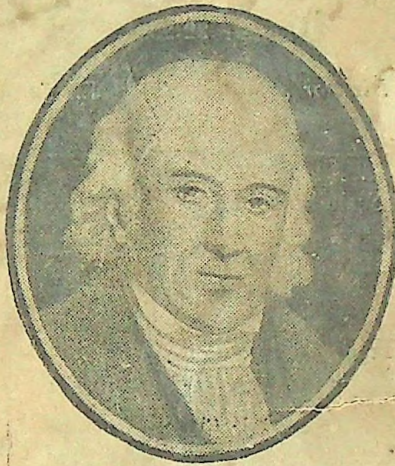


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The
HOMŒOPATHIC HERALD

EDITOR

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

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Editorial**THE MERIT OF HOMŌEOPATHY AND AN IDEAL
SYSTEM OF MEDICINE**

It is the merit of Homœopathy that by utilising the clinical aspects of diseases, both natural and consequent on "Drug provings" medicine assumes its true place in being an art—"the art of healing". Hahnemann realised that clinical phenomena are those which render themselves perceptible to our senses as a resultant of actions and reactions of forces—physico-chemical, vital and psychological operating in and through the human organism. The study of totality of symptoms and individualisation of patients and drugs is the pivot round which the whole Homœopathic philosophy revolves. The physicians of the orthodox school, considering them strictly as scientists, always attempts to study things and phenomena from causal point of view. They seem to forget the complexity of the notion of causality and the difficulty of applying of mechanistic cause in biological domain where the concept of creative or evolutionary cause is the most relevant to the purpose. Vital phenomena are in a continual flux. We can arbitrarily break the chain at some points and demoninate the successive parts as cause and effect, but that is highly improper. That is why Homœopathy discards the causal mode of thinking in the study of biological phenomena which comprise the subject of medicine. Clinically Homœopathy is satisfied by noting the co-existence of objects and phenomena and sticks only to the descriptive level. This attitude may not be scientific but under the present circumstances there seems to be no other alternative technique for study of Man as a whole and treating him as a whole. Hahnemann found the Art-part of Medicine, seriously

defective in his time ; and also noted the attitude of the mistake of a whole generation of orthodox medical men before his time who were (and still are) obsessed with the idea that a theory of causation was essential to any rule of treatment and who neglected the clinical symptoms (which were ever before their very eyes) and carried on a wild-goose chase in search of cause and explanation of such supposed causes. It was Hahnemann who placed before the world that the healing art can be developed independently of the scientific aspect of medicine. The orthodox group considers the Homœopaths as not being scientific enough whereas the latter consider the former as not being practical enough so far as the cure of patients is concerned. Homœopaths accept the facts on their face-value whereas the other group clamours for a theoretical explanation before they accept a fact. That is why (1) Homœopathy attempts to explain nothing ; it offers a plan of investigation ; (2) Speculated neither with theories of life nor of health nor of disease-conditions or nature of drug actions on living organisms or cure of diseases but it helps one to select a remedy for a disease-condition that will be curative thereof ; (3) Homœopathy has no remedy for the name of a disease, has no specific for any disease by name but it has a specific for each individual case of disease ; and (4) Homœopathy can cure a disease without the necessity of arriving at a nosological diagnosis and as such it can nip a disease in the bud. And this serves the chief purpose of a practical physician. All this is possible as Homœopathy adopts the clinical picture of diseases and drug actions as the basis of the therapeutic art.

My dream of an ideal system of Medicine in future :

The human being is a triune organism of body, life and mind. Though each of the aspects, physico-chemical, vital and psychological which the human organism presents is relatively important, it is the vital aspect which is the most relevant for us physicians. Hahnemann had not the time to systematic the knowledge regarding the category of life. It is here that Ayurveda scores in having made a scientific study of life and having elucidated general principles for facilitation of comprehension. Ayurveda maintains that the vital phenomena are

capable of being explained dynamically by scientific laws involving terms and conceptions appropriate to the category of life. A spirit of synthesis, in the truest sense of the term, should work in the field of medicine. I hope that Homœopathic therapeutics associated with Ayurvedic Dynamic concepts of "Tridost theory" supplemented with the knowledge of auxiliary sciences of modern western medicine would make a system which would be as near to perfection as possible. In the meantime I like to draw pointed attention of our Central Government to take necessary steps to create chairs on Comparative Medicines, Eastern and Western, ancient and modern in Colleges and University of our country, which will go a great way to evolve an ideal synthetic system of Medicine in future.

B. K. SARKAR

"NEURALGIA : SOME CONSIDERATIONS"

E. G. McVIOR, B.D.S. (N 2)

Dental Surgeon

Auckland, New Zealand

*"For all the happiness mankind can gain
Is not in pleasure, but in rest from pain."*

(Dryden)

Numerous articles have been written on the subject of neuralgia. Many describe the condition fully, but in all cases treatment recommended is indecisive. We have been told that neuralgia is an intractable pain, which can be removed only by surgery or alcohol injections. Where the patient will not accept this cure, he is sent away with a prescription for analgesics, tranquillizers, barbiturates, or anticonvulsive drugs e.g. dilatin. Some have tried hypnosis, trilene inhalations, vitamins, and anti-migraine remedies, but the general picture obtained from the literature is one of palliation but not cure.

We may look upon neuralgia as a disease in itself or merely a symptom in the patient's disease complex. Characteristically the literature emphasises neuralgia as a disease in itself and

suggests treatment accordingly. It would appear to be more correct, in my opinion, to consider neuralgia as a symptom of the patient's disease complex and, by considering the problem from this wider aspect, evolve a different avenue of attack upon this symptom.

Firstly, however, let us consider briefly some features associated with this painful condition. A short discussion only is necessary as the basic facts are known to all members of the profession. Neuralgia is defined as a pain experienced by the patient over an area of nerve distribution for which no apparent organic cause can be found. Apart from the pain experienced, there appears to be no loss of function, except for some possible muscle wasting in a few cases. The pain is intermittent in that it comes and goes and lasts for a varying period of time. It may come a number of times a day, or only once a year, or even less frequently. Loss of function, which is a feature of neuritis, is not evident. Although the acute nerve pain of neuritis can be truly termed a neuralgia in that it is a nerve pain, continued neuritis ultimately terminates in loss of motion or sensory function, therefore it is necessary to distinguish between acute and chronic neuritis.

