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LECTURES

ON

CLINICAL MEDICINE,

DELIVERED IN THE

HOSPITAL SAINT-JACQUES, OF PARIS.

By M. Le Dr. P. JOUSSET,

Physician to the Hospital Saint-Jacques, of Paris; Professor of Pathology and Clinical Medicine; formerly an Interne Laureate of the Hospitals of Paris; Editor of *L'Art Médical;* late President of the Homœopathic Medical Society of France; Author of "The Elements of Practical Medicine"; Honorary Member of the American Institute of Homœopathy, etc.

TRANSLATED, WITH COPIOUS NOTES AND ADDITIONS,

By R. LUDLAM, M.D.,

Professor of the Medical and Surgical Diseases of Women and of Clinical Midwifery in the Hahnemann Medical College and Hospital, of Chicago; Author of "Clinical Lectures on the Diseases of Women," and "Clinical Lectures on Diphtheria"; Member of the State Board of Health of Illinois, etc. etc.

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AUTHOR'S PREFACE.

By permission of the authorities of the Hospital Saint-Jacques these Clinical Lectures are now offered to the medical public. The notes and cases that form the basis of the volume have been taken by the students, and the only warrant for their publication is the good work that has been done in the wards of the hospital.*

During the three years in which these Lectures have been given we have encountered some cases of almost all the diseases on the list; but, among acute disorders, we have principally treated *pneumonia*, *bronchitis*, *pleurisy*, *typhoid* and the *eruptive fevers*, *erysipelas*, *diphtheria*, *dysentery*, *acute articular rheumatism*, *hemorrhages*, *asthma*, *affections of the heart*, *the stomach and the liver*, *aortitis*, *phthisis*, *herpes*, *hydrarthrosis*, *sclerosis of the kidney*, *scrofulous keratitis*, *hemorrhoids*, *vaginismus*, *pelvi-peritonitis* and *peri-uterine hematocele;* and chronic affections have likewise furnished their proportion of cases for study and treatment.

The publication of these Lectures will afford physicians an opportunity to judge of the value of the Homœopathic treatment.

The doctrine of Hahnemann, like all other scientific doctrines, has made great advancement, and we can only judge of the value of this progress by the application of its principles at the bedside of the sick. As a faithful disciple of the experimental method, we accept what it has demonstrated to be true, and reject what it has shown to be false. Following this rule, we have taken the Materia Medica that is founded upon a knowledge of the effect of drugs upon the

* This hospital is on the official list of the government hospitals in Paris, and is an authorized center of medical teaching, like the Hôtel-Dieu, La Charité and others.—L.

healthy man, and the law of similars, verified in the clinic; or, in other words, physiological experimentation and professional experience, as the basis of what we may justly call *positive* therapeutics.

We cheerfully acknowledge and insist that Hahnemann was the first to enter on this path, and we very willingly recognize him as our leader, who took the initiative in therapeutics; but, in a science of observation like that of therapeutics, we place experience above all our masters, and are forced to reject whatever he has said that does not conform therewith.

We have been reproached by some very radical members of our school of practice with a want of faith in Homœopathy exclusively, and we do not deny the charge; for, as the title of our journal (*L'Art Médical*) indicates, we believe in *experimental therapeutics.*

We do not make this declaration because we intend to desert the cause of medical reform, or to accept any position in the gift of the Old School. Our entire professional life is a protest against such an interpretation of our position. For forty years we have submitted to unheard-of reproaches rather than abandon what we have believed to be the proper ground of truth in therapeutics; and at the end of so long a career, we shall make no compromise of our opinions that we might have occasion to regret. Our statement of the case is offered, therefore, because, for the good of the sick, for the honor of the profession, and for the interest of physicians, it is very important that this misrepresentation should cease.

The three points of the therapeutical reform that we advocate and defend are an *experimental Materia Medica, indications that are drawn from the law of similars* and the *use of such doses as shall be determined by clinical experience;* and where is the society or the Faculty, or where are the physicians who believe it their right and their duty to reject such a system of treatment?

There are those, also, who accuse us of discarding entirely the employment of attenuated remedies, and the use of indications that are to be drawn from the law of similars, in

order that we may resort to almost any kind of irregular medication; but our practice, which is open to the public, will show the falsity of these accusations. At the same time it will also show how seldom we resort to palliatives, and to empirical means, and in what cases we prefer the stronger preparations to those which are infinitesimal.

Moreover, this volume will serve as an answer to an "explanation" which our adversaries enjoy having given of our success. They say that: "Intelligent Homœopathists reserve their little pills for the trivial cases that would get well of themselves; but that, in grave disorders, they give the same doses that are prescribed by the Allopaths." A very slight examination of our clinic will convince the most skeptical that, as we have already said, with us the size of the dose does not depend upon the mildness or the severity of the disease, but rather upon its complex and complicated character.

Apart from the therapeutical subjects that form the essence of our work, we have discussed and answered certain very important pathological questions. Whenever it has been necessary to make our instruction more clear, we have added such illustrations as would render the text more easy of comprehension, as well as more minute and exact.

We sincerely trust that this volume may aid in spreading the truths of *positive therapeutics*, and also in diminishing those prejudices which are as decidedly opposed to the true interests of the profession as they are to those of our patients.

We believe that it will be useful to physicians who have not yet surmounted all the difficulties of the Homœopathic method, because, by the side of the general precepts that are given, they will find the application to a case in point; and special cases are the doctor's daily bread. It surely is something to know that bryonia, phosphorus, tartar emetic and arsenicum are the chief remedies in pneumonia; but it is much more important to know the peculiar remedial characteristics that would lead us to prescribe one of them in preference to the others. But we cannot have a complete knowledge of the special therapeutics of pneumonia without having the history of a certain number of cases to aid us

in the choice of our remedies, and clinically to demonstrate the value of our therapeutical indications. This is the real object of these Lectures; and it is this peculiar feature of the work that distinguishes it from a treatise on general pathology.

P. JOUSSET.

TRANSLATOR'S PREFACE.

The science and the art of Medicine represent the two sides of a piece of coin which cannot be separated without violence. Clinical experience is the gold, the silver, the copper, (or the brass) that has been stamped in the medical mint, and that is kept in store and in circulation by physicians the world over. The stamp may vary with the caprice or the credit of the government that issues the coin; but the exchange value of the metal that carries the mark will be the same everywhere and at all times.

In preparing and publishing these lectures, the author's object seems to have been to harmonize and to unify the science and the art of medicine, to balance them properly, and not to extol either at the expense of the other. How far he has succeeded the English reader will now be left to judge.

The reasons that might be assigned for the re-issue of this volume are that, having read it carefully, and having known its author personally as a man of rare attainments, of high personal character and veracity, and of a large and extended experience under the most favorable circumstances, the translator was led to believe that he could not confer a greater favor upon his American and English friends than to bring it out in its present form.

He begs, however, to say that the translation — which has been made with Dr. Jousset's sanction and approval — is a liberal and not a literal one, great pains having been taken not to misinterpret the text on questions that are still at issue among us.

The notes and additions are designed to increase the interest and value of the work without adding greatly to its size. The clinics on *puerperal pelvi-peritonitis*, and *puerperal pneumonia*

especially, it is hoped, will be acceptable to the general practitioner.

The translator hereby returns his thanks to Drs. Small, Comstock, Vilas, Hawkes, Fellows, Jessen, Pennoyer and others for their kind and valuable contributions; to his friend and former pupil, Dr. W. A. Barker, for his careful supervision of the proofs as the volume passed through the press; and also to his publishers, for the taste and perfection with which they have issued the work.

The index is very complete; and a table of French and English weights and measures is added for ready reference.

R. LUDLAM.

526 Wabash Ave., Chicago, Sept. 1879.

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THE MEDICAL CLINIC

OF THE

HOSPITAL SAINT-JACQUES, OF PARIS.

LECTURE I.

SUMMARY.—The Clinic. Homœopathy, and its place in therapeutics: note. The legitimate rôle of empiricism and of palliative medication: note.

The Clinic.

GENTLEMEN: In opening these Clinical Lectures, I feel it my duty to answer a question which is perhaps in your thoughts, and which certainly has addressed itself to me. Have you come hither from mere curiosity, or from a desire to learn and to practice a branch of the Healing Art?

I trust it is the latter motive that has prompted you; for, in the future, it alone will encourage you to persevere, and to make the time which you consecrate to the study of Homœopathy alike profitable to yourselves and to your patients.

You all know that the *Clinic* consists in the application, at the bed-side of the patient, of the medical knowledge that you have acquired from books and from the lectures of your teachers. It ought not, therefore, to be, as Trousseau understood it, a mere lesson in nosography; nor, as other professors have made it, simply a course upon therapeutics. For us, the Clinic has a well-defined purpose or object; and that object is, firstly, the application of semiotics and of therapeutics at

the bed-side of the sick; and secondly, to demonstrate the superiority of homœopathic remedies in the cure of those patients whom you will have occasion to see in our wards.

Homœopathy, and its Place in Therapeutics.

But, gentlemen, there is an important question which it is necessary to answer before beginning our course of instruction, and that question is, *What is Homœopathy?* And what place should it occupy in Medicine?

Without having read the ancient authors very profoundly, you perhaps know that, until the seventeenth century, the therapeutic ideas of Galen were almost sovereign in our art; and that its roots were so deeply implanted in the ground-work of medicine, that even now, after three hundred years of strife, we still find the deep and indelible traces of its influence. And there is nothing in this that should astonish us. Its strength was in the very simplicity upon which his hypothesis rested. Admitting that there are four humors in the animal economy, and that their alteration or their combination was the cause of all diseases, we have two indications, *id est*, for antidotes and evacuants. Surgical diseases and cases of poisoning gave palpable proof of the validity of this doctrine. A dislocation occurs: place the articular surfaces in apposition, and you have a cure. In a case of poisoning, evacuate or neutralize the poison, and the patient is saved. The substance of this doctrine is found in the well known axiom, "*Sublatâ causâ tollitur effectus* and *contraria contrariis curantur.*" No one can deny the truth of these principles when they are applied to diseases arising from external causes, such as cases of poisoning, parasitical affections, etc.; but when, as the disciples of Galen did, we attempt to apply the same principle to diseases that are due to internal causes, we are wrong. It is not necessary for me to tell you that an internal and an unknown cause are synony-

mous; you do not, I am sure, confound the conditions which may favor the development of a disease with the cause of the disease itself. For what is contingent and what is essential cannot be identical. Cold is not the cause of rheumatism, of pneumonia, or of quinsy; but it is the accident which favors the development of these diseases. The cause is in our own bodies, which are more or less likely to contract this or that disease. The proof is that the same external influences will produce a variety of diseases, according to the susceptibility of the persons upon whom they act.

If I have digressed, it is to more firmly establish the fact that the internal cause of disease is unknown; and that, if it is unknown, we cannot reasonably expect to find its opposite. Before giving an antidote, you must know the poison. And so humorists, solidists, animists, and all those who have sought for the internal cause of disease, have strayed away from the truth, and have thrown aside the one useful thing, which is the mode of action of the remedies employed, that they might treat a pathological hypothesis by a pharmaceutical one.

I certainly do not pretend to say that Hahnemann was the first physician to rise above this order of things. For there were those before him who foreshadowed the truth, among whom I may cite you the names of Paracelsus, Von Helmont, Stahl, Storck, and John Hunter, all of whom declared forcibly against the errors of Galen, and each of whom felt the necessity of reform.* But no one of these great

*The name of the celebrated Haller should also have been included in this list. In his *Essays on Medicine*, page 163, our good friend Dr. William Sharp, of Rugby, England, makes the following forcible quotation from Haller: "In the first place, *the remedy is to be tried on the healthy body*, without any foreign substance mixed with it; a very small dose is to be taken, and attention is to be directed to every effect produced by it: for example, on the pulse, the temperature, the respiration, the secretions. Having obtained these obvious phenomena *in health*, you may then pass on to experiment on the body *in a state of disease*."—L.

masters developed that reform as Hahnemann did. He not only felt the necessity, but he formulated his doctrine and saw it definitely applied. The principle which serves as the basis of Hahnemann's doctrine may be found in this, that if you wish to obtain a prompt, certain and lasting cure, you must choose a medicine which, given to a perfectly healthy person, will produce symptoms that are analogous to those of the disease which you are treating. Hahnemann discovered this law in 1790, while he was translating Cullen's Materia Medica on the use of Peruvian bark in fevers.

Do not imagine, gentlemen, that Hahnemann was satisfied with this first great fact. Those of you who have any doubts on this subject have only to read the admirable chapter in the Organon entitled "*Unintentional Homœopathic Cures*," in order to be convinced on this point. There you will see how the reformer labored to demonstrate his new method. But it was not enough to prove the truth by evidence that could be drawn from the past; it was necessary to establish the new doctrine on a firm and immovable basis. It was with this object in view that Hahnemann relinquished his medical practice, and that he spent ten years of his life, in experimenting upon himself and upon those about him, in order to learn the action and effect of remedies; and it is as a result of this voluntary seclusion that we have the complete and detailed account that he has given us of one hundred medicines. In regard to these provings there can be no doubt of their genuineness, for they were all made with ordinary doses of the drugs used.

This first service rendered by Hahnemann to science has been accepted by the profession, and to-day there is not a therapeutist, or a so-called therapeutist, who dares to publish a materia medica without giving at the same time the results of experiments both upon the healthy man and upon animals. But the law of similars, although it may be found in Hip-

pocrates and Von Helmont, was less universally accepted; or at the best, it was stolen and adapted for the benefit of the specific school, and afterward decorated by Trousseau with the title of the "Substitutive Method."

If homœopathy had rested on these two principles alone it is very probable that it never would have stirred up the wrath of the doctors; but, unfortunately for the peace of the fraternity, the law of similars implied the giving of medicines in small doses. In fact, if the ordinary doses were administered according to the doctrine of similars they would almost always prove dangerous to the patient. In trying to imitate us the advocates of specific medication have shown the serious results that may come from giving large doses of strychnia in chorea, for example. Who would dare to prescribe opium or tartar emetic in ordinary doses,—the first for cerebral congestion or the second for vomiting? The benefits to be obtained from these medicines would be purchased at the price of aggravations that are often dangerous. It was for this reason that Hahnemann himself gave small doses at first, and then, seeing as a consequence satisfactory results, he reduced them until they became almost infinitesimal.

Well, gentlemen, that this part of his doctrine has created more or less opposition, that it has shocked the intelligence, and that it appears to be more or less hypothetical, does not concern us. The question of infinitesimal doses knows but one jurisdiction, and is to be settled in only one way; for clinical experience alone should and must finally decide upon their value or their worthlessness.

I come now to consider the errors that were shut in with the homœopathic doctrine, as it was understood by its founder; and who need be astonished that some errors were included in it?—for where in this world will we find perfection? Moreover, is it not through or because of their errors that great men are allied to humanity? Hahnemann's shortcomings ex-

plain themselves. From the first he had been repulsed, he had lived alone, a target for the persecutions of those to whom he was conscious of being superior; and then, after all sorts of misfortunes, came success, and with success, flattery and adulation and all the intoxication of triumph. Surrounded by disciples, whose heads were turned with what he had done,—the acknowledged master and leader,—he imagined himself to be almost infallible, and fancied that his mission would not be accomplished until he had explained everything in medicine. He accordingly formulated a pathology, and also a physiology, as he had formulated a system of therapeutics.

