is the same as in chronic disease, but obviously the complete cycle must take place in a very much shorter space of time. To obtain a shorter beat it is necessary to have a greater difference between the interfering waves. In acute cases therefore the remedy must be *less similar* to the disease than in chronic work. In other words, if the interference theory is correct, the similimum is not *always* the optimum remedy.

Even in our accepted teaching we can find some small but, I think, definite confirmation of this iconoclastic conclusion. For we were taught that we should rarely give the constitutional remedy during an acute illness. That rule, founded no doubt on practical experience, is sound. But search as we may, we shall not find any support for it in the accepted principles of homœopathy. If a remedy fits the general make-up of our patient and in addition covers the acute symptoms, surely it must be the similimum *par excellence*. And so alongside the teaching of the pre-eminence of the similimum in all cases of disease, we have a rule which, in effect, says, "do not use a similimum in acute cases" !

Within our clinical experience, too, there is one type of case which tends to show that the similimum may not always be ideal. I suppose that most and perhaps all of us have had the experience of finding an apparently perfect drug picture in an acute patient, and yet failing to get any improvement until a less likely remedy has been given. Fortunately instances of that kind are very rare indeed, but they do occasionally crop

up and it is hard to account for them if the similimum is always the optimum remedy.

When, some years ago, I began to think along these lines, I regarded the question as being one of purely academic interest. For it seemed that until we should have some more accurate method of estimating fine degrees of similarity, we could neither find clinical proof of the theory nor put the latter to any practical use. It was only when I started to prepare this paper that I realized that in the case of the nosodes this was not so. For here we have a group of remedies each of which must surely bear the very highest degree of similarity towards its parent disease and which might, therefore, from their clinical use, yield evidence either for or against my theoretical belief. And, moreover, it seemed as though the theory could have some practical value by guiding us in the use of nosodes in acute disease.

In the literature I have been able to consult evidence either for or against the theory has been disappointingly small. The difficulty is that the theory in no way denies that a very large percentage of *cures* may occur. The important thing however is the *kind of pattern* the illness takes on after the nosode has been given.

The strongest evidence *against* my theory is probably Clarke's reference to Dr. Anulphy's experience. Dr. Anulphy, you will remember, used *Tuberculinum* in acute T.B. and obtained undesired aggravation which, however, disappeared when he changed to a higher range of potency. Such disappearance of aggravation most certainly does not fit in with the theory. Unfortunately, however, we are not told how many cases were so treated............... Moreover we are not told whether the aggravations affected acutes more than chronics.

A most interesting and perhaps significant experience was that of Dr. Bonnell, of which passing mention was made earlier in this paper. He treated twenty cases of smallpox with *Variolinum* and cured every one whilst the non-homœopathic doctors in the same epidemic had a mortality of twenty per cent. Regarding his twenty cases, Dr. Bonnell wrote : "..... to these

twenty cases I gave two powders of *Variolinum* 30*x* for four or five days. Among these twenty cases two were black or confluent smallpox. One of my cases, a woman, had black hæmorrhagic smallpox. She was very low for nine days. All her hair came out, and all the tissue fell off her nose and ears. She was a hideous looking sight, more like a corpse than a living person."

Here again the information is too scanty to be regarded as strong evidence. But one feels justified in speculating as to whether the severity and the charactristics of the three cases particularized were really due to the disease alone, or were in fact the result of an unfortunate reaction between disease and nosode. Were the two black or confluent cases in that state when he first saw them, or did the disease change its severity and character after encountering the *Variolinum* ? .... In any case we must admire Dr. Bonnell's courage and faith in refraining from giving another remedy during those ghastly nine days.

Mention of *Variolinum* reminds us of Swan's experience with that nosode. Here, surely, was something quite unique in homœopathic history. I suppose we all have used nosodes prophylactically without any untoward reactions at all, yet Swan, at one fell swoop, lays low 160 out 200 people.

The fact that eighty per cent. developed symptoms while the remaining twenty per cent. got off scot free is interesting, however, for it suggests that homœo-prophylaxis, like homœopathic cure, may be an interference phenomenon. If that is so then it means that this type of immunity is created by the elimination, through interference, of some component of the clinically healthy individual's complex wave; an aberrant component which, however, does not induce symptoms unless its intensity is reinforced during an interference beat............

Satisfactory guidance as to the wisdom or unwisdom of using nosodes in acute cases could only be found by comparing results in a large number of patients, half of whom had received the specific nosode while the rest had been given remedies which were unrelated in origin to the illness. In the absence of such

evidence the question must remain a matter of individual opinion.