Neuritis is an actual inflammation of the nerve, which may affect the sheath of the nerve, the interstitial fibres of the nerve, or the nerve fibres themselves, or all three, and may be caused by toxins, trauma, exposure to severe degrees of heat and cold, lack of vitamin B, poisons etc. When we consider that these factors can also be responsible for neuralgia, we can conclude that neuralgia is a neuritis, because all pain is a manifestation of nerve involvement. Neuralgia, however, is a reversible state which can lead to ultimate complete recovery, whereas neuritis progresses to paralysis or sensory loss. The degree of nerve intoxication is probably the real distinguishing feature between neuralgia and neuritis, the former being reversible, the latter being progressive. Because the latter is progressive, there will eventually be loss of pain when loss of function is complete. With these brief comments we can leave neuritis and focus our attention on neuralgia.

Neuralgia is a rather loose term which should refer only

to a nerve pain which is experienced over a specified area shown to correspond to the actual anatomical distribution of a nerve. The term neuralgia lacks scientific accuracy, but we are justified in using this term as nearly everybody knows what a neuralgia is held to mean.

We know that a nerve is affected by impulses applied either in the terminal filaments, the nerve trunk itself or at the ganglion and that a sensation arises which registers itself as pain felt over the area of anatomical distribution of the nerve. Specific specialized nerve endings receive pain stimuli and transmit their sensation to the central nervous system along nerves of fine calibre, which may be unmyelinated or contained within a thin medullary sheath. These fibres originate from the cells of the peripheral ganglia of the spinal cord or the brain and transmit their sensations primarily to the cortex and also thalamus where they are recorded and enter into consciousness, but one thing is certain and that is that pain resulting from lesions of organic origin must coincide with the true anatomical distribution of the nerve or ganglia involved.

Other symptoms may be noted such as ocular disturbances, flushing of the face sweating and lachrymation, but whether these symptoms are only secondary to prosopalgia is a matter of opinion. We must not lose sight of the fact that every neuralgia must have a positive pathology. Not knowing this pathology in all cases is insufficient reason for diagnosing the condition as a neurosis. It follows that the only right and rational treatment of neuralgia is to go to work ætiologically and cure causally and, because the causes of neuralgia may be numerous and frequently complex, it follows also that the treatment in individual cases may be varied and complex.

Pain sensation is nature's way of warning the individual that noxious elements are at work within his system : it is simply a message therefore obliteration of the pain alone is not curing the patient in all cases. Where there is excessive damage to nerve tissue it will be impossible to feel pain, e.g. in the superficial mechanical destruction of tissue, and similar circumstances exist when the pain pathway is destroyed by

surgery or school injections. The message may not get through to the brain but the pathological condition in the tissues may continue to develop or progress without being registered in the conscious mind. Pain is always a sign of injury, therefore all painful stimuli betray tissue damage but this is only so if the nerve endings are not grossly destroyed and the nerve pathways remain intact.

Because pain is a subjective symptom, we must rely on the patient's description of the painful sensations to assess its importance. We call it a subjective symptom because it is a symptom totally experienced by the patient alone and cannot be seen or felt by the observer. This gives the patient a great deal of latitude when describing his symptoms and quite often the patient is not very precise. It is frequently difficult for a patient to localize pain accurately, in fact many patients are quite confused in their efforts to outline the boundary of the pain experienced. Furthermore, the patient's description of the pain is influenced by his own threshold of pain. The excruciating pain described by the patient with a low threshold of pain may be a mere inconvenience to the patient who has either a higher threshold or greater self control. It is important therefore to assess the patient's stability, personality etc. Nor must we be too hasty in diagnosing a neurosis just because the patient's description of the pain does not exactly fit the anatomical facts. In the hustle and bustle of modern life tensions are built up which can accentuate or magnify a pain and though it is possible that we may overlook this fact, the patient is not very impressed if we discount his symptoms and suggest a visit to the psychiatrist. The patient is experiencing pain and he has come to his doctor or dentist for relief. That pain is very real as far as the patient is concerned.

It has been demonstrated that there is little difference between the pain threshold levels of different individuals. This may be so experimentally but clinically this is open to doubt. People vary so much in their response to pain that one can conclude that either the pain threshold levels of individuals differ markedly or their response to pain is altered

due to heightened mental irritability. The second alternative is probably more correct as a characteristic feature of the person suffering from neuralgia is the heightened irritability of the patient. The emotional state of the patient is therefore important to assess since an emotional patient may exaggerate his symptoms. Nevertheless we must not overlook that this mental irritability is a sign of physical departure from health. We must therefore be careful to differentiate between the patient's emotional response to painful stimuli and their actual true physical sensation. Despite this the patient's history remains most important and forms our principal means of attacking the problem.

The treatment of neuralgia is certainly not easy. To date surgeons have mainly relied upon removal of ganglia or sections of nerve tissue. Decompression of the nerve is a comparatively recent operation and alcohol injections into the nerve ganglion or nerve foramina a comparatively old form of treatment. Despite these means, relief is often not total and quite frequently only temporary. The simple fact that patients cannot obtain permanent relief from pain serves to emphasize one of the problems of modern medicine—extensive knowledge in one direction (i. e. knowledge of anatomy and physiology of the nervous system and its relation to pain) counterbalanced by uncertain results when efforts are made to apply that knowledge. In this particular complaint we can conclude only that other factors apply which complicate our diagnosis and assessment and which serve to emphasize that the human body is exceedingly complex and very difficult to understand entirely. The French proverb suggests that "there are no diseases, only sick people." This is probably very close to truth in many cases of neuralgia.