Such, gentlemen, was the origin of the triple dynamism which is physiological, therapeutical and pathological. I cannot enter into a discussion of this error, for it would carry me too far from my subject, and besides it is unnecessary, for the followers of this extreme view are not so numerous as they were. For myself, I am quite of the opinion of my teacher, Tessier, who made a résumé of this question in these words: "The doctrine of Samuel Hahnemann may be divided into two parts, viz., pathology and therapeutics. Term for term, the one comprehends all of his errors and the other all of his truths. So that, in speaking of the pathology, or the errors, of Hahnemann, we mean the same thing; and his therapeutics, or his truths, are also identical. Consequently, in what is called homœopathy there is the hemisphere of error and the hemisphere of truth."

Far from admitting the triple dynamism in physiology, we accept the doctrine of a substantial union of body and spirit; in pathology we are essentialists,—that is to say, we consider diseases as distinct species, not constituting veritable entities, but to be described and studied as belonging to the natural species.

The Legitimate Rôle of Empiricism and of Palliative Medication.

I must add one thing more, which is, that although homœopathy is applicable in a great majority of cases, yet it cannot fill all possible indications. Until the day arrives in which the Materia Medica is perfectly known I must invoke the aid of *empiricism*. When that day comes the empirical method must disappear from the domain of science; but, meanwhile, some of its resources are indispensable, for to it we owe the use of the *thlaspi bursa pastoris* in metrorrhagia; of the *sedum acris* in fissures and spasmodic contractions of the anus, and many other similar resources.

This same *thlaspi* is remarkably useful in the irritable bladder, which has been so carefully described by Dr. Gant.* We have found it of great service in this condition in the case of women who, it was supposed, were suffering from anteflexion of the womb.—L.

Besides, it often regulates the employment of mineral waters, and their administration must be empirical until conscientious and intelligent physicians shall have given us their pathogenetic and curative history, like that of Cauterets, for example.

If we get the author's idea,—and it would be very unkind to misinterpret him,—he holds that there is a "scientific frontier" against the empirical use of remedies, but that, until the resources of pathogenesy, and of clinical experience in their application, are better known and more available, we have not absolutely secured that frontier.—L.

Concerning the *palliative* treatment, of which we should avail ourselves in incurable diseases, "Where the physician cannot cure, it is his duty to relieve." Therefore, in cases of cancer, or of phthisis, that have reached the cachectic stage, do not hesitate to assuage pain. In hepatic or nephritic colic, if you find that the ordinary attenuations do not bring their accustomed relief, it is your duty to mitigate suffering, either

* The Irritable Bladder: its Causes and Treatment, etc., by Frederick James Gant F.R.C.S., Philadelphia, 1872.

by an injection of morphine or by some other palliative means. In any case, where a curative result cannot be obtained without the use of doses that are relatively large, you should employ them without hesitation. To sum up the whole question in a few words, we believe and profess that *therapeutics were made for those who are ill, and not for the doctors*, and that in this branch of medicine, especially, a narrow spirit and a too absolute faith are the sources of the most deplorable errors.

Now, gentlemen, that you understand our doctrines in regard to pathology, as well as to the Materia Medica, we shall enter without further comment into the proper domain of the Clinic, and our next lecture will be devoted to the study of the diseases of those patients who are in our wards.

LECTURE II.

SUMMARY.—Asthma, *case;* of emphysema, both transitory and confirmed; indications for *ipecac.* in asthma. Puerperal pleurisy followed by phthisis; indications for *cantharis* and for *arsenicum.* Chlorotic neuralgia; indications for *belladonna.* Bronchitis; indications for *ipecac.* and *bryonia.* Ascites, *case;* differential diagnosis of: indications for *apis, jodium, arsenicum* and *prunus spinosa;* good effects of *china.* Rheumatic endocarditis; aggravation by the *cactus grandiflora.*

Asthma.

GENTLEMEN: In No. 1 of the woman's ward is a patient, sixty years of age, whose sufferings began eight years ago. Since that time she has been subject to attacks of asthma and to menorrhagia. The latter is not of a serious character. She came here to be treated for bronchitis, which, engrafted upon asthma, is sometimes very alarming. My predecessor had been giving her bryonia, and she was improving under the influence of this remedy when I took the service. At that time her symptoms were as follows: coughing in the morning, abundant expectoration, dyspnœa, and, upon auscultation, we found prolonged and double expiration. It seems that in diseases of this kind the expiration may be spasmodic, for, while in a normal state, the inspiration is the longer of the two, the opposite is found to be the case with our asthmatic patients. This woman also suffers from insomnia. I gave her *arsenicum*, 12th dil., and with favorable results. I then prescribed *ipecac.*, in the hope of diminishing the asthma and the emphysema, but was unsuccessful. I resumed the *arsenicum*, in the 3d trit., during the day, and gave *nux vomica*, 3d trit., at night. This is what she is now taking.

I wish to call your attention, in this case, to the proper lesion of asthma, which is *emphysema.* This lesion occurs in

two forms, which it is important to distinguish. In fact, one form is transitory, and consequently curable; while the other is beyond the reach of therapeutics. These two forms of emphysema may be easily recognized by certain symptoms. Transitory emphysema is characterized by an exaggerated sonorousness and a prolonged whistling expiration, which is also spasmodic, and sometimes double.

These symptoms are most discernible on the back of the thorax. Sometimes this emphysema is of short duration. I have known it to disappear with one attack of asthma. At other times it will last for several months, but in this form it is always curable. It may be experimentally induced by a section of the pneumogastric nerve, and is attributed to the paralysis of the muscular fibres known as Reissessen's muscles. The partially-paralyzed vesicles become distended by air; an effort of the respiratory muscles becomes necessary, which causes the spasmodic breathing. Instead of being sonorous at first only, as is the case in a normal condition, the expiration is sonorous throughout the whole of its duration, and this produces the prolonged expiration.

In the confirmed emphysema the increased sonorousness of the thorax is coincident with a decided decrease in the respiratory murmurs. These phenomena are very marked in the case of one of our patients,—the woman who is in No. 5. In this confirmed emphysema, which may be considered as a more advanced lesion, there is not a rupture, but a perforation of the partition which separates the vesicles, so that one finds in them such cavities in the pulmonary tissue as interfere with hæmatosis. We see, therefore, why this lesion is incurable. If I have occupied a good deal of your time on this subject, it has been to prove that there are cases beyond the power of therapeutics to relieve, and that among them may be included all those cases in which there is any destruction of tissue whatever.

But to return to our patient in No. 1. I told you that I had prescribed ipecac. for her, and, *apropos* of this, I shall give you the physiological history of this drug. You know that, given in large doses to animals, it produces slow and difficult breathing; that is the fundamental character of its action. Observe now the kind and number of respirations in all asthmatic patients, and you will see that they are less frequent than in a normal state, and also that they are painful and difficult. Here is, then, the homœopathic reason for the prescription of ipecac. in asthma. This medicine will, you know, produce paroxysms of dyspnœa analogous to those of asthma. To convince yourselves of the truth of this statement, you need only refer to any allopathic treatise on therapeutics, particularly to that of Trousseau and Pidoux, where you will find examples such as I have cited.

Now, if you consult Hahnemann, you will find, in the pathogenetic symptoms of ipecac., difficult and whistling expiration, pulmonary congestion, bronchitis, and sometimes hepatization. All of these facts militate in favor of the use of ipecac. in asthma, especially where the disease has been of long duration, and where you will often find a coincident bronchitis, catarrh, and a greater or less degree of congestion.

Lastly, not wishing to omit anything, you will find in the "*Dictionnaire des Sciences Medicales*," edited by M. Jaccoud, an article on asthma written by Prof. Sée, in which, after having acknowledged the depressing effects of ipecac. on the muscular system, he advises against the use of this drug in therapeutics, which, he says, in certain cases increases the suffocation, and in so saying contradicts in four lines not only himself but all clinical experience. For myself, convinced by observation and by clinical results, of its efficacy, I urgently recommend you to use ipecac. in all cases of asthma and of asthmatic dyspnœa, whether complicated or not with

bronchitis. You will find this medicine of the greatest service in cases of difficult, noisy breathing, suffocation, blueness of the lips, etc. If these symptoms are accompanied by nausea I can assure you of an almost certain cure.

Let me say, in passing, that the characteristic of ipecac. is the spasm; it is not only indicated in transitory emphysema, where there is a spasm of the respiratory muscles, but likewise in the laryngeal spasm of stridulous angina, and also in the spasm of the rectum which characterizes dysentery. I shall hereafter give you the indications for nux vomica and arsenicum, the two remedies which, next to ipecac., are most frequently used in asthma. Trousseau has also extolled the empirical use of iodine in the form of the iodide of potassium; and, lastly, belladonna and stramonium have been employed, especially in the form of cigarettes or fumigations.

Cuprum, which like ipecac. is a remedy for spasms, is indicated in asthma.

Puerperal Pleurisy followed by Phthisis.

Next to our asthmatic sufferer in No. 2 of the women's ward is a patient who was delivered of a child three months ago. Several days after her labor she was seized with a chill, that was followed by fever, a cough, pain in the side and difficulty of breathing; in fact, all the symptoms of pleurisy. She has, however, remained at home until within the last few days, when the persistence of her sufferings decided her to come to us. On a first examination we found an absolute flatness or percussion in the lower part of the right lung, describing the parabolic curve which Damoiseau has insisted upon as characteristic. There was a complete absence of respiratory murmurs, and of the thoracic movements. Finally, at the point of the scapula there was egophony of a low bass tone. We prescribed *cantharis*, 3d dil.,—a remedy which we have used successfully for twenty years, and the indications for which you will find in the homœopathic provings.

I am anxious about this patient, not in regard to the pleurisy, which is really better, but on account of the pulmonary phthisis, of which the pleurisy was the forerunner. She has already had a chill followed by fever at about three o'clock every afternoon. Yesterday during the fever the thermometer indicated 102.9°. At the same time, by auscultation we found moist râles at the apex of the left lung, with difficult breathing, whistling expiration, feebleness of the voice, pectoriloquy, and all the symptoms of pulmonary induration, with some points of softening.

We will not, however, be discouraged, but try to give her relief for at least some time to come. I have prescribed *arsenicum*, 12th trit., which is particularly indicated in periodical fevers.

Chlorotic Neuralgia.

A little farther on, gentlemen, you will find a very simple case of trifacial neuralgia in a woman who has the carotid murmur, some menorrhagia, intercostal neuralgia; in a word, the diagnostic signs are evident. I have not, however, prescribed iron; but I have given her *belladonna*, which seems to me indicated equally by the trifacial neuralgia and the sensitiveness of the skin to the touch. It is but right for me to add that the moment I have the results I expect from the belladonna, I shall substitute for it iron and arsenicum, which are the two remedies that I prefer in chlorosis.

When this form of neuralgia occurs in young hysterical women, we have learned from experience to place great confidence in the *citrate of iron and strychnia* in the third trituration. Where a similar condition results from a too prolonged lactation, or from nursing and having the menses at the same time, *calcarea phosphorica* is the remedy.—L.

Bronchitis.

The patient in No. 4 is a woman already old, and who says she has been under treatment in the city for pneumonia. However that may be, she was in a most wretched state

when she entered here, and her constitution was well nigh broken from poverty, trouble and disease. An examination of the thoracic organs revealed the existence of an old pleurisy, which has caused a comparative dullness throughout the whole extent of the left side. She suffered when she came to us from a very sharp and frequent cough, and a relapse of the bronchitis. I gave her *ipecac.*, 12th dil., and *bryonia*, 12th dil., alternately every two hours, and in three days the cough was nearly gone. I recommend these two remedies to you in bronchitis with sub-crepitant râles and pulmonary engorgement, *id est*, in capillary bronchitis. I know that if we followed the law of similars exclusively, we should prescribe tartar emetic, phosphorus and pulsatilla, the pathogenetic symptoms of which correspond very well with the bronchitis. But if I may be allowed to make the assertion, clinical experience is a basis as solid as the law of homœopathy itself, and that experience has decided in favor of the course that I recommend to you. The great fault of Hahnemann and his first followers was in their refusing to admit the truth, in their desire never to vary from the indications of the Materia Medica. In some cases, gentlemen, it will be well to precede the use of ipecac. and bryonia by aconite for twenty-four or forty-eight hours, especially where there is much fever and great thirst. At some other time I shall give you the indications for tartar emetic, for Kermes' mineral, for the arseniate of antimony, for pulsatilla, for arsenicum, and for phosphorus.

Syphilis.

Next to this woman is a patient with syphilis, and whose case is specially characterized by crusty *syphilides*, seated upon the face, and by periostitis, located on the frontal bone. This patient is therefore on the line which divides secondary and tertiary syphilis. The *iodide of potassium*, two grains daily,

prescribed by my predecessor, Doctor Molin, has had a good effect.

Ascites from Amyloid Degeneration of the Liver.

I hasten, gentlemen, to speak to you of two more interesting cases. The first is that of a man with ascites.

Case II.—Mr. Chanson, forty-one years of age, a printer, entered on the 5th of January; had never been ill until August, 1873. At that time he had an attack of pleurisy in the left side. In October of the same year he still coughed, had sharp pains in the loins, and œdema of the legs. In November the dry cough increased and became frequent, especially at night. Emaciation, dyspnœa, and all the symptoms of an incipient phthisis, obliged him to stop work. After taking *phosphorus*, 3d trit., the cough nearly disappeared, but the pain in the loins continued. On the 20th of December, while riding on the top of an omnibus, the patient suffered from intense cold, and a chill which lasted ten minutes. This was followed by ascites, which in less than a week had assumed immense proportions. When I resumed the hospital service, on the 15th of January, he was pale, cachectic and much emaciated, with an enormous development of the abdomen. In the latter there was decided fluctuation and dullness, the outline of which changed according to the position of the body. The intestines floated in the abdomen, and were pushed toward the epigastrium. The veins were largely developed on the mesian line. There is no tumor evident to the touch. It is impossible to determine the limits of the liver or the spleen, on account of the effusion. He has thirst,—the urine is scanty and extremely red, with a deposit like that in cirrhosis. Upon testing it we found that two-thirds of the urine was composed of this sediment,—but there was no albumen in it. The pulmonary affection seems to have been arrested. He coughs but little; moist râles, however, may be heard at the apex of the left lung. There is also a small cold abscess with caries on the right tibia. He has slight fever every evening.

All these symptoms may be due to an effusion which is symptomatic of tuberculous granulations in the peritoneum, or to a compression of the vena porta, which sometimes de-

pends upon sclerosis of the liver, and at other times upon an amylaceous degeneration of it. The effusion increased rapidly, notwithstanding *apis mel.* was given in the third and also second triturations, and *jodium* in the third trituration. There was insomnia, with a loss of appetite, and, above all, a dyspnœa, which decided us, on the 27th of January, to resort to tapping. At this operation we removed eight quarts of a transparent liquid, greenish in color, pitchy in consistence, containing a large amount of albumen. After the operation we ascertained that there was no abdominal tumor, that the liver was of the proper size, and that the spleen was slightly enlarged. The day of the operation the patient was somewhat feverish, the pulse was 104, and the temperature 101.12°. Continued the *jodium.*

The fluid accumulated again so rapidly that, although giving *arsenicum*, 3d trit., we were obliged to repeat the tapping on the 31st of January, four days after the first one. At this time we withdrew thirteen quarts of liquid. On the 5th of February, the *prunus spinosa* having failed us, we made a third operation. Since that time, and through the influence of *china*, 6th dil., the effusion is much less rapid. The urine is more abundant and without deposit, the appetite has returned, and the general condition of the patient is satisfactory.