Although open to conviction, I believe that in acute cases a remedy unrelated in origin to the disease is preferable to the specific nosode. Nosodes, I believe, have the power to cure such cases but the great majority of patients will be exposed to aggravations more longlasting than any the unrelated remedy might induce. Moreover, it is possible that such lengthy aggravation might be a danger in a severe illness, especially were the patient of low vitality.

Leaving this highly controversial field we can turn now into the better explored territory of nosode therapy against the sequelæ of infectious disease. The first nosode, *Psorinum,* was prepared by Hahnemann for the purpose of eradicating an hereditary taint of disease, and the same principle underlies the use of nosodes in the post-acute conditions of their specific illnesses—except, of course, that in these conditions the taint is not inherited but acquired. There is no doubt whatever that of all the ways in which nosodes can be applied against their own diseases this is by far the commonest. The earlier pioneers, Hering, Swan, Burnett, etc., were all more especially concerned with those diseases which had a high mortality, such as hydrophobia, smallpox and diphtheria, and those of known chronicity, particularly tuberculosis and gonorrhœa. Their work has proved to be an invaluable contribution to homœopathy, and it does in nowise detract from its worth to suggest that Dr. Margaret Tyler made a discovery which is equally valuable and in one way more remarkable than theirs. For whereas they were tackling diseases whose ravages were only too well known, Dr. Tyler envisaged, and later proved the existence of something which had never before been suspected, and which, but for her perception, might have lain hid indefinitely. That the common infectious fevers, after apparently complete recovery, could harmfully affect the health of their victim for the rest of his life was, in my view, a discovery that ranks extremely high in the history of homœopathy.

I imagine that any homœopathic doctor to-day could testify to the value this discovery has proved in our treatment of

chronic disease. Some indication of its value in my own practice can be found in the fact that during this past year my partner, Dr. McDonnell, and myself have used related nosodes in twenty-three cases, from which we had only three failures and twenty complete cures.

I do not propose to weary you with a monotonous recital of all these twenty-three cases, most of which would no doubt be paralleled from your own experiences. I propose instead to select from them a few, chosen because they either pose a problem or present unusual features which add to their interest.

The first case is the one I classify as a partial failure. The patient was a lady, 47 years of age, who in the July of last year developed a corneal ulcer in the left eye. She was given, quite empirically, two doses at a four hour interval of *Tuberculinum* 200. The ulcer was about two millimetres in diameter. It healed completely in sixteen days. The following October her hairdresser rubbed a small area of skin behind the ear with some hair preparation as a test for sensitivity, and succeeded in producing a spreading impetiginous rash. This responded quickly to *Arsenicum alb.* 200. Later the same month the patient's mother died, causing extreme depression and irritability. *Natrum mur.* 200 soon restored her to a more normal balance. That, then, is the background to what followed this year.

In February last she developed another corneal ulcer in the same eye, of about the same size as the former one but in a different position. Taking of her case elicited the following symptoms : —

Used to be a very chilly subject ; still likes warmth but not so chilly as formerly.

Averse fat.

Very depressed at times, "I can soon cry."

Likes sympathy.

Past History :

"Suppressed measles" in early childhood ; extremely ill. "Specialist had to be called in."

During childhood constantly troubled by eyelids agglutinating.

I gave one dose of *Morbillinum* 200, and the ulcer was completely healed in two days.

Three months later another ulcer apparently identical in size and position appeared. It took four days to heal after another dose of *Morbillinum* 200.

The next month she had another ulcer, smaller this time and in a different position. This also cleared in a few days following a further repetition of *Morbillinum* 200.

After this she kept well for four months, but in September she appeared with a larger ulcer, this time on the right eye. I gave *Pulsatilla* 200, and healing was complete in two days. On the 8th of November she came along with another ulcer on the right cornea. But this time she attributed it, probably correctly, to some shampoo, applied by the same hairdresser, which entered the eye and immediately caused it to flare up. She was very disgusted because she said that after the last medicine she had felt wonderfully well in herself—"Better than I've been for years." She had another dose of *Pulsatilla* 200 and it now remains to be seen whether—assuming her hairdresser mends her ways—*Pulsatilla* can hold her better than did *Morbillinum*. Should it fail to do so I will probably repeat the nosode in a higher potency.