One of the most noticeable factors which comes to the reader's mind as he reads through the literature is the clinician's preoccupation with the pain itself. The case histories concentrate on a description of the pain and its location and distribution but very rarely the writer mentions any other factor concerning the patient. When we remember that pain is an expression of a pathological condition in the process of evolving,

it is difficult to believe that, during the period from the moment the pain first began to be noticed until the time patient first sought relief from the practitioner, the patient had no other expression of derangement within his person. It is usually accepted that the onset of neuralgia is gradual over an extended period of time until the climax is reached when the patient visits his doctor or dentist. This period may extend over months, or one or two years, or even longer. During this period the patient will have passed through a phase of departure from perfect health. This alone may have lowered his threshold of pain considerably. The neuralgia may be but a terminal symptom which arose late in the patient's general state of health. One of the problems of medicine is determining the period of onset of disease. Medical practitioners are all aware of the numerous patients who visit their surgeries complaining of obscure conditions for which no real diagnosis is possible and no name can be given. Nevertheless although there is at this stage no pathological evidence of disease, the patient is still unwell. The patient senses his condition and knows he is not right. He may express this as general exhaustion which cannot be overcome by rest, or sensation of temperature sensitivity, e.g. sudden abnormal sensitivity to cold, or a host of other symptoms to indicate that something is wrong.

Formerly the expression "neurasthenia" was used to cover such complexes but this term is not used nowadays. The physician will simply tell his patient that he is "run down" and send him away with an iron tonic or tranpuillizers or barbiturates to make him sleep. These complaints of the patient are the first expressions of derangement and it is at this stage that the patient is most curable if only the physician knows how to cope with these symptoms. It is not until a gross pathological condition is present, however, that diagnosis becomes certain, and, in many instances, the patient is beyond redemption when this stage is reached. Carcinoma and true Tic Douloureux are two examples which come readily to mind to convey this thought. The point that I am bringing to mind is that a chronic disease evolves gradually, but continuously :

in its early stages it is curable but difficult to diagnose ; in its late stages it is easy to diagnose but difficult to cure. This remark is not meant as a mark of censure, because any professional person who has been in practice long enough will soon realize how extremely complex the human mind and body are and he will be excused if, at times, this complexity is beyond his ability to discern, diagnose and treat. Every patient is an individual and every individual varies so that no two people need necessarily present the same symptoms nor require the same treatment. When one then considers all the symptoms and all the combinations and permutations that are possible the task often becomes well nigh herculean. It is to the credit of the professions that all these conditions have been gathered together and tabulated in books and journals to make an accurate diagnosis possible. Our lack of success in the treatment of such conditions as neuralgia etc. shows that our knowledge is still very superficial. It will not be until all cases can be cured completely that we can say that our knowledge is adequate.

We cannot truly cure a neuralgia if we do not consider the underlying syndrome. A cure of neuralgia can only be accomplished when the total self of the individual has been cured, in other words, the pain of neuralgia is not itself the disease, it is only the body's method of calling out for help. Pain is an expression of tissue damage therefore cutting the pain pathway leaves the tissue damage untreated and eliminates the body's ability to register the tissue changes involved. The value of this warning system of pain can be appreciated when we remember that a person can be awakened even from heavy sleep by the pain warning mechanism. We can conclude therefore that neuralgia is more frequently a symptom and not a disease in itself, examples being pleurodynia subsequent to herpes zoster, and sciatica associated with rheumatism, Salivation, lachrymation, muscle spasms, greying hair associated with neuralgia also betray general factors intermingling with the neuralgia symptoms themselves. The essential feature is that the neuralgia may be simply another symptom in the patient's general condition and should be treated as such.

Where neuralgia exists alone it may be an early symptom in a syndrome which has not yet fully developed. A syndrome as such is merely a collection of associated symptoms, which recur at any one time in an individual. To classify a series of symptoms as a syndrome often leaves the examiner content with the classification, and leaves him powerless to match his diagnosis with effective treatment in the case of neuralgia.

Because the pain is seldom persistent but fluctuates in severity from time to time to time, either completely disappearing periodically or varying in intensity, it is evident that the patient's level of health at the time is very important and also fluctuating otherwise the pains would be spasmodic or continuous without intermission or relief. Transient pains are usually associated with localized hyper-irritability. These pains are frequently triggered by such things as sudden temperature changes, e.g. sudden draft of cold air a warm air, motion of muscles, vibration, touch etc. which suggests that the pain is more likely to originate at the level of the nerve endings. It is not pure coincidence that these same stimuli are responsible for rheumatic complaints also. People suffering from rheumatism are notorious for explaining that they can predict weather changes before the visual change in weather conditions become noticeable merely from the pain sensations which they experience. In a typical neuralgia we have the deep-seated constant pain which may extend over head, face, or neck and which may be bilateral as well. It has been considered that these pains are probably due to neurovascular disorders rather than true nerve disorders alone but their similarity to the pains of rheumatism are too close to be overlooked. As rheumatism is also associated with neurovascular disorders this similarity is further emphasised. The modalities of pain are similar. However, the paroxysmal character of the pain and the absence of swelling of the parts, help to distinguish the pains of neuralgia from those of rheumatism.

In any of these complaints the problem is one of hypersensitivity which is the natural sequel to hyper-irritability of

the tissues involved. In the case of neuralgia the irritating factor may lie at any one of a number of levels as follows :

- (1) At the terminal nerve endings.
- (2) In the nerve fibre itself anywhere along its course.
- (3) In the ganglion.
- (4) Inflammatory conditions surrounding the ganglion or nerve fibre and causing irritation of the ganglion or nerve.
- (5) Irritating effect of muscular metabolites on nerve endings.
- (6) Viral inflammation of nerve endings, e.g. herpetic conditions.
- (7) Compression of the nerve due to (a) bone compression, (b) fluid pressure in the bony canals from inflammatory exudates, (c) inflammatory swelling of the nerve trunk.
- (8) Presence of neuromas.
- (9) Brain interpretation of the pain sensation.

Continued:

HOMŒOPATHIC EXPERIMENTS IN OPHTHALMIC PRACTICE

BY FRANK R. NEUBERT, M.D. D.O. (OXON), D.O.M.S., M.F. Hom.

It is a great pleasure to be once again in the arena of Homœopathy, but to-day I am not fighting in support of my campaign for "Scientific Homœopathy", but wish to talk to you about a few experiments with homœopathic remedies in my ophthalmic practice.

It is a serious fault in the psychology of public speaking to apologize beforehand for what one is going to say, but it will not be the first fault I have made here.

Two months ago, when I promised to read a paper to you, I suddenly decided to write an essay on another subject ; only eight days ago did this paper begin, and during that eight days I have made one visit to London already for our Ophthalmological Congress. I have had to burn much of the midnight

oil to include even a few of my case reports, and if you see the unexpected phenomenon of the lecturer falling asleep instead of the audience, I hope that you will not make an error in your diagnosis of the cause.

