

him, "You will have a reaction. It will last so long." If you don't, you lose him.

If you tell him he will have a reaction and that he has to consider it not as an aggravation but as a sign of the medicine's working and as a sign of a cure coming, then he will be glad about it but, surely, if you give to some young girl with chronic sub-febrile temperature a high potency, she will have such a reaction that it will tear her to pieces. Then that would be bad. Then you have to counteract it. You can always counteract it quickly. But it is not necessary to have such a reaction.

We don't have much malaria here, as Dr. Jimenez mentioned. Therefore, we don't have so much experience with malaria cases, but we have enough other cases so we don't need malaria to experiment with *Natrum mur.*

I am very glad Dr. Holoconbe is also of the same opinion because he has had immense experience in these cases.

So, I thank you very much for your kind comments.

—*The Homœopathic Recorder, October, 1952*

## VOMITING IN INFANCY AND CHILDHOOD

D. M. FOUBISTER, B.Sc., M.B., Ch.B., D.C.H., F.F.Hom.

MADAM President, ladies and gentlemen, I feel greatly honoured to address the Faculty of Homœopathy. It was suggested to me that a paper on modern trends in pædiatrics might be acceptable, but the subject seemed too large to cover adequately in a single lecture. The reason I have chosen this title is simply that it links together a number of otherwise unrelated conditions frequently encountered (apart from one or two of them) in hospital pædiatric practice. Differential diagnosis will not be dealt with in a comprehensive way, except in the case of recurrent vomiting in infancy.

### INFANCY

Shakespeare described infancy as the age of "mewling and puking in the nurse's arms." It is indeed true that vomiting is more common in infancy than in any of the

other "seven ages" of man. It is often a protective act. Thomson and Findlay<sup>1</sup> write "Nature has sought to make up to the baby for his lack of judgment in feeding and his dependence on others for the choice of his food by giving him great facility in rejecting from his stomach any meal that is unsuitable in quantity or quality". Vomiting is so easily induced in infancy that there is a wide variety of occasional causes of vomiting such as teething, worms, excitement or fatigue. Sometimes vomiting becomes habitual, the newly-born infant vomits meconium or blood swallowed during parturition and a habit is set up which may persist in spite of all attempts to alter the diet.<sup>2</sup> Not infrequently no cause at all can be found for vomiting, and in such cases so long as the infant continues to thrive and gain weight satisfactorily the vomiting can be disregarded.

#### *Onset of Infection*

The onset of an acute infection in infancy and early childhood may be ushered in by vomiting, diarrhoea and vomiting convulsions. Vomiting is typically present in some febrile conditions such as pyelitis or tonsillitis but can occur with any infection.

In looking for the cause of a fever in infancy and early childhood it should not be forgotten that otitis media and pyelitis may be without any localizing symptoms, and unless the ears and urine are examined routinely the diagnosis may be missed. In one series of a hundred cases of pyelitis admitted to a children's hospital 60 per cent. had no localizing symptoms and only four were correctly diagnosed prior to admission. The finding of over six pus cells per low power field of the microscope clinches the diagnosis. When there are signs of meningeal irritation along with vomiting, it should be remembered that meningismus is a fairly common condition in children and the apices of the

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<sup>1</sup> John Thomson and Leonard Findlay (1933): Clinical study and treatment of sick children, 5th Edition, p. 148.

<sup>2</sup> Ibid.

lungs and the ears should be examined. It may be quite impossible to be sure of the diagnosis without a lumbar puncture.

### *Intracranial Conditions*

Tuberculous meningitis with its insidious onset and progressive deterioration presents a very different picture, but a history of vomiting at the onset is highly characteristic. Head injury and tumour have to be considered with such a history. Although both subdural hæmatoma and cerebral tumours are rare they must be remembered. One-fifth of all cerebral tumours occur in childhood.

### *Abnormalities of the Alimentary Tract*

Congenital abnormalities of the alimentary tract give rise to persistent vomiting from the first day of life if there is atresia or considerable stenosis, but may not in the case of stenosis give rise to trouble till solid food is added to the diet. Of other surgical conditions, appendicitis which is common in childhood is rare in infancy. Obstruction due to intussusception occurs usually between six and eighteen months but can occur at any age.