I regard this case as only a partial nosode failure because of the rapid response *Morbillinum* evoked compared with the sixteen days which the first ulcer had taken after *Tub. bov.* I should say that *Tuberculinum* here probably had no effect at all and that in that instance the ulcer healed spontaneously. It is interesting to observe how *Pulsatilla* also acted with rapidity. One may wonder whether it would have done so, or indeed would have acted at all had not *Morbillinum* cleared the ground.

Two days before the case we have been considering came to see me in February another lady in her late twenties consulted me with the same trouble. She had two corneal ulcers in the left eye, one rather large—about three millimetres, the other about two. Twelve months before she had been subject to attacks of inflammation in the eyes and had had her refraction done. The glasses stopped the acute inflammatory attacks but she had still noticed the eyes becoming injected after ex-

posure to cold winds. I gave her a single dose of *Tub. bov.* 200 without any good effect at all. Five days later the ulcers had both appreciably increased in size and the pain was very severe. I then discovered that she had had measles twice in early childhood, and I gave her a single dose of *Morbillinum* 200. Improvement started immediately and within a week both ulcers had disappeared. There has been no recurrence and cold winds no longer inject the eyes.

The coincidence of improvement synchronizing with the dose of *Morbillinum* suggests that it was at least the main factor in the cure. She gave no history of T.B. in either herself or her family. But she was of the slender pale blonde narrow-chested type one associated with the T.B. diathesis, and it is possible that she was just passing the peak of aggravation when *Morbillinum* was given. I think, however, that the latter nosode was more likely to have been the one that did the trick.

In the treatment of the sequelæ of acute infections it has, as a rule, been my practice to give the nosode in those cases only which are fairly far removed in time from the original acute illness, unless the symptoms calling for treatment are themselves of an acute character. In this latter type of case or where the sequelæ follow close on the heels of the primary fever I prefer the acute remedy. In general I have found this discrimination to work well. The following case seems to suggest that there may be exceptions which prove the rule. The first of these cases is not included in the twenty-three because it happened well over a year ago. It concerns a little girl aged 5½ years old. There was a history of having been troubled by a persistent slight cough ever since an attack of whooping cough two years earlier. For some months before I saw her the cough had been steadily worsening and was, when she was brought to me, very severe indeed. I gave her *Pertussin* 30, two doses. The following day the cough was very much worse. The aggravation passed and in three days the cough had completely stopped. After ten days of apparently good health the cough returned as bad as ever, and on two succeeding days she vomited with the cough. A single dose of *Drosera* 200

brought on a two-day aggravation, and then the cough suddenly stopped and has not recurred since.

There are in this case some interesting features. At the first consultation I was in two minds whether to give *Drosera* or *Pertussin.* In favour of *Drosera* was the extreme severity suggestive of an acute cough. On the other hand the cough had been active for three and a half years and its development up to its present severe form had taken several months. The latter consideration finally tipped the scales in favour of *Pertussin.* Now it may be my decision was wrong; that here was a condition calling for an acute remedy. But there is another possibility. It may be that my mistake lay in giving two doses of *Pertussin* instead of one. I did so, of course, as a kind of compromise; having still the feeling that the state was really a sub-acute one. Supposing I was wrong in this, and that the case was truly chronic. In such a case the potency wave would be built up by the two doses to some twice the intensity of the disease wave. It would effectively neutralize the latter but itself would only be partially damped. And so, ten days later, when the damping phase had passed it would make its presence felt by producing a proving of *Pertussin* and simulating a mild attack of whooping cough. If that were so then the proving would have petered out in any case, though its dispersion might have been helped by *Drosera.*

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Just over a year ago a lady aged 54 years consulted me on account of lumbo-sacral pain and also a pain "like a bruise" at the lower angle of the right scapula. She was a newcomer to St. Annes, and four months before I saw her she had been