One of the most boring occupations is for a general practitioner to listen to a specialist talking on his speciality, for, whereas the practitioner is reputed to know everything about all the organs, the specialist knowt nothing about only one of them, but he cleverly disguises the fact by the use of composite words and baffling phrases. To-day, however, I shall attempt to translate into ordinary language some of the terms which you may have forgotten since your student days, or with which you are otherwise unfamiliar, and I hope that you will not think that I am trying to be patronizing. I have tried to adapt my case reports to a homœopathic audience and have omitted most visual acuties, tonometric readings, campimetry records, and the like.

I must preface my paper with a few words on Homœopathy in general. There are two methods of prescribing. The first is the classical method by which a patient is almost psycho-analysed and his symptoms carefully repertorized: the result depends largely upon the elucidation of all his symptoms, the consideration of all details, and the relative importance which the physician attaches to each factor. The second method is the empirical. In this, a drug picture is considered to fit a case because of the similarity of some outstanding features common to both the disease and the remedy, and shooting almost in the dark, the prescriber hopes to score a therapeutic bull's-eye. In theory this procedure is to be condemned, but in practice it works. This is the method by which *Arnica* is prescribed for trauma, heedless as to whether the hurt person is better for heat or for cold, by which *Gelsemium* is prescribed for influenza, *Belladonna* for scarlatina, *Drosera* for pertussis, and so on, and by which the vast majority of homœopaths carry on their practices. It is almost the only method which is used so successfully in pædiatrics, mental diseases, and veterinary medicine. The remedies may be grouped into the hæmorrhagic ones like *Lachesis*, *Crotalus*

horridus and *Phosphorus* ; the circulatory, like *Ergot*, *Arsenic* and *Cactue*, and so forth, a classification which I consider to be of the greatest importance, particularly in those morbid changes which have perhaps signs but no symptoms until they become well established. This is particularly the case in my own work.

Changes in the lens can be seen long before there is a decrease in visual acuity, and the exhibition of the relevant "cataract remedy" might possibly forestall the incapacitating effects which are likely to follow ; changes in the vascular picture might be seen long before a patient complains of headaches, breathlessness, black-outs, or even has a stroke, and the diseases which are heralded by fundus changes are legion. My interest for the last two years has been in the corneal epithelium and in changes which can be seen in the plexus of vessels which lies in the limbus of the eye, that one-millimetre-deep zone in which the cornea merges into the sclera. This has been the subject of an essay, and I believe that further study will show that here lies an area where the earliest signs of some diseases may be seen by anybody trained to use a microscope and interpret the things which he sees.

The plan which I intend to follow this afternoon is an anatomical one taking the various parts of the eye from before backward.

The Skin

The ophthalmic surgeon is seldom, or never, interested in skin diseases until they have spread to the eyelids or begun to affect the eyes themselves, I have never considered the treatment of skin diseases to be one of the brightest spots in the allopathic treatæent, and I have never understood why no homœopath ever produced an illustrated book demonstrating the effects of unorthodox treatment.

In empirical Homœopathy, *Apis*, *Arsenic*, *Graphites*, *Hepar sulphuris*, *Rhus toxicodendron* and *Sulphur* spring to my mind.

One patient (Mrs. H., age 46, 47192) was sent to me when a generalized eczema spread to her eyes. The skin was dry and scaly over most of the body and she had had forty boils during the past twelve months. The conjunctivæ were grossly

injected and new vessels were growing into the cornea. The condition of the eyes, the symptoms of which she complained, and the modalities, suggested *Apis*, and three powders of 30c produced a great improvement, reduced the itching, and enabled her to sleep. Two new boils in the axilla responded to three powders of *Hepar sulph.* 30c, but she was not cured. A full history indicated *Sulphur* and she felt very much better on that remedy, but it was not until I gave six powders of *Graphites* 30c that I considered her perfectly well.

Unfortunately, two months later, a new patch of eczema appeared, and nothing that I could give relieved her. By this time she had begun to regard me as a repository for all her ills, and I had to remind her that I was neither a dermatologist nor a general practitioner and eventually I lost contact with her.

Perhaps I should explain here that I regard my Homœopathy as purely experimental, and therefore would not be able to treat a case with homœopathic remedies professionally, and also that I have the greatest difficulty in side-stepping the many issues that are brought to my surgery that are not purely ophthalmological.

From the homœopathic aspect, it is interesting to see how a remedy will often produce side effects which are unexpected. Such a case was Mr. B., age 29 (47736), who came for an ophthalmic consultation and gave a long account of headaches, head noises and neuralgia. *Sulphur* appeared to cover most of his headaches, and three powders of 30c produced one of those dramatic results common in homœopathic literature, relieving, as well as the headaches, an occupational eczema which had caused him much inconvenience. I did not realize at the time that I had treated a highly neurotic patient, and eighteen lengthy consultations followed until the sending of a bill in medium potency produced the desired effect.

Two more cases are of interest from the dermatological aspect. Mrs. W., age 40 (47611b) was one member of a family which I keep under observation for genetic abnormalities in eyes and brain. Among her many complaints was a pruritus ani which flared and regressed in tempo with a general

inflammation of the eyes and adnexa. Over a long period she received *Apis*, *Sulphur* and *Calcium carbonate*, with varying results, *Benadryl*, because increased sensitivity was suspected, and pituitrin injections and atropine which successfully aborted a corneal herpes. Her general practitioner put her in and out of hospital for varied complaints over a number of months, and whether she was cured or just tired of treatment I do not know for she passed from the ophthalmic sphere.

The other was a Mrs. P., age 40 (47522), who had a pruritus ani which had been treated three times by X-ray and complete cure claimed by the radiologist. She stated that the treatment had made her so ill and the complaint so much worse that she dared not go back, a lesson to those of us who claim cure without an adequate follow up system. I had no hesitation in diagnosing trachoma and was not surprised to learn, when I gave my opinion, that she had lived most of her life in China and had collected quite a number of specialist opinions both for and against such a diagnosis. I gave *Aurum metallicum* 30c (three powders), experimentally and empirically for the trachoma, and the condition improved. Later, 10m produced a violent exacerbation. Recent reports from China give thanks for a complete relief of the pruritus and I only wish that I could examine the cornea with my microscope.

