

The Homœopathic Treatment of Asthma.

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There is a general consensus of modern opinion on the absence of a specific cure for asthma, and on the necessity of individual investigation of each case. But Hahnemann wrote nearly a hundred years ago that "no real cure . . . can take place without a strict particular treatment of each case."

Orthodox opinion considers asthma as the reaction of a special type of individual, as a whole, mentally and physically, to his particular environment, using the word environment in its widest interpretation. This special type of individual has either inherited or acquired, probably the former, an autonomic (vegetative) nervous system, so balanced that the parasympathetic (vagus) responds more quickly to stimuli than its antagonist. Associated with this vagotonia is an unstable condition of the colloids of the blood and body fluids.

The measures indicated in a case of asthma are:—

(1) *To remove the source of mental stress.*—This is very rarely possible except in the case of children; even if it can be accomplished, the patient will still be left helpless in the face of another different psychological impasse presenting itself.

(2) *To reintegrate the patient's mental forces.*—Here is the scope of psycho-analysis, wisely directed. Homœopathic drugs also have an influence on the mental reactions. To quote the Organon again, "There is no powerful medicinal substance in the world which does not very notably alter the state of the disposition and mind." Even modern medicine can accept this statement, supported by Pawlow's researches on the influence of drugs on conditioned reflexes.

(3) *To remove the physical exciting cause.*—This is sometimes possible. Here is the range of action, unfolded by the development of the cuti-reaction. Sometimes the exciting cause thus demonstrated is so universally present as to render this approach to cure impracticable.

(4) *To desensitize or otherwise alter the reaction of the patient's tissues that he no longer reacts to the exciting physical cause.*—The main scope of homœopathy will be found under this heading. The homœopathic prescriber, in investigating the totality of the symptoms, not only apprises the symptoms characteristic of the syndrome in general, but also assesses the peculiar and significant symptoms which indicate altered reactions in many other organs apart from those producing the symptoms of asthma. Thus a complete picture obtained of the entire extent of the malady as a whole.

CONTRIBUTED CASES*

I.—By Dr. HERVEY BODMAN, Bristol.

W. R., aged 38, was an animal dealer. He first reported on July 24, 1902, complaining that since an attack of pneumonia four months ago he had been suffering from asthma. Lately the attacks had occurred every night. He had been burning powder to obtain relief. He was given arsenicum iodatum 3x, and a fortnight later he was very much better, and had used the asthma powder less frequently. He was given arsenicum album 3, and a month later was able to state that he had discarded the use of the powder. He was then given cuprum ars. 3x, and was not seen again for seven months, when he reported that he was free from asthma.

I. R., aged 9. This little girl was brought up to the out-patient department with a history of four years of asthma. The attacks were chiefly nocturnal. She was first seen on January 15, 1906, when cuprum ars. 3 was prescribed. Ten days later she was better, but a month later she was brought up with an eczematous rash; she was given arsenicum iodatum 3x, and seven weeks later her mother stated that she was better than she had been for months. Six

* At the request of the Editors, in order that the method of practice according to the rule of similars might be illustrated, contributed cases have been sent by several practitioners.

months later she reported that she had suffered from no bad attack for two months; during that time she had been given arsenicum album 3 and sulphur 6. But during the next winter the asthma recurred again; carbo veg. 6, calcarea carb. 6, arsenicum album 3x, were prescribed as indications arose, and in May of the following year she complained of flatulence with the attacks. Lachesis 6 was given, and no more was heard of the patient until five years later, when her mother reported her as quite cured.

II. Dr. FRANK BODMAN, Bristol.

Case 1.—Miss S P., aged 9½. May 21, 1925. Previous history: Measles, pertussis, frequent colds. Nocturnal asthma; attacks several times a week.