The absence of a tumor, and the rapid reproduction of the effusion, oblige us to reject the theory of a tuberculous affection of the peritoneum. The absence of change in the volume of the liver compels us to exclude the idea of cirrhosis, for which, for that matter, the usual cause is lacking. This man is, in fact, neither syphilitic nor intemperate, nor has he any affection of the heart. The rapid return of the ascites, the development of the subcutaneous veins along the mesian line, with the course of the blood from above downward, and the absence of the œdema of the lower limbs, establish the certainty of a more or less complete obliteration of the portal vein. The tuberculous lung and the cold abscess of the tibia satisfy us that the patient is scrofulous. Our diagnosis is therefore *amyloid degeneration of the liver.*

Rheumatic Endocarditis.

The next patient of whom I will speak to you, gentlemen, is a young man who, after an acute attack of articular rheumatism, has endocarditis. This is not a rare thing, and I only wish to call your attention to a phenomenon in a well-proven case of medicinal aggravation. I prescribed *cactus grandiflora*, 12th dil., for this patient. The night following he suffered frightfully with pain in the heart, and anguish, and I found him in the morning exhausted from it. I suspended the medicine for two days, and the pain in the heart ceased. I then gave him *cactus*, 6th dil., which was followed at night by the same pain and exhaustion as before. The remedy was so strongly indicated in the case that I held to it, and knowing, also, that the higher attenuations will sometimes produce an aggravation, I prescribed cactus in the first dilution, which he is taking with good effect. Here, gentlemen, is, I think, an incontestable proof of the value of infinitesimal doses; and cases that are analogous to this one are not scarce, I assure you.

We shall return to this case at another time, and then you will have its complete history.

LECTURE III.

SUMMARY.—Rheumatic endo-pericarditis (continued), *case;* indications for the *cactus grand.* Medicinal aggravations; indications for *arsenicum, nux vomica* and *cuprum* in the treatment of asthma. Asthma, *case* (continued). Pleurisy, then phthisis following labor, *case.* Incipient phthisis, *case;* cure by bryonia and a vegetable diet. Semiotic value of pain in the superior intercostal spaces. Pemphigus, *case;* indications for *rhus toxicodendron* and *cantharis.* Lumbago, *case;* indications for the *actea racemosa*: note. Erythematous angina, *case;* indications for *belladonna.*

Acute Articular Rheumatism with Endo pericarditis.

GENTLEMEN: You may have noticed in one of the private rooms a young man,—a student,—who had been under treatment for some time when I took the service from my predecessor. I found him suffering from a high fever, the joints were swollen and painful, and he complained of a sharp pain in the region of the heart. The diagnosis of the cardiac lesion was not as easy as at first might be supposed. In fact, the general symptoms were those of endocarditis, but upon auscultation we found signs of insufficiency and contraction of the aortic orifice, one predominating after the other, in turn. Two vascular murmurs could be heard at the apex, one,—the stronger and systolic,—corresponding to a mitral insufficiency; the other, less strong,—diastolic,—corresponding to an auriculo-ventricular contraction. There was, besides this, a slight friction sound, just where the apex of the heart strikes the thorax. A single vascular murmur could be heard in the carotids. At the end of a short time we had, to complete the picture,—the vibrating and characteristic pulse to which Corrigan's name has been deservedly attached.

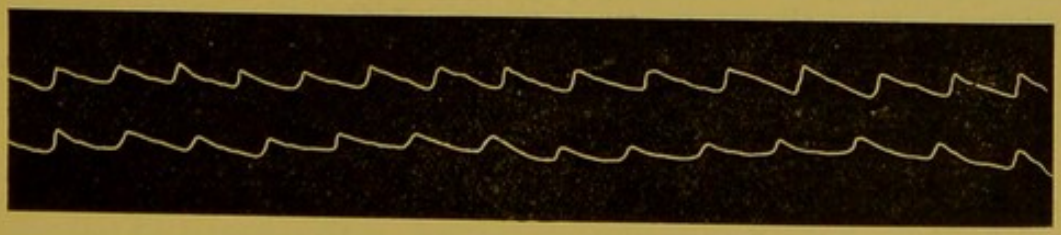
In brief, then, the symptoms in this case are insufficiency and contraction of the aortic and of the auriculo-ventricular orifices; but, as this lesion is still in process of development,

the signs of insufficiency and of contraction predominate alternately. Here is the detailed history of the case:

Case III.—M. L. P., twenty-three years of age. In 1864 he had his first attack of rheumatism with pericarditis; was confined to his bed with this attack for three months. This left him with a cardiac affection. In May, 1866, there was a return of the endocarditis, followed by pleurisy, which kept him in his bed two months. In 1871 he contracted syphilis, chancre, roseola and pustules. Since that time his health has been relatively good. In 1873 he had another attack of articular rheumatism. He entered this hospital on the 24th of December, 1873. The condition of the patient at this time was as follows: Considerable fever; the finger-joints are swollen and painful; there is sharp pain in the region of the heart, and dyspnœa. There is a noticeable enlargement of the heart, with pericardial friction at the apex, and in this same place the diastolic and systolic murmur in breathing (insufficiency and mitral contraction); at the base the systolic and diastolic murmur predominate over the first sound (insufficiency and aortic contraction, with excess of the contraction). Traced sphygmographically, the ascending line is very short, a little oblique, level; the descending line very long, without dicrotism, and with some inequalities. The pulse is small, feeble and frequent, and the *bruit de souffle* is heard with the first sound of the heart in the carotids and in the crural artery.

In this case, therefore, the physical signs of aortic contraction are the predominating symptoms.

Trace No. 1.



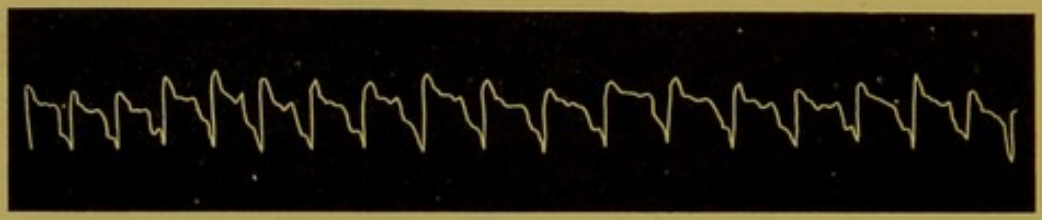
January 16. *Chininum sulphuricum*, 3d trit.

January 17. Evening, the pulse is 96; morning, pulse 92. The breathing is less difficult. The same treatment.

January 20. Morning, pulse 84. Last evening the pulse was 104, and the temperature 101.3°, with pain in the joints. *Chininum sulphuricum*, 2d trit.

January 21. The pains in the joints are much less severe, but there is a sharp pain in the heart. *Chininum sulphuricum*, 2d trit. The *bruit de souffle* predominates at the base of the heart during its diastole. The pulse is strong and vibrating without intermission. The sphygmographic tracing shows us a type of aortic insufficiency; the ascending line is vertical and very high, terminating with a hook; the descending lines, with dicrotism, are very pronounced.

Trace No. 2.



January 22. The same condition. *Cactus grand.*, 6th dil., two drops in 200 grammes of water; one teaspoonful to be taken every three hours.

January 23. Great agitation since the patient began to take this medicine; sleeplessness and apprehension.

January 24. The pulse, which was 92, has fallen to 84 this morning. The patient sleeps well. The pain in the heart, which yesterday was intolerable, is much less severe since the remedy was omitted.

January 25 and 26. The patient has slept well, and has no pain about the heart. The pulse, morning and night, was 88. *Cactus grand.*, 12th dil., four globules.

January 27. A less quiet night. The cardiac pain is very severe. Stop the *cactus*.

January 28. Has had a decidedly better night; no pain. *Cactus*, 1st dil., three drops.

January 29. The improvement continues. *Cactus*, 1st dil., five drops.

January 30. The patient is greatly agitated and sleepless, with sore throat since yesterday evening, from the effects of which the pulse was last night 124, and the temp. $103\frac{2}{5}°$. This morning the pulse is 92, and the temp. $102\frac{1}{5}°$. *Belladonna*, in the mother tincture, three drops.

January 31. Fever last evening; pulse 112. This morn-

ing it is 92. The throat is better. The tonsils are less swollen, and the pain is not so severe. *Belladonna* continued.

February 2. No fever; the throat is well, and we return to the *cactus*, 1st dil., three drops.

February 3. The pulse is less vibrating, and there is less pain at the apex of the heart.

February 4. Less pain in the apex of the heart.

In view of the general condition of the patient I ordered *chininum sulphuricum* — a remedy which has generally been successful in like cases. He had already taken aconite and bryonia. Under the influence of this remedy the general state of the patient was a little more satisfactory and the joints were less painful, but as the condition of the heart remained the same, I prescribed *cactus grand.*, 6th dil. You know this medicine was first recommended to us by Dr. Rubini. Its principal indications are: sharp pains in the heart, producing sometimes syncope; sensation as though of an iron hand about the heart; unequal and intermittent pulse; determination of blood to the head, and intense cephalalgia. Dr. O'Brien has published in the "Monthly Homœopathic Review," of London, a cure of rheumatic endocarditis by cactus; and, although this medicine has failed me in a similar case, I recommend its use because I have several times been successful with it.

The day following the administration of the cactus, finding the condition of the patient considerably worse,—which was manifested by sleeplessness, intense cardiac pain, anxiety, etc., I suspended the use of this remedy. During the two following days, the patient being calmer, I prescribed cactus, 12th dil., which caused a return of the exacerbation. I next gave saccharum lactis, and with the same result. I then prescribed the first dilution of cactus, with good effect. The young man continues to take it, and, under its influence, is daily improving. I have interrupted its use but once, and that was for three days, during which time he took belladonna for an incidental angina.

Of Medicinal Aggravations.

This is the appropriate place, gentlemen, in which to say something on the subject of medicinal aggravation,—a subject which, as you are aware, has been frequently discussed in our school of practice, but which has never yet been settled. You will find among our physicians many who utterly deny the whole matter of medicinal aggravation; while there are others, on the contrary, who see proofs of it every day, or who think they do. In my opinion, neither one class nor the other is exactly right; for, in this case, as in many others, the middle ground is the best. The question is a delicate one, and the more delicate because of the diversity of opinion as to what constitutes medicinal aggravation.

If, after giving a remedy, you find that your patient grows worse, you should be able to distinguish between its action and the natural progress of the disease. For example, the pathogenetic symptoms of diarrhœa, or of the exanthemata, which may appear during the administration of arsenic, should not be referred to medicinal aggravation as a cause. What, then, are we to understand by this term? It is the aggravation of the symptoms of a disease produced by the homœopathic medicine itself analogous to its own proper symptoms,—an aggravation that is generally followed by improvement in the morbid condition, when the use of the perturbing agent is suspended.

Certain mineral waters produce similar effects,—*Eaux-Bonnes*, for instance, and notably the *Mont-Dore*, for consumptives. During the cure, and immediately after, the patients often experience an aggravation of the disease symptoms,—the cough, the hæmoptysis and the fever. Where the treatment is successful the bad symptoms disappear, and the patient is greatly improved.

In the same way, from having taken the cactus, our pa-

tient suffered an aggravation of the pain and sleeplessness, followed by a marked improvement, until at length he was able to take the remedy in stronger doses.

In our next lecture we shall speak again of the different phases of the cardiac lesion.

Asthma — (Continued from page 12.)

Let us now glance at the patients who are actually under treatment. *À propos* of the asthmatic woman in No. 1, and who is still improving, I gave you, as you will remember, the pathogenetic history of ipecacuanha in this disease. Next to it in point of importance we should place *arsenicum*, the use of which has been so valuable, and the employment of which is traditional in like cases. It is to the presence of arsenic in the waters of Mont Dore that we must ascribe their efficacy in phthisis. Arsenic, for that matter, contains in its provings the following symptoms: coryza, with incessant sneezing and running at the nose, difficult, whistling respiration, with constriction of the chest; and it is not Hahnemann alone who has asserted this; for Morgagin, Guldenkee, Rau and Guilbert have observed the same symptoms among its effects. The indications for arsenic are drawn from the predominance of the symptoms during the night, such as anxiety, a tendency to syncope, burning in the chest, but, above all, *the expectoration of a frothy substance resembling the beaten white of an egg.*

After arsenic come *nux vomica* and *cuprum*, which will render you signal service, especially in dry spasmodic asthma, with spasms of the diaphragm. Nux is most appropriate when there is coryza, with sneezing, when the attacks come on after eating, or in the morning, and where the patient is subject to hemorrhoids. Cuprum* is the great remedy for

* See an article on the use of Cuprum in Asthma, by Dr. Claude, published in the "*Bulletin de la Société Homœopathique*," 1872.

cramps, especially when accompanied by blueness of the lips, and where the spasmodic element predominates.

Case I.—This woman, sixty years of age, is a hemorrhoidal subject. During the winter, for eight years, she has had asthma. In our last lecture we left her improving under *arsenicum*, She was taking that remedy in the morning, and *nux vomica* in the evening, both in the third trituration. To the symptoms given respecting the lungs we should add exaggerated sonorousness with prolonged and sibilant expiration, intermission in the movements of the heart, but without abnormal sounds, and which are probable signs of auriculo-ventricular contraction. Under the influence of arsenicum and nux vomica the patient is certainly better. She sleeps, coughs and expectorates but little, and still the signs of emphysema continue. *Kermes'* first trituration, continued during the time the patient remained in the hospital, diminished the expectoration considerably. She left on the 11th of June, much relieved, but not cured.

Pleurisy, then Phthisis after Delivery.

The next patient, in No. 2, is a woman who entered the hospital a few days ago. She came to us for pleurisy contracted some days after her confinement. The pleurisy entirely disappeared under the influence of *cantharis*, but the upper part of both lungs show signs of tuberculous softening, and a hectic fever with a daily chill called for the administration of *arsenicum*. I prescribed it in the twelfth dilution, and obtained an evident amelioration of the subjective symptoms; but unfortunately her temperature is always at nearly 104°, and the disease is not arrested. The patient, however, is a little stronger, has a good appetite, the effusion is completely absorbed, and I hope soon to be able to send her into the country, and that such a change will retard the progress of her disease. I prescribe *phosphorus* for this patient, with a vegetable diet. Here are the notes of this case:

Case IV.— Madame Salmon, aged forty, a dressmaker, entered the hospital on the 24th of January, and left it on the 14th of March. This patient has always had good health. She was confined three months ago, and caught cold the eighth day after her labor. This resulted in the production of a severe dry cough, and oppression, loss of appetite, and a stitch in the right side. She kept her room for one month, and, at the expiration of that time, commenced work before her health was fully re-established. For two months she walked a long distance each day to and from her work. On returning she would have a chill, and during the night, sweats that were limited to the right side. The appetite had almost entirely disappeared, and the feebleness was so great that she was finally unable to walk home.

On entering the hospital, we found an absolute dullness on the right side extending over the inferior two-thirds of the thorax. The upper line of dullness was of a parabolic form. There is a complete absence of the vesicular murmur. On applying the hand to the chest there are no perceptible thoracic vibrations, there is ægophony, but no murmurs; and want of breath. The menses have not returned since her confinement, although until now she has always been regular. The fever generally comes between one and five o'clock in the afternoon. Her temperature is always between 102° and 104°.

January 25. *Cantharis*, 3d dil., three drops in 200 grammes of water; one spoonful every three hours. The diet to be a vegetable one.

January 26. Evening, temp. 102.5°, pulse 100; morning, temp. 102.2°, pulse 96. Slight respiratory murmur in the right side. The same treatment.

January 27. Evening, temp. 102.2°, pulse 84; morning, temp. 102.2°, pulse 92. The respiration is stronger, and the patient has some appetite. The same treatment.

January 28. Evening, temp. 102.9°, pulse 100; morning, temp. 102.5°, pulse 96. The effusion continues to decrease. The same treatment.