Next I should like to report two cases of twitching of the eyelids.

Each of these patients was a sufferer from essential hypertension. One Mrs. le P., age 46 (47392), has a blood pressure which varies around 260/130. Life was made much more bearable *Pulsatilla* 1m and 10m, three powders of each, and she lost most of her remaining symptoms on *Glonoine* 30c. A constant twitching, mainly confined to the left lower lid, was however, a severe disability and even disturbed her at night. *Nux vomica* 200c, *Agaricus* 1m, *Spigelia* 30c, *Agoricus* again in 30c, 200c, 1m, repeated, and *Opium* 30c, failed to prevent the condition getting worse.

A similar case, Mrs. F., age 51 (47112), unfortunately died before I had tried more than one remedy.

In this section is a man, age 68, Mr. Mck. (47431), who

had had radium treatment for a squamous-celled carcinoma; he developed a fundus lesion which is an all too common complication; *Crotalus* 200c has had no effect and I hope to try *Radium* homœopathically at a later date.

A case of herpes zoster of the supra-orbital branch of the fifth nerve is of interest. Mrs. A. age 71 (47812) had had the typical skin condition extending over most of the right side of the forehead for five weeks and the eye had become involved with a conjunctival reaction and an insensitive cornea. *Rhus tox.* 1m, *Variolum* 200 c, and *Carbo oxide* 6x and 30c, failed to alter the condition, but *Hypericum* produced a rapid improvement and a return of corneal sensitivity. I am anxious to try this remedy in subsequent cases.

The Lids

The lids, with their hair follicles and their sweat and oil glands, are subject to many troubles, of which styes or abscesses in the hair follicles are among the most common. I have found that *Hepar sulph.* (six powders 30c taken t.d.s. or one a night) relieves most conditions of furunculosis, and styes seem to respond quite successfully. I would like to tell you of one woman who had had 15 boils lanced during a period of nine months. I sent her three powder of *Hepar sulph.* by her husband who had told me the story, and heard later that the two newest boils had repressed and that no more developed. This was certainly empirical Homœopathy.

Squamous blepharitis is a condition in which, due to a lowered resistance in the host, the normal skin bacteria invade the hair follicles and result in those red-rimmed eyes with missing lashes which we see so frequently. It is probably the only condition which responds to the continued use of penicillin.

Homœopathy will however, at times relieve the condition. Miss C., age 24 (47722) had had a had blepharitis for a long time. She developed a very severe reaction to penicillin when the calcium salt was given in error, but *Apis* 30c three powders, relieved this temporarily and three powders of *Sulphur* 200c cured it and the lid condition completely.

Two more cases in which I used *Hepar sulphuris* are interesting. Mrs. R., age 68 (47748) developed an abscess on the left lower lid which I incised and drained. Three weeks later she developed one on the other side which *Hepar sulph.* 30c, three powders, quickly relieved. The other, Mr. T., age 30 (47635), developed a similar picture after having been jabbed with a piece of stick. I removed a splinter of wood, cleaned up the wound, applied penicillin; I gave *Hepar sulph.* when the incision continued to discharge, but three weeks later I removed another chip of wood over an inch long, impossible though it seems, but obviously the cause of the delayed resolution.

While in the region of the lids one must consider the lacrimal apparatus, and what a problem on occasions this presents! I shall describe three cases.

Mrs. C., age 67 (47785) was a woman who was dying of hypertension. She had the worst dacryoadenitis that I have seen: the left side of the face was level from the bridge of the nose to the external canthus and was one large, hot, inflamed mass. Operation was out of the question and I prescribed guttae penicillin 1,000 O.U. over the lids (for the eye could not be seen), penicillin injections, and *Hepar sulph.* 30c, t.d.s. I was so much surprised as her general practitioner to see it subside daily, and a week later there was hardly any evidence. She died in twelve months without any return of the inflammation.

A second case has been seen more recently. She has a mucocele of the sac as large as a half walnut-shell, which her doctor has probed heroically each week for eighteen months. One never likes these cases of "failed treatment", and although she has only had six powders of *Hepar sulph.* 30c, there is already a vast improvement.

My next patient is in another category, Miss T., age 32 (47079). Ten years ago she had an operation on her nose, and during the German occupation the left lacrimal sac was removed by a general surgeon. Unfortunately the site became reinfected and a sinus continued to discharge.

I operated eighteen months ago and removed a large thick fibrotic sac and cleaned up the nose thoroughly. The incision

never healed, and a second discharging sinus has remained. *Hepar sulph.* 200c, six powders, at weekly intervals had no effect, and the injection of 100,000 units of pure penicillin into the sac followed by six intra-muscular injections has also been useless. I have tried *Silica* 200c (six powders) without effect and am now giving her *Puls.* 30c, which I learn to-day is also useless.

Perhaps time will prove that Homœopathy is a valuable addition to our armamentarium inflammation of the sac.

The Conjunctiva

I am very sceptical about the role of Homœopathy in the treatment of inflammations of the conjunctiva and shall refrain from giving my results until later.

With a nice warm incubating chamber like the conjunctival sac, easily accessible to the bacteriologist, the microscopist, and the photographer, the homœopaths could have written a whole volume on the efficacy of their remedies both locally and by mouth. As usual, a wonderful opportunity has been lost, and penicillin has practically put an end to any ambitions in that sphere now.

(To be Continued)

DISEASES OF CHILDREN

DR. ABHOY PADA CHATTERJEE

(Continued from page 224)

If uncomplicated with other symptoms, external hydrocephalus is not a dangerous disease, except the periosteal variety which is generally accompanied by symptoms of constitutional irritation, and may terminate in caries of the bones of the skull.

For the treatment, the principal remedies are: *Arnica*, *Rhus tox*, *Helleborus*, *Belladonna* these remedies will however, not do for the periosteal variety. Here the hardness of the swelling disposes us, before thinking of a watery exudation, to diagnose an osseous tumor, an exostosis, and this leads us to suspect a syphilitic, mercurial, herpetic or some other

be more or less lost for a few hours only or the child may drag along for a number of days in a semi or completely comatose state. Fever is usually present. The hemiplegia, noticed few times the child recovers consciousness, is generally complete. and times the paralysis is not complete at first but occurs and subsequent convulsions. The right side is frequently Protruded than the left, the face is commonly not involved. In these subjects no apparent cause is known for the they are ascribed to indigestion, worms, or to a L They may also be ascribed to fright, and perha are similar cause.