Shy, nervous child; chilly, forehead sweats, aversion to milk, chilblains; sil. 30. July 7, 1925: No attacks, but some sneezing and shortness of breath; sil. 200. July 21. One attack. September 2, 1926: Wheezing, damp weather; no asthma since last July; sil. 30. December 21: Slight attacks. February 1, 1927: One attack of asthma; Sil. 200. June 19: One attack of asthma. September 20: No further attacks; sil. 200.

This patient has not reported again, but her mother was seen in December, 1928, and reported that there had been no further attacks.

Case 2.—Master S., aged 5. July 30, 1925. Previous history: Pertussis, bronchitis, nasal obstruction; has suffered from nettle-rash; uncle had asthma; patient developed first attack of asthma on going to school for the first time.

Retiring, shy child; cries when spoken to; always cold; sil. 30. September 1, 1925: No attack; sil. 200. November 19. One attack; sil. 200. Did not report again.

Case 3.—Master N. J., aged 10. October 6, 1925. previous history: Influenza, measles, pertussis, cough, colds in the head; brother an asthmatic; patient has had asthma nearly three years.

Fear dark, fear alone, very imaginative; colds always go to his chest; thirsty, desires cold drinks; phos. 30. October 20, 1925: Very much better. November 10: Tonsillitis. December 29: phos. 30. January 19, 1926: Better; no further attacks.

Case 4.—Mrs. F. D., aged 33. Asthma since the age of 14. Jaundice four years ago; pertussis badly when a child. On examination, an adenoma of thyroid; heart, apex beat outside mid-clavicular line. Burns powder to relieve asthma. Unhappily married to drunkard. Irritable, restless, desires fresh air. November 9, 1926; Kali Iod. 6. November 25: Better; Calc. phos. 6. December 10: Menorrhagia; Phos. 6. December 21: Senecio 6. January 9, 1927: Menorrhagia; Phos. 30. February 12: Has not been using so much powder. X-ray of lungs shows fibrosis of right lung, glands at the hilum enlarged; Ars. alb. 6. March 10: Sil. 30. March 24: Very much better. April 7: Sil. 30. May 19: Sweats profusely; Sil. 200. June 16: Sil. 1,000. March 26, 1928: No further attacks. Has had intercurrent treatment for concussion.

Case 5.—Mr. W. R., aged 51. Asthma followed pleurisy twenty-five years ago. Uses Potter's. Never had urticaria. Always worse in the spring. Bowels always loosely opened. Warmth aggravates. April 21, 1927: Sulph. 30. May 5: Only used powder twice. May 19: Sulph. 200. June 2: Better than for years. Did not attend again.

III.—By Dr. W. W. RORKE.

Case 1.—January 27, 1925: A housemaid, aged 16, has suffered for three years from frequent attacks of "tightness of the chest" and wheezing respiration, usually worst on walking in the morning. No bronchial catarrh with the dyspnoea and hardly any cough, but there is free flow of nasal mucus during the dyspnoea.

Weather changes do not appear to cause the attacks, but they are more frequent in winter. The attacks occur

regularly before the menstrual period and at other times irregularly.

Natrum phosphoricum 10 m. prescribed.

December 22.—The attacks diminished in frequency and severity soon after the medicine was given, and there was no attack at all from the middle of February until the beginning of July, since when there have been occasional slight attacks which have become more severe and more frequent during the past month. There is very marked depression during the attacks.

Sepia 10 m. prescribed.

The patient has had no attack of asthma since the first week of January, 1926.

Case 2.—November 3, 1925: A widow, aged 43, has suffered from asthma for *seventeen years*. It is usually worse in the month of May. Difficult expiration with some cough but no sputum. No rales or rhonchus heard.

Worse after sleep, wakes her at 1-30 a.m. Must seat up and lean forward. Worse after exertion. Worse after eating cheese, milk, pork, rabbit, pigeon.

Phosphorus 1 m. prescribed.

June 9: Has had no attack of "suffocation" since taking the medicine until had a "chill" a fortnight ago. The attack was not severe. She says: "It is a treat to be alive now." No prescription. June 30: Had a severe attack on June 25th.