taken ill with pneumonia during which whooping cough had developed. In addition her past history included four other attacks of pneumonia, two of which, including one at the age of five, had also been associated with whooping cough. On those two occasions also the pneumonia had started first, the whooping cough developing during the illness. A single dose of *Sulphur* 200, given early in the October of last year, quickly banished the lumbo-sacral pain and also brought about a slight improvement in the scapular ache. Towards the end of the month her father died, and for the grief she had *Ignatia* 200. Last January she developed influenza for which she got *Gelsemium* and *Nux vom.*, which cleared the 'flu except for a persistent cough. She became very depressed; typically *Nat. mur.* A single dose effectively dealt with the depression, and she felt perfectly well except for the cough which remained unchanged. She now told me that nothing could be done about the cough. She had had it every winter since pneumonia-cum-whooping-cough fourteen years before, and each year it had continued well into the summer. Because she was feeling so well in herself I left her on placebo until the end of January. By that time the cough had become paroxysmal and she reported that she had actually whooped twice. On the 31st of January I gave her *Pertussin* 200, one dose. The day after she had the remedy she whooped once, thereafter the whooping stopped. By the end of the first week there was no other change, but the following week saw a rapid improvement so that by the 15th the cough had completely gone. She herself was amazed and said: "I never thought you'd do it; it has always lasted till the summer." The last time I saw her was in March. She was still well and still expressing astonishment at the effect of the "little pills". From her last doctor, she said she had had innumerable different bottles of medicine, none of which had affected the cough at all.

Sulphur, as you know, is as a rule effective in the sequelæ of pneumonia. It would seem to be either equal or nearly equal in similarity to such cases as is *Streptococcin*. (By the interference theory two remedies dissimilar to one another can be exactly equal in similarity to the same patient, for one can be

of slightly less frequency and the other slightly more than the disease vibration.) I had a case this year however where *Sulphur* failed and *Streptococcin* succeeded. It was the case of a man aged 30 years, who had had asthma ever since pneumonia in infancy. *Sulphur* brought no improvement at all. Because the breathing was always easier near the sea I gave *Arsenicum album* which made him worse. Last May he received *Streptococcin* 200, single dose. This brought a very considerable improvement all round, not only in the asthma but in other concomitant symptoms such as periodic headaches, and, more important still, in his general feeling of well-being. He lives some way inland from St. Annes and when later in the summer he developed 'flu he sent for medicine and was given *Gelsemium*. Later still he developed boils, for which he had first *Merc. sol.* and then *Silicea.* Following these illnesses his asthma returned and on the 25th of last month I gave him a second dose of *Streptococcin* 200.

The three cases which follow and which bring this paper to its close were experienced by Dr. McDonnell. One day he was called to treat a child who had the day before developed a cough. *Phosphorus* had no effect at all, but the following day the mother volunteered the information that a few days earlier the child had had its first diphtheria and whooping cough immunization at the clinic. *Pertussin* had immediate effect and the cough had gone in a couple of days. A week later he had another case of cough, and remembering the former case asked whether the child had been immunized recently. On learning that it had he gave *Pertussin ;* again with rapid effect. I have never had the experience of cough following immunization. The question arises whether such a cough may be a transient reaction which would pass in any case without a remedy.

The final case concerns a lady in her middle forties who consulted Dr. McDonnell because of a persistent irritating cough. She had been in contact some months before with two cases of whooping cough. The cough, she said, had started almost immediately after. She herself was convinced that it had been due to her coming into contact with the two cases, but her brother, who is a doctor, laughed at the idea because.

he said, the cough was nothing like whooping cough. Dr. McDonnell gave her a single dose of *Pertussin* and, at the same time, arranged for her to be X-rayed. The cough disappeared altogether in a few days. The radiologist's report showed that the lady quite certainly had pulmonary T.B.

This case seems to me to be probably the most interesting of all the ones I have described. It appears to suggest that between tuberculosis and whooping cough there may be a link, which also could explain the effectiveness of *Drosera* in both diseases. Although the lady's cough was not one of the pertussis type, the rapid effect of *Pertussin* surely indicates a whooping cough element. The questions that arise are, did the patient in fact catch whooping cough, the character of which was modified by the underlying T.B., or did the whooping cough contacts trigger off a sub-acute exacerbation of the hidden tuberculosis ?

It has been made apparent, I trust, that this paper, where it seeks to elucidate, does so in no dogmatic way. The fascination of homœopathy, as in all science and art, lies not so much in what we know as in the vaster field of things yet to be discovered. From the first my whole purpose has been to present certain views and problems in the hope that these might stimulate controversy, out of which perhaps there may emerge some small further insight into the *modus operandi* of the homœopathic principle. If this object be achieved I shall rest well content.

(*To be continued*)

—*The British Homœopathic Journal, April, '57*

INFECTIOUS DISEASES AND THEIR NOSODES

DR. MITCHELL

(*Continued from page 461*)

DISCUSSION

The PRESIDENT was sure that the members were very grateful indeed to Dr. Mitchell for his very thoughtful paper. He had considered very carefully an extremely interesting sequence of events in this series of patients and had delved quite profoundly into some of these deeper problems of immunity. Dr. Mitchell's observations were a challenge to one's own thinking and he hoped there would be a good discussion on some of the points which had been raised.