Sa honia is a not uncommon symptom, and occurs in of the ses.

mental Defects—One of the most serious consequences of render hemiplegia is the failure of mental development. A hands at the number of these cases drift into the institutions of teeth to minded children. Three grades may be distinguished passes only Sa y, which is most common when the hemiplegia prescribed Sa y, which is most common when the hemiplegia two grains from birth, imbecility, which often increases with when opment of epilepsy; and feeble mindedness, a retard rather than an arrested development (Dr. Osler).

Treatment—The treatment of infantile paralysis should be in great measure prophylactic. In many instances these conditions depend upon injury at the time of birth, especially occurring in forceps deliveries and from long continued head compression. Protracted labour sometimes cause of greater degree and longer period of compression than does the application of forceps, when the latter are applied the child is usually delivered quite promptly, whereas in protracted labor the head may remain impacted in the pelvic outlet for hours at a time; each succeeding vigorous pain driving the head down harder than before and causing that much more compression. In such cases the prophylaxis will depend upon the application of the forceps and prompt delivery of the infant. If convulsions are present after birth Cicuta, Zincum, Belladonna, Gels. and Stramonium may be demanded. As basic remedies Sulphur, Calcarea, Kali carb, Psorinum and Lachesis will be found serviceable, Causticum is another excellent

remedy for hemiplegia paralysis, Arnica, Hypericum and Ledum are useful if forceps delivery or long impaction of the head is causative. (Dr. Fisher). Opium is an excellent remedy in the coma that follows upon convulsion associated with paralysis.

Recently I had a case of Hemiplegia which was dega^s also by imminent Doctor of the city both Allopaths and Homoe^{le} path cured by with Santonine and other remedies Master Bibhu 2 years 8 months old. Son of Sree Bejoy Chatterjee of 84 S. N. Banerjee Road, Calcutta. In 1969 on 16th December the boy was attacked with fever with loose stool, convulsion 6 p.m. to 6 a.m. took various injection etc. In the morning left leg become paralysed stool and urine stopped, Doctor advised to admit the boy to the hospital. They diagnose^{actival} encephalitic hemiplegia, Jerking of hands stopped, fist, and they discharged the patient after night, advised ma^{en a whole} leg with olive oil. ally and by

Gradually the boy had teething, can talk but as been lost, or walk. In 1970 in the month of July all on a^y ambitions in after a cold & cough, with twitching of left side upp^{. (continued)} became paralysed (whole left side with stoppage of urine) stool but no fever. Again admitted at P. G. Hospital treated for Tubercular Meningitis about a year. No improvement, then homoeopaths of the City lastly by Dr. B. K. Basu M.D. He prescribed lastly Tarentula Hispania for the numbness of leg, trembling, twitching and violent jerking etc., which was much aggravated. As Dr. Bose refuses to treat the case his father came to me on 2nd January, 1972 at 9 P.M. at night. I took the whole history of the case, with facely history. Mother susceptible to cough & cold, grand mother and Aunt (Pateral) had Hysteria Father was also very nervous, Maternal uncle had Epileptic fits. I prescribed Hyoscyamus 30 in number 10 globule two globules in one ounce of distilled water, put two marks 1st mark to be taken 1st day night and rest mark add equal quality of Aquad to make again two makes & shake 10 times before use in this way twice daily. On 7th January, reported me that twitching and jerking much less, slept well at night passed stool and urine

free leg. Advised to continue the medicine another week, on 16th January father reported to me that the boy was trying to bite every thing with much grinding of teeth, restless sleep, twitching, of arms & legs with frequent urging for urine a few drops each time. Convulsive movement of the hands and arms with jerking I think of Cina or Belladonna but I tried to reportarize the case. I consulted Dr. Clerk's clinical Repartory to the Dictionary of Materia Medica I found—Hemiplegia left only two remedy. Physostigma and Santonine, Hemiplegias Right Irridium and Irisflorentina (page 75). At once instead of thinking Cina and Lachesis etc., I consulted New Remedies of F. S. Whiteman M.D. and found Santonine produce a Sort of paralysis accompanied by rigidity of the muscles It entirely destroys the irritability of muscles rendering them completely rigid, convulsive movement of the hands and arms. Jerking with great restlessness, grinding of teeth together sleep disturb. Always wants to pass urine passes only few drops at a time. Bowels constipated etc. I prescribed Santonine for the destruction of Lumbrici 3x trit. two grains trituration in a spoonful of sweetened milk, a time when the stomach is empty as before feeding twice daily for three days. To much susprise I found jerking of legs and arms stopped after expulsion of earth worm about 8 to 10 inches long. In the latter parts of January gradually all symptoms gone the boy could stand, try to walk on support. Both knees knock together, toes do not leave the floor, heels do not touch floor. Treatment urine not by drops but with floor, stool constipated I prescribed on 28th January, Lathyrus 200/10/2 ʒi oz of Distilled water put 2 macks/st mack/sp day then again add equal quality of aquis. distates after a week gave one dose. In this way whole month of February. In the month of March to the improvement can stand himself can walked by support. Still under the treatment. Better mentally and Physically.

Continued

HICCOUGH (Singultus)

DR. N. C. DAS

(Continued from page 222).

- H. after cold fruit : puls.
- H. after drinking : puls.
- H. after meals and during smoking : sep.
- Frequent h. with nausea : staph.
- H. while smoking staph.
- H. often severe after eating : staph.
- H. after hot drinks : verat-a., stram.
- H. in the morning while smoking : verat-a.
- H. in children : ign., stramo.
- H. after cold drinks : ars-a., nux-v., puls.
- H. after hot drinks : stramo., verat-a.
- H. after cold fruit : ars-a., puls.
- H. after warm food : ing.
- H. after tobacco : ign., sep., staph., nux-v., verat-a.
- H. worse motion : bry., hyos.
- H. inclined to get angry ; peevish : agnus-c.
- H. after smoking tobacco : ant-c.
- Violent h. : ant-t.
- H. in meningitis : arnica.
- H. : berb-v.
- H. after eating ; also of infants : borax.
- H. before and after dinner : bov.
- H. and nausea : brominum.
- H. and eructations : coffea.
- Aftar eating sleepiness ; h. violent h. cycl.
- Frequent h. : dros.
- H. after either one or all meals : graph.
- H. after eating and drinking ; from smoking : ign.
- H. with nausea : ipec.
- H. after eating, with soreness in pit of stomach : kobaltum.
- H. in bed : lachnantes t.
- H. : lauro.
- H. with retching day and night : mag-ph.