January 29. For two days the patient has had a chill at about two o'clock in the afternoon, during which the pulse has been 108, and the temp. 102.9°. This morning the tempera-

ture is 102.2°, the pulse 92. The pleurisy is doing well, but, on a careful examination, the apices of both lungs are found to be the seat of a tuberculous infiltration, which is partly softened. *Arsenicum*, 12th dil., six globules in 200 grammes of water; one spoonful every three hours.

January 30. The chills have ceased, but the fever at night still persists. The temperature is 103.10°, and the pulse 88. Morning, temp. 101.8°. The same treatment.

January 31. No return of the chills. Evening, temp. 100.76°; morning, pulse 92, temp. 100.7°. The same treatment.

February 2. The pulse and the temperature are normal, except about 2 o'clock P.M., when she has fever, but no chills. The same treatment.

February 3. Fever at irregular intervals. Yesterday, at 5 P.M., the temperature was 104°, at 6 P.M., 103.25°. This morning the temperature is 102.2° and the pulse 96.

February 5. At 3 P.M., temp. 104°; at 6 P.M. it was normal. In spite of this fever, the effusion has completely disappeared. *Phosphorus*, 30th dil., four globules in 125 grammes of water; three spoonfuls a day.

Phthisis and the Vegetable Diet.

There is another patient with phthisis, in a private room, who is a young pharmacy student. He has, as you may have known from his symptoms, a large cavity in the apex of the right lung. I have put him on a vegetable diet, although I am not certain that he will be able to bear it, as he already complains of diarrhœa. Sometimes a diarrhœa is the consequence of this regimen, although its effects are usually of an opposite kind. I will speak to you on this subject hereafter.

Incipient Phthisis.

I wish now to speak to you of a young man who is ill of a suspected bronchitis, and who, by the use of *bryonia* and a vegetable diet, has left the hospital entirely cured.

CASE V.—Morquet, seventeen years of age, a wood-turner,

entered on the 14th of January, and was discharged from the hospital on the 23d of January. Men's ward, No. 5.

The father and mother of this patient having both died four years ago, three months apart, after having coughed for years, the family antecedents are unfavorable. The young man presents all the external signs of tuberculosis. He is thin and narrow-chested. He says that, excepting the youngest, his brothers have good health. That brother has had trouble with his eyes from infancy,— a disease which is common in those of a scrofulous constitution. Up to the time of this sickness our patient has enjoyed good health. On the 25th of December he took cold, which was followed by a dry cough, a slight expectoration without blood, and no fever. When he entered the hospital, on the 14th of January, he had had no treatment. An examination showed his condition to be as follows:

On percussion we observed an obscure sound at the back and upper part of the left lung. At the apex of the right one, and at the base of both lungs, the sound is normal.

By auscultation, a loose rattling is heard at the apex of both lungs,— now over the right, and again over the left one. The expiration is harsh and prolonged on the left side. The patient complains of a pain, which is aggravated by the cough and by pressure. He has had this pain ever since the cough commenced; it is located on the left side in front, in the intercostal space, and below the spine of the scapula behind.

January 15. Since entering the hospital this man has been on a light diet. He has no fever. The pulse is 50. *Bryonia*, 12th dil., four globules.

January 19. The neuralgic pain in the back has disappeared, but it continues in front. It is, however, much less severe than when he entered. The cough is less frequent, but a little troublesome at night. No fever. Pulse 54. *Bryonia*, 12th dil.

January 21. The general condition of the patient is improved; the neuralgic pain in the back of the chest grows less severe each day. The expectoration is greenish and not abundant. *Bryonia*, 6th dil.

January 22. The cough has entirely left. The pulse is 50. *Bryonia*, 6th dil.

January 23. The pain from pressure on the back of the chest has gone. Pulse 50. *Bryonia*, 6th dil.

January 25. The patient left the hospital cured.

I invite your attention to the semiotic value of pain in the superior intercostal spaces. In phthisis, this pain, increased by pressure and the respiratory movement, is connected with an intercostal neuralgia, that depends upon a dry pleurisy, and this pleurisy is connected with the tuberculosis of the apex of the lung. Hence we see the significance of the pain in the superior intercostal spaces, in a patient with a cough. Concerning a vegetable diet in phthisis, I will speak to you shortly.

A Suppurating Hygroma. Pemphigus.

Before closing, I will say a word of a young patient who is being promptly cured of pemphigus by the use of *rhus toxicodendron* and *cantharis*. Here are the brief notes of the case:

Case VI.— Jansot, aged seventeen, a student, entered the hospital on the 16th of January and was discharged on the 1st of April.

A fortnight before coming here, this patient injured his knee by a fall. A slight painless swelling ensued, but which was not sufficient to prevent his walking as usual. At the end of two weeks the knee began to pain him, the swelling progressed, and the patient was unable to make the slightest movement. Several times, after entering the ward, pus was discharged from the wound, and then it healed again.

On examination we found a transverse wound of slight extent, with an evident rupture of the bursa near the patella.

January 17. Compression, by means of a silicated bandage was resorted to, and at the same time *silicea*, 30th dil., was given internally.

January 24. The swelling seems closed. Since yesterday he has some fever, and bullæ of pemphigus appear on the face and upon different parts of the body. I ordered *rhus toxico-*

dendron, 3d dil., three drops in 200 grammes of water; a teaspoonful to be taken every three hours.

January 30. The pemphigus is disappearing from every part of the body excepting under the bandage about the knee. Violent pains in the knee compel us to remove the bandage. The patient has chills and some fever. *Aconite*, 2d dil.

January 31. No more chills, but the fever is continuous and very severe; the temperature being 103.10°, and the pulse 92. Continue the same remedy.

February 1. The fever has declined decidedly. The eruption on the leg disappeared, but new bullæ showed themselves on the following days.

It was only after eight days' employment of the *cantharis*, 3d dil., that this trouble entirely disappeared.

February 6. An injection of iodine, one part to three, was made into the bursa.

February 7. There is some inflammation of the serous bursa and of the surrounding parts.

February 15. The silicated bandage was re-applied.

The application of this bandage was continued until March 1, when he complained of so much pain that it had to be removed. The sac secreted anew, and pretty freely, a plain serous fluid.

March 2. A second injection was used, but it caused no inflammation.

From this time a graduated compression was applied, and, thanks to this means, in the space of a fortnight the discharge had rapidly disappeared, the extent of the sac had diminished, the wound had contracted, and the patient was allowed to sit up. No new symptoms appeared, and the young man has gone away well.

There are still two patients who are ill with benign affections of which I must speak to you. One of them has the lumbago, and the other erythematous angina.

Lumbago.

Case VII.—Alexander Duroy, aged seventeen, entered on the 17th of January, and left the hospital on the 31st of January.

This patient is a lymphatic young man, scrofulous, and has been subject from infancy to dental inflammation with abscesses. Two weeks ago, and without any apparent cause, he was seized with a violent lumbago. Before his reception into the hospital he had taken *bryonia*, 3d dil., but without relief. I gave him *actæa racemosa* in the 1st dilution. The pain continued for three days, but was less severe each day. On the 24th, as the patient showed a marked improvement, I continued the same medicine, and on the 31st of January he left the hospital cured.

There can be no doubt of the efficacy of this remedy in many cases of lumbago, especially when there is an accompanying stiffness in the muscles of the neck and back, and a severe drawing, tensive pain at the points of the spinous processes of the dorsal vertebræ. In women, more than in men, perhaps, it is called for by a feeling of weight and pain in the lumbar and the sacral regions. For spinal pains of a rheumatic or neuralgic character, which are the sequelæ of epidemic meningitis, it is almost a specific. Our preference is for the alkaloid — *macrotin* — in the third decimal trituration. But, in susceptible persons who have had rheumatism with more or less cardiac difficulty, it should be given very cautiously for fear of an aggravation.—L.

Erythematous Angina.

Case VIII.—Josephine Tromelet, aged fourteen years and six months, entered on the 22d of January, and left the hospital on the 25th of January.

This patient presents all the appearances of a lymphatic person. She is subject to attacks of angina, which return every winter. She is also a victim to a more or less painful cephalalgia. The attack of angina from which she is now suffering began on the 18th of January, and was accompanied by a more than usually violent headache. Prior to this seizure she had not been exposed either to cold or to dampness.

When she entered the hospital her symptoms were as follows: sharp pain in the back of the pharynx, increased by deglutition, and which provokes the accumulation of saliva in the back of the throat; the voice is very much changed; the mucus discharged from the back of the throat is red and bright; the inferior maxillary glands are not inflamed. She has but slight fever; the pulse is 90. *Belladonna* in the 3d dilution.

January 23. Deglutition has become easier. The headache is sensibly diminished. Pulse 86. *Mercurius sol.*, 3d trit.

January 24. The patient improves constantly. The headache is entirely gone, and the deglutition is no longer painful.

January 25. She left the hospital cured.

LECTURE IV.

SUMMARY.—Signs of emphysema. LOUIS and the numerical school. Indications for antimony in the treatment of asthma. Menorrhagia, *hamamelis* in. Lobular pneumonia is grave bronchitis. Articular rheumatism and endopericarditis, *case* (continued); the evolutions and modifications of the cardiac lesions demonstrated by the sphygmograph. Aggravation from the *cactus;* happy effect of *spigelia*. Pleurisy followed by phthisis, *case;* vegetable diet; indications for *jodium* and *arsenicum*. White swelling; indications for *argentum* in scrofulous affections of the bones. Mild typhoid fever, *case;* indications for *bryonia* and *china*. The inconvenience of a fanciful diagnosis. The homœopathic treatment may shorten the duration of disease: note.

Emphysema — (Continued from page 10).

GENTLEMEN: You remember that the bed in No. 1 was occupied by a woman with humid asthma. When she came to us she complained of dyspnœa, which troubled her most at night. I shall not refer to the catarrhal affection that accompanied the suffocation, and which gave to the physiognomy of our patient a stamp quite peculiar to herself. When she left the hospital her condition was much improved. She still coughed a little, and traces of the emphysema remained, but the dyspnœa and the incessant coughing, of which she complained on entering, had both disappeared.

In my second lecture I spoke to you of emphysema as the lesion which is proper to asthma, and told you that there were two degrees or varieties of this lesion, the first of which is transient and curable. It is due to a dilation of the pulmonary vesicles, and is a *transitory* affection. The second, which is utterly incurable, is caused by the permanent dilation of the pulmonary vesicles, in consequence of the destruction, by atrophy, of the walls which separate them. This latter is the *confirmed* emphysema. I must remind you of the unre-

liability of the symptoms usually attributed to emphysema, because of the neglect of a proper distinction between the two varieties of the affection.

Louis, who made no distinction between permanent and transitory emphysema, assigns five symptoms to pulmonary emphysema: 1st, the circumscribed arching of the thorax. 2d, its exaggerated sonorousness. 3d, the absence of the vesicular murmur. 4th, whistling and sonorous râles; and 5th, harsh respiratory murmurs.

I wish to call your attention to the fact that this authority, who achieved so singular a renown as an exact and conscientious observer, speaks of the *absence* of the respiratory murmur, instead of its *diminution*, and that he has entirely forgotten the pathognomonic sign of emphysema, which is a prolonged expiration. Let me add, for the instruction of the present generation, respecting the medical intelligence of the "numerical school," that these five signs attributed to emphysema are of no value unless several of them coëxist; and, also, that Louis never saw them all united but four times in ninety cases. We do not propose to go into the history of the contests and criticisms which this subject has survived, but in a few words to give you the signs of the two kinds, or degrees, of this peculiar affection.

Transitory emphysema.—Exaggerated sonorousness, with prolonged expiration, which is spasmodic and double, almost always whistling.

Confirmed emphysema.—Exaggerated sonorousness, contrasted with feebleness of the respiratory sounds. If there is a complication with catarrh, a moist râle may be heard, and as these râles strengthen the respiratory sound, the prolonged expiration may still be recognized.

In the case of the patient in No. 1, after having relieved the dyspnœa by *ipecacuanha* and *arsenicum*, we resorted to the preparations of antimony to control the catarrh. You know

that there are three principal antimonial preparations, *id est*, tartar emetic, the sulphur of antimony, or Kermes' mineral, and the arseniate of antimony. The *tartar emetic* is indicated in catarrh when there is fever, the cough is severe, and above all when the face is congested and there is an absence of thirst and a desire to sleep. *Kermes' mineral* may also be used in catarrh when there is an abundant expectoration in the morning, but only when there is no fever. The experimental study of the arseniate of antimony has yet to be made. Notwithstanding this, it is a good remedy that we may employ empirically where the cough is severe and is accompanied by dyspnœa. These medicines should generally be given in the first and the third triturations, twenty centigrammes in 200 grammes of water, and three or four spoonfuls in twenty-four hours.

Puerperal Pleurisy — (Continued from page 24).

I will only say a few words to you to-day concerning the patient in No. 2. You recollect that she has phthisis, which was preceded by a pleurisy contracted while she was yet in the puerperal state. For some time past she has had a hectic fever of the retarding type. This fever runs very high, the temperature rises to 104°, and is accompanied by chills. This last symptom, as I have already told you, disappeared under the influence of *arsenicum*, 12th dil. For the last eight days she has been taking *phosphorus*, 30th and 12th dil., which has diminished the fever and the cough. On the whole, this patient is better. I will speak of her again shortly.

Hamamelis in Menorrhagia.

In No 3 of the woman's ward is an hysterical patient, whose history I will give you some day in the future. To-day let us note that *hamamelis* in the first dilution has had a most happy effect for the relief of a too abundant flow of the menses, from which she has habitually suffered.

Lobular Pneumonia, or Grave Bronchitis.

You have seen, in one of the private rooms of the hospital, an infant, twenty-three months old, which was a victim to a severe dyspnœa, complicated with somnolence and intense feverishness. This child, the complete history of whose illness I shall give you in my next lecture, is suffering from an acute pulmonary affection, to which many names have been given, as, for example, lobular pneumonia, capillary bronchitis, and suffocative catarrh. I call it grave bronchitis: bronchitis, because in fact the primitive lesion is situated in the bronchial tubes, and the congestion, and even the extensive hepatization, which usually complicate this disease, are secondary. They follow the inflammation of the bronchii as epidydimitis follows inflammation of the urethra. I will add that the continued symptoms of this affection are those of bronchitis, and not of pneumonia; also, that the etiological conditions and the epidemic influences combine to place this disease among the catarrhal affections.

These discriminations in diagnosis are exceedingly practical. There is a wide difference in point of fact, clinically and therapeutically, between an idiopathic and a broncho-pneumonia, or an attack of pneumonia that is secondary upon and complicated with bronchitis.—L.

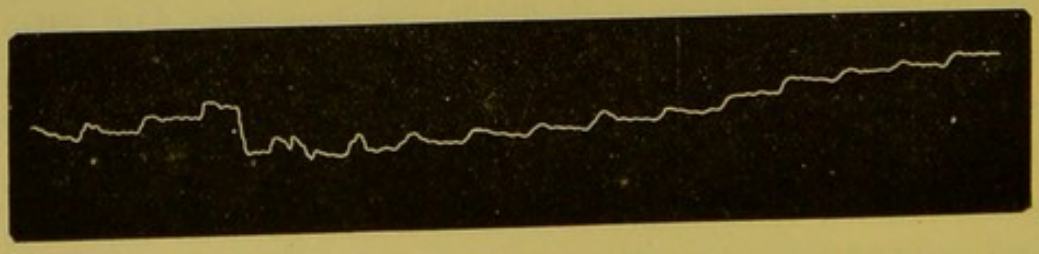
We style this a grave bronchitis because it is a disease that is much more fatal than pneumonia; for while authors may dispute the name and the nature of the malady, they are in perfect accord as to its dangerous character. Our little patient has already been ill eleven days with bronchitis. The temperature is 104°, and there is considerable oppression of breathing. Both lungs present the sub-crepitant râle and the souffle, and it is therefore as serious a case as need be. But the child is taking *ipecac.*, 12th dil., and *bryonia*, 12th dil., and we have the greatest confidence in these remedies. In our next lecture I hope to announce that it is cured.