Dr. T. D. Ross said that it was always a pleasure to have a paper from Dr. Mitchell, his contributions in the past had been thoughtful, carefully written and plainly presented and the present paper would fully maintain his high standard. Dr. Mitchell had dealt with several fascinating aspects of the art of Homœopathy, each worthy of a full discussion. His first point was not one which excited him, and isopathy, the old argument about Homœopathy not to forget the type of Homœopathy which was the subject of a paper by Mr. Everitt at the International Congress—*Rhus tox.* for Rhus poisoning and Penicillin for penicillin poisoning and so on. It did not matter in his own view, whether one said a thing was isopathic or homœopathic and he did not think the arguments about potentizing a remedy and thus making it different were very important. Gold was always gold whether it was potentized or not, and with regard to the difference in the tuning he would quote Bell from the book on diarrhœa about psorinum. He finished by saying : "Whether it derives from purest gold or filth, our affections for its wonderful efficacy remain unchanged."

He was very interested in the proving of *Variolinum* by Dr. Swann, he was struck by it and inclined to not quite be-

lieve it until he had an experience of his own which occurred a few years ago during the smallpox scare in Glasgow. It caused a bit of a scare and everybody was getting vaccinated and he gave *Var.* 30 to a number of people at the hospital, except those who preferred ordinary vaccination, eight powders four-hourly. It was intended to repeat the dose every two weeks during the epidemic, but it petered out. He did not know for how long *Var.* would give protection.

The effects of the *Variolinum* were :

GENERAL SYMPTOMS

Tiredness was most usual 12 to 48 hours after the dose lasting one or two days except one case which was exhausted for a week. One healthy young woman said she began to feel tired 24 hours after the powder, she wanted to lie down, legs felt weak.

Fever and chills : up and down the back with considerable malaise in a healthy much vaccinated woman. Chills like water down the back in one case.

Headache : intense frontal headache, dull head, pressing all round the head, frontal headache over left eye with chilliness headache was common and varied from slight to severe, eyes were weak and in one case there was conjunctivitis which required *Pulsatilla.*

Nose and Throat : full and dry with sleepiness, headaches, and aching all over.

Skin : Irritated, large weals after hot bath, irritation of old vaccination scars, itching all over, in bed, spots like flea bites on the back and left thigh.

Digestion : Nausea soon after dose, bad taste in mouth, one or two loose stools, loss of appetite, epigastric pain in a man with duodenal ulcer.

Nervous symptoms : Tired for three days.

Back and limbs : sore, back stiff all over, stiff right side of chest and back.

Menses : in one woman who suffered considerable malaise, engorged breasts before menses which were early and profuse.

The scale of the proving was small but it convinced him that *Var.* 30 acted powerfully, producing illness like influenza and

a tendency to arouse old lesions. It should be known by homœopathic doctors that *Variolinum* had this power and that the claim for it as a preventive and curative remedy were probably not exaggerated.

He might add a little about Dr. Bonnell's series of cases. Dr. Bonnell treated these people and was taken into the Law Courts because he would not vaccinate but his proof of the power of the homœopathic remedies in prevention and cure was so sound that he emerged with colours flying. He started by convincing his lawyer who asked for the powders.

Dr. Mitchell's experiences with *Diph.* and *Merc.* were of the greatest interest. One knew of the rapid cure by remedies like *Merc. cy.* and *Lachesis,* but he had not much experience with them in prophylaxis. Dr. John Paterson found that *Diph.* given to Schick-negative people did not hold them negative for long. He would prefer an acute remedy as an immediate prophylactic. He did not see why they should not allow ordinary *Diph.* immunisation, but he did not like it combined with whooping cough. Dr. Mitchell's antidote to the cough with *Pertussin* was most interesting. He had seen one or two of the bad effects but they did not strike him as very serious, it struck him it might be due to the aluminium content in the diph. toxoid.