Spasmodic, nervous h. : mosh. (hydr. ac., sul-ac., ign., cajup.).

Obstinate h. : zinc-val.

Violent h. : ratanhia, nux-v.

Obstinate h. : viburnum pru.

H. after dinner : borax.

Constant h. : colch.

H. from smoking : ign., sang-c.

H. frequently ; periodically : lyco.

H. after eating : paris quad.

H. while smoking tobacco : sang-c.

H. especially after breakfast : zinc-met.

Violent spasmodic h. : stram.

Eructions alternating with h. agar-m.

H. in the afternoon : agar-m.

Frequent h. : agar-m.

H. after dinner : alumina.

H. very frequent ; at times with stitches in left side of chest : am-m.

H. : anacardium.

H. : h. frequently ; while smoking : ant-cr.

Frequent h. after eating, every time followed by eruptions : ars-a.

Frequent h and eruptions : ars-a.

Convulsive h. : ars-a.

H. at night, when rising, with scratching, nauseous taste in mouth : ars a.

Long-continued h. in the hour when the fever should have come : ars-a.

Violent h. in the forenoon and after dinner h. : bar-c.

H. after eating : borax.

Severe h. so that the throat is madic rough from it : borax.

The suckling has h. very frequently : borax.

Eructions with h. : calc-c.

H. the whole day, till evening : calc-c.

Frequent h. : calc-c.

Violent h. for a quarter of an hour : calc-c.

Hiccoping eruptions at dinner : carb-an.

H. especially after every movement : carb-v.

Great tendency to h. at the slightest occasion : carb-v.

H. : caust., con.

Frequent h. : coloc., cup. met.

H. : repeated h. : dig.

H. which does not rise quite up into the throat, six or seven times : dig.

Eruclations combined with h. : dulc.

Frequent h. : Euphorbinum.

H. in the morning after rising and after dinner : graph.

H. after a meal with dullness in the head or drowsiness : graph.

H. after every meal, whether hot or cold : graph.

H. in the evening for an hour : graph.

H. after eating : hep. s.

H. : iod.

H. continual h. before midnight : kali-c.

H. frequent h. for 3 days in succession : lyc.

H. after evening meal : lyc.

Frequent h. with eruclations afterwards, in the morning after rising : mag-c.

Constant h. in the evening : mag-c.

Abortive h. causing cramp-like pains in the stomach., mag-c.

Violent h. during dinner so that the stomach pained him severe h. after dinner : mag. mur.

Severe h. before and after dinner : mur-ac.

H. every afternoon, after dinner. Viovent often long-continued painful h., mostly in the evening or during dinner, sometimes with bitter regurgitation from stomach : nat-c.

Frequent h. : nat-c.

After eating h. ; h. ; violent h. : nat-m.

H. for several days. : nat. m.

H. ; h. from morning till evening : nitr. ac.

H. frequent, before breakfast : nitrum.

Constant h. ; h. after dinner so severe that the scrobiculus cordis feels pressed and pains as if sore : phos.

Hiccupping eructations, passage of flatus after eating :
platina.

H. in the evening, long-continued H. after dinner : sarsa.

After supper h. : sep.

H. after eating for a quarter of an hour : sep.

Eructations alternating with h. : sep.

H. during smoking of tobacco, water gathers in the
mouth : sep.

H. before and after meals : sil.

H. for 25 minutes between 12 o'clock and twelve thirty : sil.

H. in the evening in bed : sil.

H. soon after eating, during the customary smoke :
stannum.

Repeated h. : stannum.

Occasional h. : stannum.

After a meal h. while walking in the open air : sul.

H. during the customary smoking of tobacco : sul-ac.

Continuous h. : sul-ac.

H, at night : sul-ac.

H. for half an hours : zinc.

H. also very violent in the evening or after break-fast : zinc.

H. in the morning : aco.

In the morning long-continued h. : aco.

H. after eating and drinking : aco.

H. during (accustomed) tobacco smoking : argentum folium.

After eating a kind of suppressed incomplete h. : arnica.

Frequent h. and eructations. After eating frequent h.,
each time followed by eructation frequent h. convulsive h. :
ars. a.

H. : asarum.

Hiccupy eructation ; a spasm compounded of eructation
and h. : bell.

Frequent h. severe h. for a quarter of an hour : calc-acet.

Loud h. : cic.

H. ; inclination to h. : coccul.

Frequent h. : coloc., dros.

H. after a meal : cycl.

Eructations combined with h. : dulc.

Frequent h. most violent h. with costiveness. All night extremely violent h. with diarrhœa. After dinner extremely violent long-continued h. : hyos.

H. after eating and drinking ; h. in the evening, after drinking : ign.

Frequent h. : menyantnes.

After eating violent h. : merc.

Frequent h. especially in the forenoon : merc.

Frequent h. without cause : nux-v.

H. before dinner : nux-v.

H. continued with short interruptions : op.

H. when smoking tobacco : puls.

H. at night in sleep : puls.

After drinking tendency to h. : puls.

H. ; repeated h. : spongia.

Frequent h : stramo.

H. occasionally : stramo.

Soon after a meal (whilst smoking the accustomes tobacco) : stramo.

Frequent h. : staphisagria.

Violent h. : stramo.

H. for half an hour : verat-a.

Long-continued h. : verat-a.