The prescriber now made the mistake of repeating the previous effective prescription without careful re-taking of the case. Phosphorus 1 m.

July 21: Attacks have been frequent and severe. Case re-taken and Lachesis 1 m. prescribed.

December 1.—Has been perfectly well until November 28, when she contracted a "sneezing cold." Snoring rhonchi heard. Considerable cough with scanty mucous sputum. Case re-taken. Kali carb. 200 prescribed.

January 5, 1926: Feels well. Has had no asthma. Increase in quantity of mucous sputum.

• March 30: Has been well until she had an attack of sneezing the day before yesterday. Marked expiratory dyspnoea now. No rales or rhonchus. No cough except on walking in morning. Case re-taken. Phosphorus 10 m. given. Has remained "perfectly well" since.

Case 3.—April 5, 1925; A paint-brush maker (male), aged 43, has been subject since 1919 to attacks of "tightness of the throat and chest" occurring about every ten days and lasting for three nights. The attacks occur from midnight to 4 a. m., and are accompanied by cramps of the legs, sneezing, and nasal catarrh. There is some cough, but no sputum. No observable effect of weather conditions. Kali carb. 1 m. prescribed.

June 30: No improvement except that there is now no nasal catarrh or sneezing. Case re-taken. Arsenic alb. 1 m. given.

September 22: No asthma since taking the medicine. No complaint except of breath if he has "a good tuck-in." Nothing prescribed. Has remained well since.

IV.—DR. H. FERGIE WOODS.

Case 1.—Miss J. C., aged 21, architectural student. Treated by me for asthma when a child; > from Tub. bov., now asthma again, < when over-tired, < night or early a. m. (often 4 or 5 a. m.). When asthma is bad, sits bent forward with elbows on knees. Out of breath easily at all times. Foot sweat, not offensive. Takes much salt. Cold <. Takes cold easily. Nerves and spirits good.

Seen July 9, 1924: Kali iod. 30 and S.l., and some osteopathic treatment.

Seen July 22, 1924: Very much better in self and in asthma. To faint traces only of asthma. S.l., more osteopathic treatment.

Seen August 24, 1924: One attack of asthma two or three weeks ago, for which Dr. McC. gave coffea, >. Two attacks since. Kali Iod. 200 and S. l., osteopathic treatment.

September 26, 1924 (letter): No >. Attacks at 3 and 5 a. m. Tub. bov. 30.

October 10, 1924 (letter): > Occasional asthma at night. S. I.

Seen May 25, 1925: Pain in right arm, < lifting any thing < lying on it, > holding arm behind head. Asthma kept away except for one attack when over-tired. Ruta 30 and osteopathic treatment.

June 21, 1925 (letter): Keeping better. Slight hay fever only. Tub. bov. 12.

June 30, 1925 (letter): Had asthma every night she took the Tub. bov. 12; no asthma since leaving it off. 1928, last heard of—keeping free of asthma.

Case 2.—Miss B. D., aged 54, convent sister. Asthma since 14 years of age. Asthma is < when undressing at night, < N. E. wind, < spring and summer. Hungry soon after a meal. Cheese <. Takes much milk. Sleep fair, if half-sitting all night. Subject to "fits," apparently epileptic, usually at 7 or 7-30 a. m., for which she has taken Bromide for years. Constipated (takes senna pods and cascara). Nervous of thunder; absent-minded; imagines someone behind her on stairs.

Family history.—Much consumption in mother's family, and mother had asthma.

Examination. —Blood-pressure: 224 systolic. Lungs, sibilant rhonchi. Bright red lips. Heart normal.

First seen on May 8, 1928: Given Phos. 12. Put on a diet which included no butcher's meat, milk, no salt.

Seen May 25, 1928: No asthma after the first 10 days. Less hunger. No fits; reduced Bromide from 20 gr. every other day to 5 gr. every other day. Blood-pressure: 220. No rhonchi in chest. Phos. 30.