Regarding the use of *Tuberculinum* and *Bacilinum* here he thought they were dealing with agents which were less pure and less completely the essence of the disease than some other nosodes, especially when made from virus. Most virus diseases, and diphtherias, ran remarkably true to type, but tuberculosis was much more varied, it might be pathologically the same but the disease broadened in its courses, it varied with the hosts' reactions, his mental attitude and the type of secondary infection. His own feeling was that progressive breaking down was due to more than just the tubercle bacillus. It was said that it was a mixed miasma, and that was very true. It was interesting how much it could be activated by some other miasms as in Dr. Mitchell's whooping cough. He thought that explained the relative inefficiency of *Tuberculinum* in acute tuberculosis. It was a wonderful nosode and if there was only

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one remedy for the treatment of chronic rheumatism that would be the one to choose, but they were talking about acute disease at the moment.

He would link up with Dr. Mitchell's theory about the use of nosodes in acute conditions. The acute remedy would help the whole patient, one could not make a nosode from a chill or a wetting, and these were big factors in an acute disease. When it came to the selection of the remedy he must question Dr. Mitchell's assumption that a nosode always bore the highest degree of similarity to the acute disease; it might not.

Dr. Mitchell's observations on the response to homœopathic remedies in acute and chronic disease were of great interest and importance. His theory of interference might well provide a most valuable answer but he was not qualified to discuss this. He could say that he had also been puzzled by the variations in the response of chronic disease, even when a limited result was good. Sometimes an improvement would occur at once then there was a negative phase when one thought it was the wrong remedy or that the condition was incurable, but if one waited sometimes an improvement developed and this time was much more satisfactory. There seemed to be see-saw course even during real improvement and it took the homœopathic doctor's art to guess what was happening. "If in doubt, wait, is the only safe rule."

Another thing he had observed relating to this interference was that one remedy might fail on one occasion and succeed briliantly on another in a chronic case. Dr. Mitchell's statement was that the *Similimum* was not always the optimum remedy in disease, if he meant acute disease and by "similimum" he meant the constitutional remedy for the whole patient, then he agreed. *Phos.* and *Sulph.* were occasionally needed in acute disease in a *Sulphur* or *Phos.* person, but few diseases had the same acute remedy as the constitutional remedy. The acute remedy had no particular reference to the constitutional remedy—he was not referring here to acute exacerbations of chronic disease.

He was very glad that Dr. Mitchell mentioned Dr. Tyler and her brilliant work on *Morbillinum* and other nosodes,

especially the viruses. Also one should be grateful to Dr. Tyler for drawing attention to *Drosera* as a valuable remedy against tuberculosis and also to the work of Dr. Currie on the cat's immunity to tuberculosis being broken down by *Drosera*. One point Dr. Mitchell brought out was the use of the nosode to prepare the way for another remedy. He agreed that a remedy went better after a nosode than before.

Finally, he would like to mention three valuable nosodes in more chronic conditions: *Medorrhinum* was a wonderful remedy in rheumatism, especially of the lower limbs : *Syphilinum* for cardiac pain during the night, patients did not need a positive WR in order to benefit from *Syphilinum*. He would also mention the bowel nosodes, he would not like to be without these remedies.

He would thank Dr. Mitchell for a good paper.

DR. D. M. FOUBISTER said with regard to *Variolinum* that he had an experience which might be worth while repeating. A young Australian was suffering from active pulmonary tuberculosis. He had to go back to Australia. It was decided that he should not be vaccinated so he was given *Var*. 200. He developed on board ship a rash which puzzled the ships' doctor, he thought it was smallpox yet the patient was not very ill, and his explanation of being given a homœopathic prophylactic was accepted as the probable cause.

Regarding the length of time of the action of nosodes homœopaths had no opportunity such as the orthodox people had in doing experiments. Dr. Grimmer believed that a high potency of a remedy acted throughout the whole season. Regarding the question of a number of acute illnesses, he found that when there was one outstanding illness—one had a better chance of helping with a nosode. If the only outstanding case was diphtheria or measles, one thought of the nosodes of that illness. When there were a number of acute inflammatory diseases such as whooping cough, bronchitis coming on early in life, he thought of *Carcinosin*, especially if there was a family history of cancer.

DR. W. RITCHIE MCCRAE said that he had followed the lecture with very great interest because of its relation to his

own observations when studying electro-physical phenomena. Dr. Mitchell's emphasis on the variety of responses to accurately chosen remedies was something which the homœopathic physician must train himself to be fully aware of. The outstanding detail of great significance was that within that parabola of preliminary reaction to the accurately chosen remedy, there was an invariable sense of increasing general improvement and this was evident even when there were painful symptoms at the same time. Whether there were painful symptoms or not, this sense of general improvement constituted a fundamental principle propounded accurately by Hahnemann and it should not be interfered with under any pretext by any other therapy.