Acute Articular Rheumatism with Endo-pericarditis.—(Continued from page 18.)

I now return to the history of the young man who occupies a private room, and whose disease is rheumatic endo-pericarditis. I wish, also, to show you the different sphygmographic tracings that we have taken at different periods of the disease, some of which, you will observe, denote an aortic contraction, and others an aortic insufficiency. In this case we have not a definite lesion, but one that is in the process of evolution,—a fact which proves that with the progress of inflammation these lesions are modified, and that, consequently, if they are changeable, they are not necessarily or quite incurable. Let us take up this case where we left it in our last lecture.

Case III.—February 5. The patient has, for some days, been under the influence of *cactus*, in the first dilution, which he bears very well; his nights are calm; there are no pains in the heart; the pulse is feeble and intermittent; the sphygmographic trace gives an obliquely ascending line, which is very short, and which ends in a horizontal one; the descending line is very long and very oblique; the cardiac pulsations are very unequal, with some intermissions; the pulse indicates mitral insufficiency, aortic contraction and aortitis. The latter symptom contrasts with the pulse of insufficiency, which we observed a few days ago. The *cactus* was continued.

Trace No. 3.



February 12. The pains in the heart have returned.

February 13. The pains are increasing; they are intermitting, and the patient suffers greatly, and they prevent sleep.

Nevertheless, the respiratory sounds are diminished in their intensity.

Stop the *cactus*, which has been taken in increasing doses up to twelve drops of the first dilution, and substitute *spigelia*, to be given in drop doses of the mother tincture.

February 14. Under the influence of spigelia the pulse became more full, and the intermissions ceased. Signs of aortitis still exist, but those of valvular insufficiency reappear; the ascending line is very long, but not quite vertical; the level one is very marked, and the descending trace almost without dicrotism.

Trace No. 4.

February 16. The pains in the heart are less severe, but the patient has fever. The pulse is 108. There is a return of the pains in the joints, and especially of the sore throat, which necessitates the administration of *belladonna*.

February 18. There is no longer any sore throat; the fever persists, and the pulse is 112, and slightly intermittent. Resume the *cactus*, 1st dil.

February 19. The patient is worse; there is complete insomnia; the intermissions are extremely painful, and especially at night. The cactus was withdrawn.

February 20. No better. *Spigelia*, 3d dil., in three-drop doses.

February 21. Better; the pulse is very good, although it beats 120. This febrile movement is kept up by the rheumatic arthritis. The intermissions have disappeared; we hear nothing but the second sound at the base of the heart. The pericardiac friction-sound and the signs of mitral insufficiency persist. *Spigelia*, 3d dil., three drops.

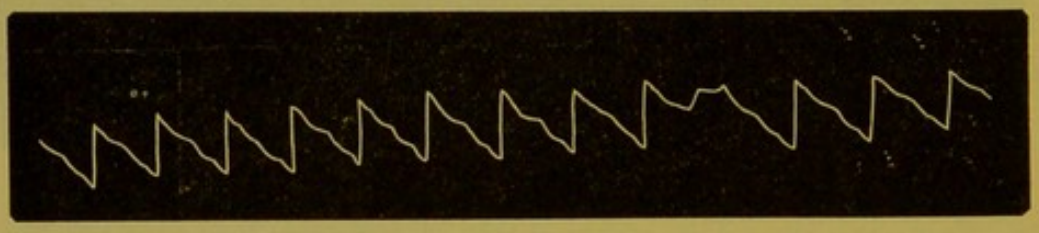
February 23. Slight improvement. *Spigelia*, 1st dil., three drops.

February 25. The intermissions have ceased; the pulse has fallen; the pains in the joints are less severe; but there is little appetite. *Cactus*, 1st dil., three drops.

February 27. There is a return of the painful intermissions. *Spigelia*, 1st dil., three drops.

The pulse takes more and more the character which accompanies aortic insufficiency; the sign of aortitis (which is found in the horizontal line of the sphygmograph) has entirely disappeared. We have the ascending line perfectly vertical, with a hook at the beginning, and the descending line presents only slight signs of dicrotism. A very marked intermission in the fourth pulsation of the tracing shows that the mitral insuf-

Trace No. 5.



ficiency still exists. The patient, who now leaves us to return to his family, is, on the whole, much improved. He no longer suffers from dyspnœa, and the pain in the heart is gone, but he sleeps and eats very little.

If you compare the five tracings obtained from this patient, you will be convinced that at one time the symptoms of aortic contraction were unmistakable (see Trace No. 1); that these symptoms, joined to a certain degree of *asystolie* (or incomplete systole), and to the signs of mitral insufficiency, reappear in Trace No. 3; and that, before this, we have a trace which is the exact type of aortic insufficiency,—I refer to Trace No. 2. Finally, the patient, evidently relieved by spigelia, presented day after day the most conclusive signs of aortic insufficiency joined to mitral insufficiency, and it is probable that these two lesions will remain indefinitely. For ourselves, we are convinced that the contraction of the aortic

orifice, and of the aorta itself (since there was a manifest level line in the tracing), was caused by the loss of elasticity of the tissues, due to a relapse of inflammation. Let us note, from a therapeutic point of view, the happy influence of spigelia over the painful intermissions of the heart and over all the symptoms of endocarditis.

For it was during the use of this remedy that the tracing showed aortic insufficiency, at the same time that the state of the pulse and of the respiration indicated a decided diminution of the inflammation of the lining membrane of the heart. We have observed the bad effect of the cactus, tried three times and with the same results, which, indeed, compelled us to stop its use entirely. For it was after its persistent use in increasing doses, until twelve drops of the first dilution were taken, that the first painful intermission occurred, and this symptom reappeared each time that we gave it.

The Vegetable Diet in Phthisis.

I wish to say a word to you concerning the patient with phthisis, now occupying a private room. It is another example of pleurisy in the right side coincident with phthisis. The regimen that I have prescribed for this patient may surprise you a little, but I will speak to you some other time of the vegetable diet in this disease.

Phthisis preceded by Pleurisy — Improvement.

Case IV. — M. D——, aged twenty-four, a student of pharmacy, entered the hospital on the 28th of January, and left it on the 31st of March. Up to the age of twenty-one this young man enjoyed perfect health. His family antecedents are excellent. His parents are strong and vigorous, and have never been subject to a cough.

In 1871 the patient was seized with pleurisy in the right side, which was accompanied by considerable effusion. At the end of two months, just when this disease was about cured, he suffered a relapse, which extended its duration to four months.

Since that time he has coughed, but less in summer than in winter. In summer the cough is slight, with morning expectoration only, and the matter raised is of a yellowish white color. In winter, since the attack of pleurisy, he is very subject to colds; and these colds always last for two or three months, and are accompanied by a dry and very rebellious cough, with fever and sweats at evening. Notwithstanding this cough, his general health has remained good. His appetite is the same as before the pleurisy. He has not lost flesh. Three weeks ago, in consequence of taking a fresh cold, he began to cough more frequently than usual. A few days later he had a chill, which was followed by a pain in the right side, above the nipple.

Physical Examination.—On percussion, the left side is normal. At the apex of right lung are decided sub-crepitant râles; and there is pectoriloquy, especially if the patient speaks in a low voice.

January 20. *Jodium*, 3d trit., and a spare diet.

January 30. The patient has a diarrhœa. *Arsenicum*, 3d trit.

January 31. No more stools. The same treatment.

February 2. The diarrhœa has returned. Stop the vegetable diet. *Arsenicum*, 3d trit.

February 3. No return of the diarrhœa; the cough is much better, and the appetite good.

February 6. The diet was resumed. Continue the same treatment.

February 9. The cough has increased, and he has night sweats. The same treatment was continued until the 18th of February. The patient being unable to support the exclusive diet, it was changed. The cough is better. His strength is returning. *Jodium*, 3d trit.

February 24. He is up and has walked about during the day. The same treatment.

March 1. The patient has had strength enough to be out all the afternoon. The cough has almost entirely ceased. The arsenicum, 3d trit., was continued until the patient left the

hospital, on the 31st of March. He left us with bright hopes of future health, but having a perfectly well-defined cavity in the apex of his right lung.

White Swelling.

One word only concerning the young man with the white swelling on the knee. He improves constantly. The fungous tissue which at first existed has given place to the more solid anatomical elements; the softness, that was perceptible to the touch, is disappearing also. We prescribed *argentum*, which produces, on the healthy person, pain in the bones and joints, and which has several times cured scrofula of the bones. I remember having treated a lady for two scrofulous attacks, which had, up to the time she became my patient, resisted all treatment. The first was a cold abscess in the back. I opened it and discharged it, but the pus formed again. I then gave her argentum, which completely cured it by absorption.

A short time after, this same lady suffered from caries of one of the metacarpal bones. I prescribed argentum at once, and she was cured in a short time.

This woman had a frightful metrorrhagia, which was kept up by the presence of a uterine fibroid. It was this state of things that led me to prescribe the *argentum oxydat.* in pretty strong doses. She took of the first trituration five centigrammes in two doses during the day.

We were not aware that any one in our school of practice had succeeded in controlling the hemorrhage that is incident to uterine fibroids, or in anywise checking the growth of these neoplasms, by the use of *argentum oxydatum*. And we sincerely regret that the author has not spoken more at length upon this very interesting subject, more especially since he "knows enough to know" what a uterine fibroid is, and would not hesitate to speak the truth of his experience with this remedy.

In our own practice, we have had some very remarkable results from *trillin*, in the third decimal trituration, for the relief of this form of menorrhagia. In one case especially,—and it was a very bad one,—occurring in the practice of my friend Dr. W. C. Barker, of Waukegan, Ill., the trillin not only relieved a

very alarming hemorrhage, but put an end to a tedious and harassing cough that had worried and weakened the patient almost as much as the loss of blood. It also relieved a severe neuralgia to which this patient had been subject.—L.

A Mild Type of Typhoid Fever.

Case V.—Miss Pinière, twenty-six years of age, was admitted on the 22d of February, and left the hospital on the 6th of March. This patient came to the hospital on the tenth day of her illness, which had commenced with copious vomiting of a greenish matter, and diarrhœa. She had been treated in the city for bilious fever. On examination, she had very few symptoms. She complained of headache, principally in the forehead, and of a stitch in the right side and in front under the false ribs. Auscultation and percussion are negative. The sensibility of the abdomen is normal. There are no spots of discoloration, and there is no diarrhœa, but a loss of appetite and continued fever. The epistaxis at the onset, and the duration of the disease are diagnostic of a mild attack of typhoid fever.

February 23. The pulse is 84; temperature at evening 101.12°. *Bryonia*, 3d dil.

February 24. Morning temperature the same; the pulse 84. Evening temp. 100.40°, the pulse 80. The pain in the side is much less, but the fever persists, being higher in the morning than at night.

February 25. The pain in the side has gone. Morning temp. 101.48°, pulse 80. Evening temp. 101.12°.

February 26. The fourteenth day of the fever. Morning temp. 101.12°, pulse 80. Evening temp. 99.68°, pulse normal. The general condition is very good. *China*, 6th dil.

February 27. Morning temp. 100.75°, pulse 76. Evening temp. 99.50°. She has a desire for food. From this time she has steadily improved; the fever has gone, the appetite has returned, and she sleeps well. The china was continued until she left, on the 6th of March.

À propos of this case, I wish to make two remarks: the first concerns the strange abuse that physicians make of a fanciful diagnosis of bilious fever. What does the term signify? To a physician who is *au courant* in pyretology it has

no signification, and is nonsensical; to a practitioner who does not know enough to make a proper diagnosis, it is a something upon which he fastens,—and when it is not a "bilious fever," it is a "mucous fever," for one name is as unscientific as the other.

The second remark that I wish to make is, that we frequently observe that when typhoid fevers are treated homœopathically they terminate prematurely on the fourteenth or the seventeenth day. Doubtless in such cases, as in the case of all cyclical diseases, our treatment is incapable of aborting them at once, or of arresting their natural evolution, but it certainly may shorten their duration, and that is a great deal to accomplish.

The typhoid fever is practically an eruptive fever, and, as a rule, one attack gives exemption in the future. In exceptional cases, however, as with variola, scarlatina and rubeola, it may repeat itself in the same patient. But, as with the modifying influence of vaccine over subsequent attacks of smallpox, and as with recurrent attacks of each of the eruptive fevers, so the second or the third repetition of this disease will not be exactly the same as the first. Some of its symptoms, or one or another of its stages, will be lacking. It will be an imperfect echo or reproduction of the original disease.

When remedies are given for this recurrent form of typhoid fever, and its course is shorter than usual, and its concomitants and sequelæ are either cut off or very much changed, it is not just or proper to conclude that such a result is always and altogether due to our treatment. This spurious type of the affection may be, and often is, aborted; but it is very doubtful, at least in our own mind, if any remedy or remedies can abbreviate the duration of a genuine, primitive attack of typhoid fever.—L.

LECTURE V.

SUMMARY.—Of the suspension of the remedy in the trea.ment of chronic diseases, and of the repetition of the dose. An intermittent febrile action in hysteria; effect of the *tarentula*. Laryngeal phthisis; *phosphorus* and *argentum*. Hysteria; nervous vomiting, *case;* indications for *nux vomica*, *ipecac.*, *ferrum*, *bryonia* and *pulsatilla*. Grave bronchitis, or double lobular pneumonia, *case; ipecac.* and *bryonia*, then *tartar emetic*; cure. Intercostal neuralgia, *case;* indications for *bryonia* and *nux vomica*.

Of the Suspension of the Remedy in Chronic Diseases, and the Repetition of the Dose.

GENTLEMEN: During the consultation, a little while ago, you may have been surprised to hear me tell certain patients not to come here again for several days after they had finished taking their medicine; and also to see me stop the use of remedies in other cases. Although you may find that this practice is recommended occasionally in the prevalent system of treatment, and especially in the use of baths, it is really due to Hahnemann. Physicians who confine themselves to the use of mineral waters agree that, occasionally, it is well to suspend all treatment for a time, in order that the organism may react against the disease.

Hahnemann made use of this idea in principle when he treated chronic diseases; and homœopathic physicians, following his example, habitually give intervals of repose to their patients, during which time all medicine is proscribed. The reason offered for this suspension of remedies is that, having a duration of action that is sometimes very much prolonged, for ten, twenty, thirty days or more, this peculiarity should be respected, and not embarrassed by unreasonable interference. I regard this as false reasoning, because this duration of the action of the medicine, which is hypothetical in the

case of a healthy man, is certainly modified by the diseased condition. What does clinical experience prove to us on this very subject? That sometimes a few doses will produce an effect that will continue, without other therapeutic influence, until a radical cure is established; that, at other times, a single dose of medicine has improved the patient's condition, and would have cured him if it had been persistently taken.

For example, one gramme of the sulphate of quinia may cause an apyrexia of from eighteen to twenty days in a case of intermittent fever of the quartan type; or one of fourteen days in a tertian intermittent; and of seven days in a quotidian. But, if one stops at a single dose, the fever will surely return; whereas, repeated doses may prevent the recurrence of the disease indefinitely.