H. in the morning when smoking tobacco to which he is accustomed : verat-a.

H. ; frequent h. : verbuscum.

H. after vomiting : verat-a. (bry).

H. while vomiting : cup-m., merc-c.

H. during sleep : merc-c., (cina). puls.

H. on thinking about it : ox-ac.

H. in typhoid : phos.

H. during pregnancy : cycl., op.

H. during cough : tab.

H. after cough : tab.

H. in drunkards : ran-b.

H. with peritonitis : hyos., lyc.

H. continuous, in into ssuction : plb.

H. with rumbling in abdomen : hyos.

- H. in concussion of brain : hyos.
- H. in children : bor., ign., ipec., hyos., kreos., mar-v., stram.
- H. infants : aco., bell., cic., hyos., ign., ipec., nux-v., puls., stram., teucrium (after nursing).
- H. with frequent sighing : ign.
- H. with twitching and jerking of limbs : hyos.
- H. momentary relief from cold water : aco.
- Painful h. and belching : aco.
- H. with flushed face and red eyes : bell.
- H. caused by hawking : calc-fl.
- H. in hydrocephaloid : cina.
- H. during sleep : puls.
- H. with liver affections : china : bell.
- H. in biliary colic : china.
- H. in meningitis : arn.
- H. after emotion : ign. (agn-c., ruta).
- H. in phthisis : lyc.
- H. in stomach cancer : carb-an.
- H. in gastralgia : sil.
- H. especially in winter : nitr. ac.
- Eruclations alternating with h, agar., bell., bry., sep.
- H. incomplete : arn.
- H. after the fever : ars. a., lach.
- H. with meteorism : mag-ph.
- H. periodical : ars. a.
- H. with oppressed respiration : puls.
- H. better by eructation : ham., zinc.
- H. better after eructation : carb-a.
- H. better by coffee : hyd-ac.
- H. after vaccination : thuj.
- H. in cholera ; hyos., ign., kreos. (carb-v., cic., jabor., nux-v., tabac).
- H. in cholera infantum, when carried : kreos.
- H. after cold drinks : ars. a., puls.
- H. after hot drinks : stramo., verat-a.
- H. after operation on abdomen : hyos.
- H. during fever : carb-v., lach., nux-mos., (ars. a., hyos., ign., sec-c., stram., ver-ac., zinc.).

H. after smoking : ign., selen.

H. with belching cajup., dios., nux-v., (ant-c., cic., china, wyeth).

H. with retching, vomiting : nux-v., (jatro., mag-p., merc.).

H. with yawning : cocc. (amyl., caris).

H. followed by spasm : cupr.

H. with hysterical, nervous symptoms : ign., mosch., (gels., nux-mos., zinc-v.)

Yawning during and after h. : amy-n., mag-c.

H. with spasms : bell., cup-m.

H. better by coffee : hyd-ac.

H. better by eructations : ham., zin.

H. better after eructations : carb-an.

SOLANACEÆ

By OTTO LEESER, M. D., Phil.D. (Berlin)

When we make a study of the medicinal plants of a family such as the Solanaceæ there is no need to linger over their botanical classification. We can rely for this on botanists. There is no doubt that they have correctly determined the main relationships of the family from the morphology and histology of the species. But these gross structural characteristics cannot be correlated to the medicinal actions of the plants. Pætic observations on the exterior of the plants as clues to their medicinal actions in the fashion of the signatura return may seem very attractive to many, but they have no place in the homœopathic materia medica. The relevant structures are on the molecular level. To understand the actions from structural characteristics of the plants, one must take account of those special chemical products of their metabolism which, being alien, can interfere with the functions of the human organism. In the Solanaceæ these substances are chiefly alkaloids, i.e. basic products of the amino acid metabolism characteristic of this family of plants. And it is the structure of these alkaloids which leads to a natural grouping of the species we use in medicine.

The most important group is characterised by atropine (or rather hyoscyamine). We shall discuss only *Atropa belladonna*, *Hyoscyamus niger*, *Datura stramonium* and *Mandragora officinalis* from among its members; *Duboisia* and *Scopolia* need not concern us here. The second group, characterized by nicotine is only represented by *Nicotiana tabacum*; the third, that of the solanine plants, by *Solanum Dulcamara* and *Capsicum annum*. In the latter, however, other non-alkaloid constituents must also be considered to play a part in its actions.

Atropine and Belladonna

Let us begin with the biggest and most important group, the atropine plants. You know everything or at least a great deal about atropine from pharmacology. But perhaps it would be a good idea to recall some of it and establish the context. Atropine is the racemic mixture of lævohyoscyamine and dextro-hyoscyamine. The plants contain only, or almost only, lævohyoscyamine; the racemic compound is formed on chemical extraction of the alkaloids. As with nearly all the alkaloids, the lævorotatory form is the more active. We are only concerned with lævohyoscyamine. But experimental investigations in pharmacology and the palliative applications based on them have throughout been made with the less active atropine.

In experimental pharmacology, the inhibiting or paralysing action on the parasympathetic nerve endings in muscles and glands has been put forward as the main effect of atropine. But that is only part of the potential action, just as, and indeed because, the neuromuscular and neuroglandular preparations on which this effect is demonstrated form only part of the living organism. Nevertheless, we may take this as a starting point and see what they have got to say with regard to therapy. First of all we have the well-founded theory that atropine is able to inhibit the action of acetylcholine, the transmitter of para-sympathetic impulses. It may not yet be

generally acknowledged, but it is a good working hypothesis that atropine may temporarily take the place of acetylcholine at the nerve endplates; perhaps because it is structurally similar, so that as a structural analogue it would stop the functioning of the physiological neurohormone. If one looks at the structural formulæ of atropine and acetylcholine side by side, a similarity is not easily recognisable. Both are esters. The tropic acid radicle of atropine can be taken as a substituted acetic acid, The tropine radicle, however, is a tertiary compound (derived from NH_3), whilst choline, a quaternary, derives from NH_4OH . Tropine could, however, combine with halides in the organism to form a quaternary salt. And it has indeed been maintained that is responsible for the action. When the large atropine molecule replaces acetylcholine the physiological regulation of the transmission of impulses fails because the enzyme cholinesterase is then ineffective. But it is also possible that the tropic acid, being a hydroxy-acid which acetylates easily, takes the acetic acid from acetylcholine and thus renders it ineffective. The parasympathetic blockage persists until the atropine is eliminated from the system. If atropine is used for its inhibiting effect, no more than a temporary suppression of symptoms can be expected.

Continued



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