Dr. McCrae had noted that if there was any sense of deterioration in the patient's well-being within the parabola of that preliminary curve, that was often due to the choice of a remedy from the patient's neighbouring group. This deterioration might be accompanied by a diminution of the original symptoms. On the other hand these or other symptoms might even increase in intensity. Whatever the concomitant clinical state might be it was urgently imperative to recognize this deterioration as a real danger signal as it demanded immediate search for the true similimum. That type of deterioration from an inaccurate remedy could certainly lead to a rapidly fatal issue in a serious acute condition. It was truly spectacular to see how the administration of the accurate remedy in such alarming states could change the picture into glowing success when death itself seemed to be just around the corner.

Dr. McCrae thanked Dr. Mitchell for his impressively interesting observations and he felt sure that a close study of his research, when it is published, will amply reward the earnest student of Homœopathy.

DR. KENNEDY thanked Dr. Mitchell for his paper. In the mustard gas provings which were carried out in the hospital during the war the nosode was more effective in preventing the burn, while the drug was more effective in treating the lesion, confirming Dr. Mitchell's view that the nosode was of less value in the acute case. This was probably one of the few

occasions the effect of homœopathic potencies had been shown in a scientifically controlled experiment.

Dr. Ross had mentioned the bowel nosodes; he had no personal experience of their use in Infectious Diseases, but Dr. Paterson always said that the nosodes were of no use in acute disease—and one must assume that Infectious Diseases were acute—they were of a specific nature and were, as Hahnemann said, self-limiting as opposed to chronic disease which was a continuous state of ill health. There were cases too of what Hahnemann called acute exacerbations of Chronic Diseases as exemplified in cases of bronchopneumonia; the patient was infected by a chronic miasm and this was merely an "episode" in his chronic, lifelong disease. It was not an acute disease as such, and accordingly one of the bowel nosodes—usually *Morgan*—should be indicated.

He was unable to follow Dr. Mitchell's remark quoting Hahnemann's reference to *Psorinum.* Was he right in suggesting that Hahnemann proved *Psorinum*? Surely, the majority of his provers would be infected with the chronic miasm Psora, being the commonest—and "cure" not a "proving" would follow its use, provided that the remedy was altered during potentization.

DR. FOUBISTER said with regard to the use of bowel nosodes in acute disease the chief one he used was *Dys. Co.* in pyelitis and broncho-pneumonia or nephritis, in any condition in which there had been terrific mental tension. Usually one missed the remedy until the sister in the ward noted that the child had been very tense.

DR. KENNEDY: I think it was maintained by being an acute exacerbation of a Chronic Disease.

DR. ROSS said he thought the cases quoted could be an exacerbation of a chronic condition rather than an acute disease. Unless they developed complications due to secondary infection one would use a bowel nosode rather than any other nosode during the acute stage.

DR. ALVA BENJAMIN thanked Dr. Mitchell for his paper. He was trying to remember if he had ever used a nosode in an acute infective condition, he did not think he had ever done

so. If one could get the proper acute remedy to fit the case excellent results were obtained and he had not had to resort to the nosode to clear the case completely. He had had some instances with the use of a nosode in chronic cases, where one had tried to get the result with ordinary remedies on homœopathic lines and it had not worked, yet one used the nosode related to that remedy, one got the improvement one hoped for. He remembered one case of a young woman with a tumour of the breast which he tried to resolve because she had been to one hospital where they recommended operation and the mother would not allow it, and although she had no stigmata of congenital syphilis from what the mother told him he thought that the father had had syphilis and he gave her *Syphilinum* and the tumour disappeared with the use of other remedies afterwards. That was a very striking instance.

SIR JOHN WEIR said that he was delighted to hear these papers from the younger members, they knew more about it than he did and it was very nice to hear what one had preached for a long while had such good results. He found nosodes were best when things were not getting on as they should.

He had a *Materia Medica* on nosodes written 50 years ago and there was a copy in the Library.

The PRESIDENT said that he would like to suggest that the immunity process in an acute infection did take a very definite time to develop. He thought it was Professor Topley in his book on immunity who produced evidence showing how the changeover from Schick-positive to Schick-negative took a very definite time after immunization and there was a natural biological rhythm for all these immunity reactions. It would be much easier to test this in a condition where there was a toxin, it was much more difficult to think of a virus infection lying fallow but the natural development to immunity had been worked out in a series.