How, then, should we be guided on this question of the repetition, or the non-repetition, of a medicine? It is by a knowledge of the agent and of its *modus operandi*, and not the mere duration of its action. What, in fact, *is* a remedy? It is an external agent. As in etiology, the external cause does not of itself produce the disease; so neither in therapeutics does the medicine alone effect a cure, but it prompts the organism, and gives it the necessary impulse to combat and to overcome the disease. This action of the remedy once obtained, we must stop it as soon as it has prompted nature sufficiently, or when it has set in motion the *vis medicatrix naturæ*.

But how are we to know when the proper time has come for withholding our remedies? We have two very precise and certain rules to guide us in this matter. Whenever the disease is aggravated by the medicine, suspend its use; and if the aggravation is followed by an improvement in the symptoms, do not return to the remedy until the improvement has ceased. If, after the aggravation, the patient remains in the same condition as at first, then you must change the remedy.

If the giving of the medicine causes a decided and real amelioration of the patient's condition, you should suspend it while the improvement continues. But should the disease not appear to be sensibly modified, continue the same medicine, or seek for one that is more appropriate.

There is no homœopathic physician who has not observed some remarkable cures obtained by the administration of a few doses of a well-chosen remedy. For myself, I will cite you from a number, the case of a child which came to my clinic, in *Rue de Verneuil*, for the treatment of a large scrofulous ulcer on the middle portion of the arm, and from which he had suffered for more than a year. All kinds of old-school treatment had failed. I gave him, for eight days, a potion containing several globules of *silicea*, 30th dil., two spoonfuls to be taken daily. At the end of that time, having obtained a slight improvement, I prescribed nothing further, and at the end of four weeks he was entirely cured.

I must add that this is not my practice in acute diseases, in which, as a rule, I repeat the remedy or remedies several times during the twenty-four hours.

In menstrual disorders, especially, we often find it best to give a remedy during the period, and then to suspend its use until another month has come around. Meanwhile, it may be advisable to give another and a very different remedy, or, in very exceptional cases, not to give any medicine whatever. As a rule, those remedies that are most exactly adapted to the monthly sufferings do no good, and may often do harm if given in the inter-menstrual period.—L.

After this digression on the purely therapeutic domain, I will return to the subject of our regular lecture, that is, to the sick actually within our wards, and I will commence with the case of the patient in No. 3, a woman who presents an interesting example of

Menorrhagia with an Intermittent Fever.

Hamamelis had lessened the too abundant flow of the menses, but the patient was much disturbed and weakened

by a quotidian type of fever, which returned in the evening and at night, the paroxysms ending with a copious diaphoresis. For this I prescribed the *tarentula* in the 3d trit., and from the second day obtained a marked improvement, which was followed on the third day by a complete cure of the fever. Here was an undoubted proof of the medicinal action.

In connection with this I will cite another example, which occurred last year in this hospital. The subject was also an hysterical patient, with a quotidian intermittent fever. I prescribed the sulphate of quinine for her, but without effect. Here, again, I succeeded in making a cure with the *tarentula*.

This bit of clinical experience will be of great value to our western physicians, who have long been in need of a reliable remedy for menorrhagia complicated with remittent or intermittent types of fever. We have often succeeded with *nitric acid*, 2d dec., under similar indications.—L.

Laryngeal Phthisis.

The next patient, in No. 4, is a woman with phthisis, of whom I have spoken to you before, and who has come to us now for the third time. Her disease is complicated with tubercles of the larynx. *Phosphorus* gave slight relief, and was followed by *argentum* in the 3d trit., which had formerly been given her with apparently good result, but which now has proved itself of no effect, or, at least, it has not caused a medicinal aggravation. To-day, in fact, the patient complains of very severe pains in the larynx. I have suspended the remedy, and in our next lecture shall be able to tell you whether we have been in this case dealing with a too strong preparation of the medicine, or whether the dose was insufficient.

Hysteria, with Vomiting.

The next is also an hysterical patient, a girl of fourteen years, who has not yet menstruated, and who comes to us for the relief of a bronchitis. This patient is subject to nerv-

ous and very intractable vomiting, an affection often met with in hysteria. She vomits after her supper, either immediately or within an hour, or an hour and a-half. Unlike the vomiting that arises from indigestion, and which is so painful, she does not suffer at all from nausea or uneasiness,— does not even grow pale. As a rule, such attacks of vomiting as this girl has are very rebellious to treatment. I knew a lady who was attacked with this kind of vomiting at the age of seven years, at the first appearance of her menses, and at forty these attacks still persisted. During all these years she had vomited daily, excepting (which is remarkable) when she was pregnant. Fortunately for the women afflicted in this way, they are not much enfeebled by these repeated attacks, and their general health is pretty good.

Here are the notes of the case under review:

Case XI.— Mlle. Rose, aged fourteen years, entered the hospital on the 10th of February, and left it on the 25th of February. This young girl has not yet menstruated. We have received her in ward 11, No. 3, in order to study the fits of vomiting to which she is subject, and which are characterized by a lack of pain and the absence of nausea. The attacks come without premonition. I must not omit to mention that the patient has an hysterical mother; nor to say that the girl herself is subject to perfectly well-defined attacks of hysteria. The vomiting is remittent. The epigastric region is not painful. There are no signs of engorgement, nor of a tumor. In this, as in the greater number of analogous cases, *nux vomica*, *ipecac.*, *ferrum* and *bryonia* have all failed, and it will probably be necessary to resort to hydropathy. However, I will add that if we have not been able to relieve the vomiting, we have been more fortunate respecting the menses, which latter have appeared for the first time under the influence of *pulsatilla*, 12th dil., and of *ferrum*, 12th dil., six globules in twelve spoonfuls of water, given alternately three spoonfuls each day.

The crowded condition of the hospital at this season of the year makes it impossible for us longer to retain this patient in our wards.

We have so often given temporary, and even permanent, relief, in cases of intractable vomiting in hysterical women, by putting the womb in place, that we cannot forbear counseling the reader to examine such cases very carefully as to the possibility that the trouble may depend upon a uterine deviation of one kind or another. In two cases I have seen it associated with vaginismus; and it is not very unusual as a sequel to severe and repeated cauterization of the cervix-uteri.—L.

Grave Bronchitis, alias Double Lobular Pneumonia.—**(Continued from page 35.)**

I wish now to speak of the happy cure of the infant which was brought to us two weeks ago,—a child of twenty-three months,—and which was, at the time of its admission, at the fourteenth day of a double lobular pneumonia. I do not hesitate to declare my opinion that, but for the resources of homœopathy, this child must inevitably have died. I prescribed for it, as is my practice in similar cases, *ipecac.*, 12th dil., and *bryonia*, 12th dil., to be given alternately each hour, and afterward every two hours. There was a slight improvement at the end of the first day, and that improvement has steadily increased. When the inflammation and the fever subsided I stopped the use of these two remedies, and gave *tartar emetic*, in the 3d trit., which was indicated by a very loose cough. To-day, gentlemen, this child is perfectly well.

Here are full notes of the case:

Case XII.—Marie Hamelin, aged twenty-three months, entered the hospital, where she had a private room, on the 7th of February, and left on the 29th of February.

This child, born of scrofulous parents, has never had good health. At the age of eight months she had an attack of pneumonia, which lasted three weeks, and which left her with a cough that continued for a month longer. At thirteen months she had an eruptive fever, which, from what her mother says of it, seems to have been the chicken-pox.

The child comes to us to-day with a capillary bronchitis, which is seated in the two sides of the chest. This affection began suddenly on the 30th of January, and was not preceded by any noticeable malaise. Two or three days before the ill-

ness the child had been exposed to the cold weather. A frequent cough and a violent dyspnœa were, with fever, the first symptoms of the disease. Before she was brought to the hospital the child had had a small blister applied on the left side of the back, at the base of the thorax, and she had also taken emetics. But this treatment had done no good. Her actual condition was as follows: a high fever; pulse 140, and temperature 104°, with considerable dyspnœa, a frequent cough and a flushed face. There is a sub-crepitant râle that extends from the apex to the base of the right lung; and the same râle, but less distinct, is heard in the left lung, at the base of which we note the bronchial souffle. *Ipecac.*, 12th dil., and *bryonia*, 12th dil., four globules in 125 grammes of water, one spoonful to be taken each hour alternately. The diet is to consist of milk.

February 10, twelfth day. The fever is somewhat less. Since last evening the temperature is 102.50°, and the pulse 140. The sub-crepitant râle is a little louder, the souffle persists, and there is a slight diarrhœa. The same prescription.

February 11, thirteenth day. The improvement continues. The temperature last evening was 101.50°. The souffle has disappeared. The breathing is not so oppressed, and the child has slept. The same treatment.

February 12, fourteenth day. Continued improvement; the râles diminish.

February 13, fifteenth day. Temp. 101.12°. The râles are loud; the child has an appetite and sleeps. *Tartar emetic*, 3d trit., twenty centigrammes in 125 grammes water, one spoonful every three hours.

February 14, sixteenth day. The general condition is satisfactory; the râle is greatly diminished, and the child is playful and has some appetite. Its temperature is 100.4°.

February 16, eighteenth day. The râles cannot be heard, and the child is cured.

For more than twenty years we have given *chelidonium* in a certain stage of what has been called pulmonary catarrh, infantile pneumonia, and capillary bronchitis. At first, we could not always distinguish between them at the bedside; nor are we very much wiser now. But this is certain, that the chelidonium has, in our hands, saved several little patients who had been given up to die, and to whose relief we were called either after another physician or in con-

sultation. The indication for this remedy is an excess of the pulmonary secretion, with inability to raise or dislodge it, probably through paralysis of the pneumogastric. It does not seem adapted, like tartar emetic, to re-open the hepatized air-cells. I always use the third dilution of the chelidonium.—L.

Ascites.

One word concerning the ascitic patient whose clinical history I gave you in a former lecture. Without being deceived concerning the result in his case, I believe that the use of the *china* has given him some relief. I was obliged, you remember, to make three successive tappings at intervals of three days each. Very well; since he took the china two weeks ago, I have not been obliged to resort to the trocar again. So you see, gentlemen, that, even in hopeless cases, we should not abandon the pursuit. If we cannot cure the disease, we may, at least, retard its progress, and give a respite to the poor sufferer. And to be able to obtain even this result will afford us great satisfaction.

Intercostal Neuralgia.

In concluding this lecture, I will speak of a case of intercostal neuralgia that was incident to a slight bronchitis. The pain in the side dated eight days back, when the patient entered the hospital, and it was so severe as to render it impossible for him to continue his work. He was cured of it in three days by *bryonia*. The indications for this remedy were, in this case, very precise,—pain in the side, increased by coughing, by breathing and by motion, and relieved by lying upon the affected side. In these cases bryonia is almost always a certain remedy. You have already seen, and will see more, examples of this kind in our service. In a similar case that I treated in the city, bryonia failed, but the patient, who was a young girl, did not cough at all. She was subject to hemorrhoids, and could not lie on the affected side. *Nux vomica* cured her.

In quite a number of cases, more especially in women who were inclined to phthisis, we have had excellent success in curing intercostal neuralgia with *stannum* in the third decimal trituration. The symptoms which call for this remedy are violent stitches in the chest and sides, aggravated by trying to take a deep breath, and even by the ordinary respiration; oppression from coughing; sudden, sharp, knife-like stitches, especially in the left side of the chest.

The *rhododendron*, at least in our experience, has been more efficient in pleurodynia than in intercostal neuralgia, with which it is so frequently confounded. My friend, Dr. D. S. Smith, has great confidence in the *ranunculus bulb*, in intercostal neuralgia. When the neuralgia extends to the shoulders he gives *rhus rad.*, in the 30th dil.—L.

The notes of the young man's case read as follows:

Case XIII.—Henri Daoux, twenty-nine years of age, a gun-maker, entered on the 18th of February, and left on the 22d of February. This man has always had good health, and is not a hemorrhoidal subject. He caught cold six weeks ago, and has coughed since that time. The cough has not been severe enough to prevent his working; he has no fever, and has not lost flesh. For the past week he has suffered from a severe pain at a point in the left side, and in the dorsal region, at the base of the thorax. Coughing and slight pressure increase this pain. On examination we find no abnormal sound over the lungs.

February 19. The chest has a normal resonance; inspiration and expiration are perfect; there is a slight, dry cough. One of the inferior intercostal nerves is the seat of the affection. The severe pains continue and have forced him to stop work. The pulse is 60; the appetite good. *Bryonia*, 3d dil., three drops in 200 grammes of water; one spoonful every three hours.

February 20. The patient has slept more quietly, and suffers less pain. The same treatment.

February 22. He left the hospital cured, and able to resume his work.

LECTURE VI.

SUMMARY.—Hysteria, *case;* indications for *tarentula, belladonna, hamamelis* and *hydrotherapia: case;* the hysterical delirium and *belladonna.*

Hysteria.

GENTLEMEN: At present we have three cases of hysteria in our ward for women. The first case is that of the young girl of whom I spoke to you last week, concerning the intermittent fever to which she was subject, and which I cured with the *tarentula.*

CASE XIV.—Miss Octavie Van Valbeck, aged twenty-two, a housemaid, entered the hospital on the 29th of January and left it on the 19th of March (ward 1, No. 3). This young woman enjoyed good health until the month of April, 1873. At that time she began to suffer from terrible headaches, the pain being principally in the left temple and on a level with the suborbital foramen. This headache is sometimes followed by an interval in which she is free from pain, but it rarely lasts more than two or three days. The menses are always regular, but the flow is too free, and the period arrives a few days too soon each month. The flow lasts for from eight to ten days. In the interval of the menses she has an abundant leucorrhœa. At the period the headache is intense. Since her illness the digestive organs are also affected. She has little or no appetite, and during the process of digestion, suffers from violent pains in the epigastrium that are often followed by vomiting.

She is habitually constipated, and complains of pains in the abdomen, which pains are increased by pressure. A physical examination of this patient disclosed, at the base of the heart, a valvular murmur connected with the first sound of the heart, which murmur extended along the arteries of the neck, and which evidently is an anæmic souffle.

The patient has frequent nervous attacks, that are accom-

panied by sighing, choking and crying. The conjunctiva has completely lost its sensibility to the touch and to pain, and the integument has spots of complete anæsthesia, and of an entire loss of sensibility to the touch. The patient recognizes only one point of a compass when both of them are applied, even at a distance of ten centimetres. There is also anæsthesia of the isthmus of the pharynx, with a loss of the power to excite a reflex nausea.

Belladonna, 12th dil., four globules in 200 grammes of water, three spoonfuls to be taken daily, was prescribed for her on the 12th of January. This remedy relieved the suborbital neuralgia. *Hamamelis*, 1st dil., three drops in 200 grammes of water, one spoonful every three hours during the menstrual period, had the effect of shortening its duration. They are no longer so profuse, and are unaccompanied by colic.

February 12. The patient is troubled with quotidian fever, that returns about nine o'clock every evening and lasts all night. It is preceded by a chill, and terminates in a profuse sweat. *Tarentula*, 3d trit., twenty centigrammes in 200 grammes of water; three spoonfuls daily.

February 14. The chill was neither so hard nor so long as usual.

February 16. The fever has entirely disappeared. We prescribed *arsenicum*, 3d trit., for the anæmia, which is the result of the too copious menstruation, and notwithstanding the taking of this remedy, the fever reappeared on the 19th of February. *Tarentula*, 3d trit., was again successfully used. The pains in the head, fever and nervousness would one after another disappear under the use of *belladonna*, *tarentula* and *ignatia*, but the relief was only temporary, and I finally decided upon employing hydropathy. I ordered a cold affusion to be taken night and morning.

February 26. The fever is entirely gone, and the patient is improving beyond a doubt. Muscular exercise was prescribed for the patient.