### *Feeding Mismanagement*

Of the causes of chronic vomiting in infancy, feeding management is by far the most important. It has been estimated that two-thirds of such cases fall into this category. It is now realized that it is excessively rare for a mother's milk to disagree with her child except she is grossly underfed. Very occasionally the mother may take too much milk stimulating foods, for instance, malted milk, or milk in very large quantities and the infant is being overfed. It is still, however, very common to find that an infant has been weaned on the grounds that the mother's milk was "windy" or disagreed in some way. Underfeeding is much more often met with than overfeeding. The infant is then excessively hungry and gulps down large amounts of air with the milk, and either has colic and insomnia, or loses much of the milk which comes up with the forcible eructations.

The colic or vomiting is unfortunately often regarded as an indication of overfeeding and the infant is made worse by having his diet reduced instead of increased. The exact position can readily be ascertained by test feeding for a day in the case of breast-fed infants who require  $2\frac{3}{4}$ - $2\frac{1}{2}$  oz. of milk per pound of expected body weight per day. The technique of feeding must also be checked. Holding the baby wrongly so that the nose is buried in the breast, or omitting to bring up the wind properly may be all that is wrong. It is often some trivial fault which is the cause of trouble.

.....

The regurgitation of one or two teaspoonfuls of milk after a feed which occurs in breast-fed infants known as possetting is normal, and should be disregarded if the baby is thriving and putting on weight normally.

A similar procedure is adopted with bottle-fed babies. The technique of feeding here also must be checked. Not infrequently the hole in the teat is too small or too big. (When the bottle is tipped over the milk should run out rapidly in drops, not as a continuous stream). A hot needle will be found useful in making a wider hole when another teat is not available.

The quantity and quality of the milk mixture is noted and checked against the infant's expected weight. Occasionally an infant is kept hungry by feeding him on the basis of actual weight instead of his expected weight.

Sometimes allowance must be made for babies with an unusually large appetite who really require more than average. It is customary to feed babies under 8 lb. at three-hourly and over 8 lb. at four-hourly intervals. Sometimes it is necessary to revert to three-hourly feeding till the baby is a heavier weight. The longer interval may make the difference between satisfactory and unsatisfactory progress. Feeding mismanagement has to be treated seriously because if it persists serious harm may be done and even death may result.

*(To be continued)*

## THE HOMŒOPATHIC STATE FACULTY, WEST BENGAL ELECTION RESULTS

The general election of members for the different Constituencies of West Bengal was over by the 5th June '53.

The following candidates have been declared to have been returned in the general election :—

### CALCUTTA CONSTITUENCY (7 SEATS)

- \* 1. Dr. J. N. Mazumdar, M.Sc., M.B., F.R.C.S., D.M.S.  
etc.
- \* 2. Dr. S. N. Ghose, M.A., H.M.B.
- 3. Dr. N. M. Choudhuri, M.D.
- \* 4. Dr. S. K. Ghose, B.Sc., M.B.
- \* 5. Dr. S. K. Das, B.Sc., M.B.
- \* 6. Dr. R. C. Roy Choudhuri, D.M.S.
- \* 7. Dr. N. K. Das Gupta, L.M.F.

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- \* 5. Dr. Ashu Roy, D.M.S.

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\* Candidates set up by the Bengal Homœopathic Institute, Calcutta.

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THE INDIAN HOMŒOPATHIC REPORTER

*Owned and Published by*

HAHNEMANN PUBLISHING CO.,

165, Bowbazar Street, Calcutta-12.

Annual Subscription Rs. 4/- ; Foreign \$2.0 ; Single copy -/6/- ;  
Special Rate for Bonafide Students.

All communications relating to the Editorial Dept., Books for Review, Journals for Exchange etc., should be sent to the Editor-in-chief, Dr. Sarat Chandra Ghose, M.D., M.R.S.L. (LONDON), 31B, Kabir Road, P. O. Rashbehari Avenue, Calcutta, or Dr. B. K. Sarkar, M.B., D.M.S., 86, Beltala Road, P. O. Kalighat, Calcutta, India.

All Business communications and remittances should be sent direct to the Publishers, Hahnemann Publishing Co., 165, Bowbazar St., Calcutta 12.

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