June 22, 1928 (by letter) (unable to come; lives at a distance): No bad attacks of asthma. No fits. Continue Phos. 30.

July 26, 1928 (letter): Rather more asthma. Wakes 5 a. m.

with wheezing. Phos. 200 and 1 m successive days and s.l.

September 10, 1928 (letter): > but still some asthma. Tub. bov. 30 (successive days) and S.l.

October 23, 1929 (letter): Asthma very much better. Eczema in left ear (old symptom returned). S.l.

November 83, 1928 (letter): Asthma much better till yesterday. Tub. bov. 30.

December 5, 1928 (letter): Asthma much better again. Eruption on ear much better. S.l.

January 17, 1929 (letter): Keeping free from asthma, S.l.

March 5, 1929 (letter): Very little asthma; a little dyspnoea, twice when dusting and once when she caught cold. Tub. bov. 30.

April 16, 1929 (letter): Practically no asthma. Some wheezing at night. Tub. bov. 30.

May 27, 1929; Asthma keeping better. Continue Tub. bov. 30.

June 24, 1929: Practically no asthma. Slight wheezing only, one or two evenings. Continue Tub. bov. 30 and s.l.

July 23—29; Taken no bromide for a year. One fit 3 weeks ago. No asthma at all. Sulph. 30.

Case 3—Mr. F., aged 49, Solicitor. Asthma since 14 years of age, < in August, < 5 p.m. and also 4 or 5 a.m. > seaside, < big meal. Takes injections of adrenaline. Had nose cauterized; no >. Heat <. < 5 p.m. (in self). Warm room <. East wind <. Takes cold easily. Nervous of appearing in public. Some indigestion. Diarrhoea with the asthma. Hates fat. Beer <. Spirits <. Raw fruit <.

Examination.—Fair hair. Blue eyes. Bright red lips. Heart and lungs not diseased, but barrel-shaped chest. Dorsal curvature (since boyhood). Deviation of fifth dorsal vertebra.

Seen November 24, 1926: Puls. 39. Put on diet to include no taking of milk. Osteopathic treatment.

Seen December 22, 1926: < No colds. No asthma. No indigestion. Continue Puls. 30. Osteopathic treatment.

Seen January 19, 1927 : One attack of asthma last week, with diarrhoea. No colds. Continue Puls. 30. Osteopathic treatment.

Seen February 22, 1927 : A cold and some asthma three weeks ago—went off more quickly. Lyc. 30 and S.l. Having treatment regularly from an osteopath.

Seen June 1, 1927 : No severe asthma for two months. Can run better

Examination.—Tongue coated at back. Descending colon loaded. Lyc. 200 and S.l. To have Plombieres douches. Continue osteopathic treatment.

Seen October 25, 1927 : No bad attacks of asthma.

Examination.—Tongue cleaner. Descending colon clear. No deviation of fifth dorsal vertebra now. Lyc. 200. S.l.

Letter, July 24, 1928 - "No asthma since I went to you and Mr. V. [osteopath], and as this is the first year I have been so free for at least thirty years, you may be sure I am deeply grateful. I have never enjoyed the summer before.

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Such is our *materia medica*—a record of actual occurrences, of events that really took place, of results that were unquestionably produced upon the healthy subject. It can never grow obsolete. Theories may be originated, may flourish and grow antiquated, and at last fade into oblivion. The hypotheses that constitute the science of pathology, after passing current for a generation or two, are sure to be repudiated in favor of some newer issue, and the very terms in which they are expressed may become unintelligible as time goes on. But the facts of our *materia medica*, expressed in ever comprehensible vernacular language, are always fresh. Being the results of pure observation and therefore *absolutely true*, no modifications in philosophy, no changes of theory can supersede them. Our *materia medica* is an everenduring work.—CARROLL DUNHAM, 1865.