February 26. Menstruation occurred, but is less abundant and less painful. *Hamamelis*, 6th dil.

March 4. Suspend the *hamamelis*, in order to return to the cold affusion.

March 6. The patient has no more neuralgia.

March 9. She does not bear the affusion as well as heretofore. Wet sheets are to be used instead.

March 11. The improvement continues; the appetite is returning, and with it the strength and sleep.

March 13. The patient is doing as well as possible. The pharyngeal sensibility not yet having returned, we prescribed the bromide of potassium in the third trituration, and this medicine was continued up to the time of her leaving the hospital. At this time we examined her throat again, and found that the bromide had had no effect on the anæsthesia. The patient, however, leaves the hospital cured of the ills for the relief of which she entered.

In a case of this kind, especially at the age of this patient, we should do our utmost to cure her of an affliction which would not only render her, but also those about her, very unhappy. For this reason I employed hydropathy, because, in such cases, the good results are sometimes of a longer duration than those of homœopathy. The affusion consisted of three pailfuls of water, of the temperature of the atmosphere, which were poured upon her every morning; and later this affusion was replaced by the wet-sheet-pack.

The second hysterical patient is at present in No. 3 of Ward 11. She is fourteen years of age, and is subject to nervous vomiting. I spoke to you of this case in my last lecture, and told you that *pulsatilla* and *ferrum* had brought about menstruation; but that the daily vomiting still continued. (See the preceding lecture).

The third of our hysterical patients has a complication of troubles which renders the diagnosis at first a little difficult. This woman has reached the menopause. For the past eight years, at each menstrual period, she has suffered intolerable pains in the abdomen and the stomach, accompanied

by vomiting, trembling, and difficult respiration, rather than by real dyspnœa. It was during one of these attacks that she was brought to us, and I confess that I at first thought her a victim of peritonitis, or of an internal strangulation. She was delirious all night. Her condition, when I visited her yesterday morning, may be gleaned from the following history:

Case XV.—Madame Mollens, aged forty-six, entered the hospital on the 23d of February, and left it on the 20th of March.

This woman, who is of a robust constitution, has been subject to the vomiting of alimentary substances for the past seven years. The vomiting is accompanied by a sensation as of a ball rising from the pit of the stomach to the throat, producing a feeling of suffocation. She complains also of pains in the abdomen, which are increased by walking, after which she has a sense of weight in the rectum, with constant and ineffectual tenesmus. Her menstruation has been irregular for two years, the flow at times being scanty, and again very profuse. The constipation is habitual, but she has freqeunt urging to stool.

February 24. The face is flushed; the pupils are dilated; there is vomiting and constipation; the urine is scanty; there is a sub-delirium, with hallucinations. I prescribed *belladonna*, 6th dil., and, after taking a few spoonfuls, the vomiting ceased. She became calm and rational, and had an excellent night; and to-day, as you can see, the attack has passed off entirely. On account of the age of the patient, I was unwilling to make a diagnosis without some confirmatory signs to corroborate my opinion. I found these in the symptoms of cutaneous and ocular anæsthesia and analgesia, which removed all doubt from my mind. In some portions of the surface I could, with a half-open compass, provoke the sensation of a single point, when both points were applied to the skin.

February 25. Continued improvement; she has had a quiet night and day, but is very impressible. *Tarentula*, 12th dil.

February 27. The same condition and the same treatment.

March 2. The nervous attacks are much lighter, and the nights more quiet. *Tarentula*, 12th dil.

March 4. The improvement continues, and the stomach alone seems to suffer. *Ignatia*, 12th dil.

This medicine was continued until the 15th, at which time the vomiting and the nervous attacks, etc., had disappeared. The menses had returned. We prescribed the bromide of potassium in the 3d trit. Under the influence of this remedy the pharyngeal sensibility returned, and the patient left the hospital on the 20th of March, entirely relieved of all her hysterical symptoms. Since her discharge from the hospital she has several times come to the dispensary. The paroxysms had returned, but less severely than at the time of her admission to the hospital. *Ignatia*, 12th dil., and *lachesis*, 12th dil., (the latter on account of the menopause), have never failed to relieve her promptly.

In the case of this patient we have been able, as you see, to put an end to the paroxysms, and even to make it, on its reappearance, less violent than before; but we cannot prevent its return each month.

If anything in a physician's experience could convert him to the author's view that "chronic diseases are incurable," the care of a few cases of hysteria, and more especially in women at the climacteric, would be very likely to have that effect. In other diseases we are accustomed to wait for the menopause as a limit to morbid conditions, and as bringing exemption from a host of infirmities; but, in hysterical subjects, it sometimes makes matters worse instead of better. In the latter class of cases we have learned to place reliance upon *gelsemium*, *belladonna*, *macrotin* and *sanguinaria*, given in the lower potencies.—L.

The Incurability of Chronic Disease.

To save you from disappointment in the future, let me tell you that chronic diseases are incurable. Take, for example, the gout. A strict hygiene, and the proper medicines, may retard its development, or cause it to disappear, for the time being, but the disease remains latent in the organism, ready to assert itself on the slightest provocation, although powerless when the exciting cause is lacking.

For the sake of illustration, take the case of a healthy man who falls and sprains his ankle; after a few days of

rest he is well again. But let the same accident happen to a scrofulous person, and the result may be that he will have a white swelling. In the same way you may fall asleep by an open window in a railway car, and you awaken with catarrhal conjunctivitis, which you will be rid of in a week's time; but, with the same exposure, a scrofulous man, on the contrary, runs the greatest possible risk of ulcerative keratitis.

In syphilis, which is never contracted without the intervention of an external agent, there is a better chance of stopping the contagion by the use of remedies which, also, are external agents. It seems, indeed, that the nearer the disease resembles, in its etiology, the affections that are due to external causes, the more responsive it becomes to the action of remedies which, I repeat, are themselves but external agents. We have an example of this in the power of therapeutics over intermittent fever and syphilis, and in its relative lack of efficacy in typhus fever and in cancer.

My teacher, Ricord, says that we may blanch the venereal disease, but that we cannot cure it. Despite such great authority on this subject, I am not entirely of his opinion, for I believe that syphilis can be radically cured.

In conclusion, gentlemen, I would say that when we find ourselves confronted by a constitutional disorder, we should treat it, if without enthusiasm, certainly without discouragement. We may not be able to exterminate the roots of the disease, but we have powerful resources against its manifestations. And it is a great thing, if we cannot destroy the enemy, so to hold him and so to bind him as to make him practically powerless.

Asthma, with Transitory Emphysema.

I will not close this lecture without a few words in relation to the man in No. 1 of the ward on the second floor, whose symptoms are interesting from a therapeutic point of

view. This patient, stricken with very marked pulmonary emphysema, which is characterized by a whistling and prolonged expiration, presents a peculiar symptom in a frothy expectoration resembling the beaten white of an egg, without a trace of thicker mucus. This expectoration being a characteristic of *arsenicum*, I prescribed that remedy in the twelfth dilution. The indications being perfect, I obtained, as I anticipated, an excellent result. The expectoration has almost ceased, and the symptoms, both objective and subjective, of emphysema, are so much improved that I hope to see the patient able to leave the hospital in a few days in perfect health, at least for the present, for we must not forget that, in such cases, relapses are frequent.

Case XVI.—M. Houch, eighteen years of age, entered on the 25th of February, and was discharged on the 24th of March.

This patient has never had either the hemorrhoids or herpes, and was never ill until 1871. At the end of the siege of Paris, during which he suffered greatly, he began to cough. The cough, which was not accompanied by dyspnœa, was most troublesome at night. It continued for six or seven months. Subsequently the respiration became impaired, and he was often obliged to stop in the midst of his work. But the attacks of suffocation, for which he came hither, have only appeared within a year. These paroxysms occur principally at night or in the morning, but are very infrequent during the day.

On examination of the chest, the sonorousness is slightly exaggerated. The expiration is prolonged over the whole chest, but especially on the right side, with sibilant râles; the pulse is 92. The expectoration is abundant, resembling in appearance the beaten white of an egg. The patient complains of pain in the side when breathing.

February 26. *Bryonia*, 12th dil.

February 27. His condition is about the same, excepting that the pain in the side has disappeared, and there is great suffocation. *Arsenicum*, 12th dil.

February 28. Less suffocation; the expiration is not so prolonged, and there are slight râles. *Arsenicum*, 12th dil.

March 2. The dyspnœa is much less marked, and the expectoration is diminished in quantity. The pain in the side has reappeared. *Bryonia*, 3d dil.

March 4. The improvement continues; there is very slight expectoration; the pain in the side is much less. *Bryonia*, 3d dil.

March 5. No pain in the side. *Arsenicum*, 3d trit.

March 9. The prolonged expiration has almost passed away; there is a slight suffocation; the cough is infrequent, with tickling in the throat. *Jodium*, 3d trit.

March 14. The taking of the jodium was followed by profuse perspiration; but the dyspnœa remaining as severe as before, I returned to the *arsenicum*, in the third trituration. This remedy was continued until he left the hospital on the 25th of March, cured of the emphysema.

LECTURE VII.

SUMMARY.—Phthisis; indications for *sulphur* and *jodium*. Of the duality of phthisis. Dysentery; indications for *mercurius solubilis* and *mercurius corrosivus*, *ipecacuanha*, *arsenicum*, *phosphorus*, *colocynth* and *secale cornutum*: *case*. Mild pneumonia: *case*. The first stage of pneumonia is already one of hepatization. Ascites: *case* (continued).

Phthisis Pulmonalis.

GENTLEMEN: There are, in the hospital, at present, a number of consumptives, of whose clinical history I will speak to you for a few moments.

In No. 1 of the women's ward is a patient in whom the stethoscopic signs are very obscure. Fortunately these signs are supplemented by a symptom which I advise you to note very carefully, for it is almost pathognomic. That symptom is a pain which is seated in the superior intercostal spaces, and above and below the spine of the scapula.

Our patient presents this symptom on the right side; she coughs but little, and is getting better. In her case, as in many others, I have prescribed the vegetable diet with success.

In No. 2 there is a woman in whom the phthisis was preceded by pleurisy. She also is improving; she gains flesh and strength, and coughs but little, although there is a slight elevation of her temperature at night. I have prescribed *sulphur* for her, which is a remedy that has done me very good service in tuberculosis. I give it, not only to those patients who present the pathogenetic indications for it, but also empirically to such as can bear it. The symptoms that call for its employment are hoarseness, a dry cough, that is sharp, and sometimes very severe, but not paroxysmal like

that of *drosera.* There are also the symptoms in the neighboring organs, viz., pains in the head, the chest, the abdomen, stitches in the side, and vomiting, all of which symptoms militate in favor of its employment. The cough of sulphur is provoked by tickling in the throat, the same as that of *drosera;* it is excited by rapid breathing, cold air, and over-talking, like that of phosphorus. It is, perhaps, unnecessary to add that, where the patient has also a cutaneous eruption, the sulphur is still more strongly indicated.

Jodium is another remedy for pulmonary consumption. The development of phthisis has, in fact, been observed in cases of iodism, where the cough, the purulent expectoration, the hectic fever, the sweats, the œdema, the emaciation, and the diarrhœa, have followed its excessive use. Jodium is also a remedy for scrofula. You are familiar with its elective action upon the glands, which makes it especially useful in cases of scrofulous consumption. The cough that the jodium provokes is short, like that of sulphur; it is oftener loose than dry; it is accompanied by a thick mucous and puriform expectoration, that is often streaked with blood. A tickling in the throat provokes it in a number of cases; and, lastly, aphonia and the signs of laryngeal phthisis are more marked than in sulphur.

Chronic Phthisis ending in Caseous Pneumonia.

The third consumptive patient is the one who died this morning. In this case the disease was chronic, forcing the patient to come to us every year. She has hitherto remained under treatment a few weeks each time, leaving us much improved in health. This year, when she entered, you recollect I called your attention to a symptom which gave me considerable uneasiness, viz., the development of tuberculous ulceration of the larynx. This ulceration caused her pain in the throat, dysphagia and suffocation. Unhappily my pre-

dictions regarding her have proved true. I will say, however, that she did not die of tuberculous laryngitis, but of a double caseous pneumonia, which attacked her a few days ago, and which gained an easy victory over her shattered organism.

Case XVII.—Mrs. Barthes, aged thirty-eight, entered the hospital on the 6th of February, and died therein on the 5th of March.

This is the third time this patient has come to us for relief. Her disease made its first appearance three years ago. It began with coughing and emaciation. The vegetable diet, *drosera* and *sulphur* reduced the fever, which had twice compelled her to enter the hospital. She had resumed her occupation as cook, but had continued to cough and to lose flesh. Her actual symptoms were as follows: emaciation, loss of strength and dyspnœa; a dry cough, which is hoarse and painful; mucous râles, with pectoriloquy at the apex of the right lung; but there is no fever. I prescribed *phosphorus*, 30th dil., 4 globules in 200 grammes of water, three spoonfuls a day. This was given for the symptoms of tuberculous laryngitis, which symptoms had for some days complicated the condition of the patient. She was ordered a vegetable diet.

February 9. The phosphorus having had no effect, I substituted *argentum*, in the 3d trit., and then in the 30th dil. Under the influence of this medicine the condition of the larynx was sensibly improved.

February 23. She has fever; the pulse is 96. Auscultation reveals nothing new. *Aconite*, 3d dil., one spoonful every two hours.

February 25, the third day of the acute stage. She has a high fever; the pulse is 130; the temperature 104°, with dyspnœa. The stethoscopic signs are not modified by the relapse. *Aconite* in the mother tincture, 3 drops.

February 26, fourth day. Her condition is about the same. The pulse is only 112, but the temperature is 105.44°. The cough is dry and frequent. The same treatment.

February 27, fifth day. We at last find the cause of the fever. The lower part of the left lung is the seat of a characteristic *bruit de souffle;* at the same time the expectoration is

brownish and serous. The fever decreases; the pulse is 112°, and the temp. 103.64°. *Bryonia*, 4 globules in 200 grammes of water, one spoonful every two hours.

February 28, sixth day. The general improvement continues; the pulse is 72, and the temp. 101.84°. The souffle of the left side is more intense and extended. The same treatment.

March 1, the seventh day. There is a slight oscillation in the febrile movement; the pulse is 96, and the temp. 102.20°. The patient feels better.

March 2, eighth day. The intense fever has returned. Morning, pulse 120, temp. 104°; evening, pulse 116, temp. 104.36°. The right lung is invaded, and its inferior portion is the seat of a very intense souffle; with sub-crepitant râles and a souffle in the left side, which was the first to be attacked. The same treatment.

March 3, ninth day. The general condition is more and more grave, with delirium, and great dyspnœa; both lungs are involved in their inferior two-thirds. The pulse is inappreciable, the temp. 104.36°. *Bryonia*, 12th dil., and *phosphorus*, 30th dil., alternately.

March 4, tenth day. The dyspnœa has increased almost to suffocation. The temperature has fallen this morning to 103.64°. The patient died the following morning, which was the eleventh day of the acute attack.

For what reasons, gentlemen, was I led to diagnosticate this as a case of double caseous pneumonia? First of all, because this patient was evidently tuberculous, and in my opinion this particular form of pneumonia is proper to tuberculous subjects. Next, the progress of the disease, which invaded both lungs, as is almost always the case in the caseous form of pneumonia. Thirdly, the contrast between the general improvement on the fifth, the sixth and the seventh days, whilst the local condition of the left lung grew worse, and the lesion invaded the right one. Again, the character of the expectoration, which was serous and more or less dark, was such as I had already observed in caseous pneumonia. Lastly,

the absence of improvement during the critical days, which are the fourth and the seventh, as in uncomplicated pneumonia. In this case the improvement occurred on the fifth and sixth days. It is nevertheless very much to be regretted that an autopsy could not be had in this case.