It was interesting to notice the effect on some of their patients who were already under treatment, particularly school children, he found from time to time a child who had been under his care for some chronic disease like asthma or eczema in the course of its school life got a routine immunization and

after that one very often observed the action of the remedy which had worked well before did not afterwards work so well. Another thing one had noticed was that these children were liable to pick up any infection within 10 or 11 days after immunization, especially if it was a double immunization. Immunization seemed to make them extremely vulnerable, they picked up any infection which was going.

It was difficult to believe the extraordinary results which Dr. Swann observed in America. The point which struck his mind was that Swann's method of potentizing was very much criticized in some quarters, it was possible that there was break down in his potentizing so that he was giving live vaccines rather than an actual potentized remedy. This might account for what actually happened.

He thanked Dr. Mitchell very much for his most stimulating paper and he would ask him to reply to the points which had been raised.

DR. G. R. MITCHELL, replying to the discussion, thanked the members for the kind reception they had given his paper. Dr. Ross's provings with *Variolinum* were most interesting. That these had been provoked by the 30th centesimal potency seemed to show that Swann's extraordinary results could not be attributed wholly to the extremely high potency he used. The questions raised by experiences such as these were important ones. It might well be claimed that the effects of ordinary lymph vaccination would have been more tolerable than some of the reactions to *Variolinum*. It is possible that *Vaccininum* could immunize as effectively as *Variolinum*. Being less closely related to smallpox it should theoretically avoid so violent a disturbance.

Dr. Mitchell was extremely interested to learn about the evidence pointing to the transient effect of *Diphtherinum* immunization. He had heard of the Glasgow experiments, which had so unfortunately been brought to an end by the bombing raid on Clydebank, but he had not been aware that, before being abandoned, they had succeeded in providing such evidence,

DR. ROSS said he could not quote the figures, but that was the general finding.

With regard to the degree of similarity between nosode and patient, Dr. Mitchell said that it had to be remembered that a nosode always occupied the same emanometer group as that of the host from which it had been obtained. It would seem likely therefore that the greatest degree of similarity would occur when the patient was in that self-same group.

He had been very interested to learn of the relationship of *Medorrhinum* and *Syphilinum* to Lycopodium patients, but he had not quite picked up what Dr. Foubister had said about *Carcinosin* in relation to acute illness in early life.

DR. FOUBISTER said that if one had a patient who had had whooping cough in the first year or first few weeks or months of life, or pneumonia, or who had tended to have many acute inflammatory illnesses early in life, he would take that as confirmatory if there were a family history of cancer.

Continuing, Dr. Mitchell said he wished to thank Dr. McCrae for the interesting and valuable support he had been able to bring forward for the interference theory from his own experience.

With regard to Dr. Kennedy's mention of the mustard gas experiments, Dr. Mitchell said that the statistical evidence showed quite clearly that *Rhus tox.* hastened recovery, but had little or no prophylactic effect, whereas the potentized gas, though ineffective for cure, was able to confer some degree of immunity. He said he had not understood Dr. Kennedy's interpretation of the quotation from Hahnemann concerning *Psorinum.*

DR. KENNEDY said he thought that what Hahnemann was saying was that most people were infected with the psoric miasm and so one would not expect them to produce good symptoms as provers of *Psorinum*—rather the giving of *Psorinum* would cure them.

Dr. Mitchell re-read the quotation and said that it seemed to him that Hahnemann was seeking to prove that *Psorinum*

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for these cases, for in cases like the above it has well proven its superiority, practically unaided, over all other measures.

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—*The Homœopathic Recorder, June '51*

INFECTIOUS DISEASES AND THEIR NOSODES

(*Continued from page 492*)

could not be isopathic because it had shown itself capable of curing psoric patients. This argument, Dr. Mitchell contended, was inadmissible unless it had first been shown experimentally that isopathic remedies were incapable to effecting cure.

DR. BENJAMIN said that if one had the right remedy in the acute illness, one would not require the nosode later.

Dr. Mitchell replied that such had not been his own experience. He had had cases where excellent results in the acute illness had confirmed a good choice of remedy, and yet in later months a persisting taint had become evident which cleared satisfactorily under the appropriate nosode.

Dr. Mitchell concluded by thanking Sir John Weir for his kind remarks. As an old pupil he would never forget how much he owed to Sir John's teaching, and he would always be grateful for all he had learned from him.

—*The British Homœopathic Journal, April, '57*