I cannot let this occasion pass without saying something concerning the caseous form of pneumonia, and the question of the duality of phthisis. We do not admit the existence of a caseous pneumonia, which is to be taken, like suppuration or gangrene, as a regular termination of the hepatized stage of pneumonia. We understand by caseous pneumonia (and if we retain this term it is because it has been generally accepted), *a tuberculous infiltration following the inflammatory process.* In one word, it is not an ordinary phlegmasia that terminates in caseification, but it is the pathological mode of development of tuberculosis that begins with an inflammation of the lungs (caseous pneumonia), or by inflammation of the smaller bronchii and the vesicles (catarrhal caseous pneumonia).

The Duality of Phthisis.

We have already, in our monograph on *Cellular Pathology*, tested the value of the arguments drawn from pure pathological anatomy, and which cause us to reject the theory of the duality of phthisis. These arguments, confirmed by the most recent histological researches, are, in substance, as follows: The macroscopic and the microscopical characters of caseous pneumonia, in the first stage, do not differ appreciably from the macroscopic and microscopical characters of the gray granulation. The only differences are in the pathological mode of development, and in the seat of the lesion.

But now we wish to offer a clinical argument against the duality of phthisis. If we put aside the cases of virulent phthisis, of acute granulation, and the acute granulated phthisis of contemporary authors, as being incontestably a

tuberculous affection, we still have an extremely large class of what are very properly called tuberculous patients. These are real consumptives, because they have in the lung a lesion which ulcerates and suppurates, and which is accompanied by hectic fever, and a more or less rapid emaciation. In some of these cases the disease has set in abruptly under the form of pneumonia, or of bronchitis, but oftener it creeps on slowly and insidiously.

In a small proportion of these cases the disease is not hereditary, or, more strictly speaking, it cannot be proved that it is inherited; but the greater number of consumptives inherit the disease from their parents. Occasionally a cure is effected; but, alas! *rari nantes in gurgite vasto*, the great majority of them succumb after a struggle of a few months, or, at the most, of a few years. Occasionally the disease is limited to the lungs, but in the greater number of cases the larynx, the intestines, the pleura, the peritoneum, the meninges, the epididymis, etc. etc., are successively attacked.

This much we learn from the clinic. But what does the fanciful pathological anatomy, that originated the theory of the duality of phthisis, assert? It says, on the contrary, that the caseous pneumonia, that is to say, the phthisis without tubercles, which begins abruptly with inflammation, which has no hereditary antecedents, which never affects or involves the whole organism, and which is, in fact, quite curable, is much more frequent than tubercular phthisis. It insists that in one hundred and thirty-nine cases of phthisis there will be one hundred and twenty-three which are *caseous*, and only sixteen that are *tuberculous* (Jaccoud's Clinic). From which it is to be inferred that the greater proportion of cases of phthisis are of the *caseous* variety, with no hereditary antecedents; no constitutional symptoms; no diarrhœa, nor hoarseness, etc.; and that they are not incurable. In other words, this teaching is directly opposed to that of clinical experience.

Among the French physicians Dr. Jaccoud is the one who has defended the theory of the duality of phthisis with the greatest ability. As he is distinguished among us for his knowledge of general pathology, we will terminate this digression from our subject proper by addressing him a single question on the nature of phthisis: Why do certain cases of parenchymatous pneumonia and of bronchitis terminate in caseous phthisis? Evidently there is no anatomical reason that will explain it, because these same diseases terminate more frequently by resolution, or suppuration, and one of them by gangrene.

There is but one answer to our question, which answer is, that inflammation of the lungs and of the bronchii terminate in caseous phthisis in subjects who are predisposed to it. In order that caseification may succeed to inflammation, there must have been a preëxisting morbid condition. This morbid condition has a name, and that name is *scrofula*, and scrofula is, if I may use the expression, the mother of the tuberculous granulation and of caseification. Therefore, pulmonary phthisis, in its various forms, is always a scrofulous disease, and the duality of phthisis is, consequently, a pathological error. There are not many morbid species, but there are many forms of a scrofulous affection.

Scrofula.

Scrofula, like gout or syphilis, and like all the constitutional affections, includes a great number of morbid processes, that are characterized by a class of symptoms and of lesions, and by a proper evolution that constitute so many common diseases, all of which are included in the greater one. This is what we call the constitutional *affection*. Thus, beginning with the most certain of them, we cite scrofulous ophthalmia, cold humors, and white swellings, which are characterized by a totality of symptoms, and of lesions that have developed in

their proper order. These comprise so many different diseases; but they are none the less inseparably bound to the morbid affection, which is the scrofula. They are thus bound to it by their succession, and their alternation in the same person; by their character as a family disorder; by a certain freedom from the influence of ordinary causes in their production; and by their lesions, which are ulceration, caseification and tuberculization. Whenever these characters can be determined, we have the right to say that the affection is scrofulous. Very well; now thése characters are proper to tubercular meningitis, to acute granulation of the lungs, to caseous phthisis, and to tubercular phthisis, as well as to scrofulous ophthalmia, and to white swelling. They are family diseases; all of them succeed and alternate with other affections which are evidently scrofulous; they are all characterized by ulceration, tuberculization and caseification; all of them are, to a certain extent, independent of external causes, and all are, therefore, scrofulous affections.

One word concerning the objection that one of several affections, as, for example, tubercular meningitis, caseous pneumonia, or acute granulation of the lungs, may attack a person who has always before been in perfect health. When this occurs, it illustrates the *fixed form* of scrofula described by J.-P. Tessier, Milcent and Bazin; and if you add that white swelling and Pott's disease may occur in as spontaneous a manner as caseous pneumonia, the objection is singularly modified; for if the white swelling, which is an essentially scrofulous affection, may appear in a person of previous good health, why may not the same happen with caseous pneumonia?

Concerning the absence of heredity as a sign which is to separate caseous from tubercular phthisis, we deny the facts as they are quoted. The researches upon which they are founded have been made in the hospitals, where the family

history is almost always unknown, or, at least, where the knowledge regarding it is limited to the immediate relatives; and we must not forget that, in questions of hereditary entailment, we should search back at least as far as the grandparents, if our investigations are to be of any value. And such thorough research as this is acknowledged to be almost always impossible in hospital practice.

Dysentery.

I come now to the treatment of another disease, of which I wish to speak to you concerning a case that presents itself to our observation in the hospital. You have seen in No. 5 of the ward for women an example of dysentery that was caused by contagion. It is the case of a servant who contracted the dysentery while taking care of her mistress, who was ill of that disease. You know that Trousseau considered the dysentery to be one of the gravest, as well as one of the most contagious, of all maladies. I think that in this respect the eminent clinical teacher rather exaggerated the matter, although it certainly is a serious disease, and one that is deserving of the greatest care in its treatment.

The remedy which I have given this patient is the *mercurius solubilis*. I ordered it because the stools were small, slimy, and unaccompanied by violent colic or blood; besides, it is recommended, but empirically, especially for women; but this would not have kept me from prescribing the *mercurius corrosivus*, if the stools had been bloody.

I take advantage of this opportunity to tell you that the benefit derived from the action of mercurius in dysentery is one of the best proofs of the homœopathic law of similars. If you will study the cases of poisoning by the corrosive sublimate in Orfila or Tardieu, you will see that the acute cases resemble the dysentery in every particular. In both there are sharp colic; small, slimy, bloody stools; pain and ulcer-

ation of the anus; and, if the poisoning is very violent, there will be added to these symptoms others, such as coldness, collapse and death, precisely as in fatal cases of dysentery.

At the onset of this disease there is another remedy that should be given, especially where there is vomiting and nausea, and that is *ipecac.* This remedy is also indicated for the anal hemorrhage. There are two other medicines, likewise, which may do you great service; the first is *arsenicum*, which is to be given when the *mercurius corrosivus* proves insufficient, and when your patient's strength is waning; and where there is thirst, sinking, great internal heat and fœtid stools, you may prescribe it with effect, not only internally, but also by injections of the third, and even of the second, trituration; 20 centigrammes in 200 grammes of water.

The other remedy is *phosphorus*, the indications for which are very similar, but which is most successful in grave cases of malignant dysentery, where the patient's condition is very serious. There is one symptom which particularly calls for its use, and that is paralysis of the sphincter, relaxation of the anus, and the prolapse of the rectum after each stool.

I will not weary you with quoting the indications for other remedies, such as *colocynth*, which is especially called for where there are green, slimy stools, with the glairy coating of green bile; nor for the *secale cornutum*, which is a less important remedy. It is better at first not to overload the memory, lest we render it unfaithful.

Case XVII.—Nathalie Adnaut, a domestic, aged twenty-three years, entered the hospital on the 27th of February, and left it on the 7th of March. In this case the disease was developed by contagion, the patient having for several days previous taken care of her mistress, who was ill of the dysentery.

The attack was preceded by a day of general discomfort and feverishness.

February 27. She has violent colic, which is accompanied by frequent desire to go to stool. The discharges are frequent, but without tenesmus or griping. The first day the discharges were a little bloody, but afterward they consisted almost entirely of slime.

February 28. Has had three evacuations during the night, and the same number during the day. The pulse is 72, and the temp. 102.20°. *Mercurius sol.*, 6th dil., two drops.

March 1. She has had but three stools. The temperature is normal. The same treatment.

March 2. No more evacuations. The same treatment.

March 6. The patient has had two stools, but no colic, and no thirst or tenesmus. *Bismuth*, 2d trit.

March 7. The discharges have ceased again, and the patient leaves the hospital cured.

We have recently treated a case of dysentery, with peculiar complications, that is worthy of record. The patient, a very intelligent man, aged forty years, of general good health, a man of family and addicted to no excesses of any kind, was seized with acute articular rheumatism. He was persuaded to send for an old-style prescriber, who, it appears, attempted to carry off the disease by hypercatharsis. The poor victim afterward told me that he had had twenty-eight stools in rapid succession, and that he had vomited several times besides. The stools at first consisted of natural fœcal matter, but finally contained nothing but slime and blood. The dysentery was quite prevalent at the time (August), but he had never had any symptom of this kind until after taking the drastic cathartic. The tenesmus and the frequent, slimy and bloody stools had continued for eight days, but the rheumatism had not abated when I first saw him. His sufferings were greatly aggravated at night, and by motion, and the perspiration was very copious and almost constant.

Under *bryonia* in the 3d dil., and *mercurius sol.*, 3d trit., given in hourly alternation, he improved steadily and both sets of symptoms gradually disappeared. He made a good recovery.

There is a form of dysentery which follows an epidemic of Asiatic cholera, and which sometimes comes in the autumn, after we have had a great deal of cholera morbus during the summer months, for which the *veratrum alb.* is almost a specific in the case of adults, and the *angustura* for the same disease in infants and young children. We had a large experience in this type of dysentery in Chicago in the year 1854.—L.

Mild Pneumonia.

Before concluding this lecture, I wish to say one word to you regarding a case of mild pneumonia; the patient is the man in No. 5.

Case XIX.—M. Malmert, fifty-four years of age, a steel engraver, entered our wards on the 27th of February, and left us on the 9th of March.

This man is decidedly corpulent, and has never had a severe illness. During the winter he has contracted a cold every two or three years, which would generally last about a fortnight, and which was accompanied by fever and dyspnœa. About the 15th of February last he suffered repeatedly from slight attacks of fever. On the 21st of the same month he was seized with suffocation, which for two days had been preceded by a pretty severe stitch in the side and back of the chest.

A physical examination of the patient disclosed dullness in the lower third of the left chest. At this point fine crepitant râles may be heard at the close of inspiration, but there is no souffle. Over the remainder of the chest, and especially upon the right side, there are sub-crepitant râles. The expectoration is rusty and adhesive.

February 28. No fever; pulse 92; rusty sputa; crepitant râles on the left, and sub-crepitant ditto on the right. *Ipecac.* and *bryonia.*

February 29. The physical condition of the lung is the same; the sputa continue to be rusty. The same treatment.

March 1. There is no change. The temperature is 99.30°, and the pulse is 92. The same treatment.

March 2. There is complete insomnia; the cough has slightly diminished; the apyrexia is complete, excepting the pulse, which was 96 in the evening and 72 in the morning. The same treatment.

March 3. The expectoration is less colored; the patient has slept, and the pulse is 84. The same treatment.

March 4. The expectoration is only slightly colored, but viscous; the cough is loose and the patient sleeps. *Tartar emet.*, 3d trit., twenty centigrammes.

March 5. On examination we find crepitant râles at the base of the left lung, but on the right side the râles are sub-crepitant. There is no souffle.

March 6. The improvement continues; the râles grow louder and less humid. *Bryonia*, 12th dil.

March 9. The expectoration continues, but is less in quantity, and the nights are good. The loud râles of bronchitis are heard in the chest. The patient wants to leave the hospital. The same treatment.

March 14. He left cured.

Andral's Clinique contains seven cases of pneumonia in which auscultation showed nothing but crepitant râles. The same symptoms were noted, as in our patient, *id est*, rusty and viscid expectoration; pain in the side at the onset of the attack; noticeable dyspnœa, and a slowness in the evolution of the symptoms. This is what Laënnec called pneumonia in the first degree, and which is characterized, anatomically, by pulmonary obstruction, the second degree corresponding to hepatization.

We have always protested against this error of pathological anatomy, and have always taught that, although it is true that the crepitant râles correspond to the first period of the inflammation of the pulmonary tissue, nevertheless, from the first, this inflammation is neither an obstruction nor a simple congestion, but an induration, that is to say, an hepatization. The last experiments of M. Cornil, on the production of the crepitant râles, have demonstrated that this symptom really answers to an induration of the tissue.

Ascites.—(Continued from pages 16 and 51.)

You have not forgotten our ascitic patient, in whose case, as you know, I made three punctures at intervals of as many days. Under the influence of china, 6th dil., this patient made a steady improvement, the liquid reproducing itself very slowly. His general condition improved every day, until, on

the nights of the 24th and 25th of February, he caught a severe cold through the ward being chilled. This was followed by an attack of bronchitis, which developed into pulmonary tuberculosis, of which he died on the 4th instant. Here is the remainder of the case in detail:

Case II.—February 10. The ascites appears to have been arrested in its progress; the appetite and strength have returned, and there is no cough. *China*, 6th dil.

February 15. Continued improvement; the abdomen is slightly swollen, but the general condition is very satisfactory. *China*, 6th dil.

February 20. Better, with free perspiration. *China*, 6th dil.

February 25. In consequence of taking cold the cough has returned. There is a copious expectoration, which is thick and streaked with blood. On auscultation, mucous râles may be heard over the entire chest, and there is rapid sinking. *Ipecac.*, 3d dil., twenty centigrammes.

February 27. The expectoration is puriform and very abundant, with dyspnœa and humid râles; the pulse is 108, and the temp. 102.56°. *Tartar emet.*, 1st trit., twenty centigrammes.

February 28. The patient is much worse, and the mucous râles are very abundant in the chest. *Arsenicum*, 6th dil., two drops.

March 3. There is no expectoration, but a quiet delirium; the pulse is 108, and the temp. 104°. *Kermes'*, 1st trit., twenty centigrammes.

March 4. The patient is dead.

LECTURE VIII.

SUMMARY.—Interstitial nephritis: *case*. The diagnostic indications for *arsenicum*, *phosphoric acid*, *belladonna*, *cantharis*, and *plumbum*, in albuminuria. Of certainty in therapeutics. Puerperal phthisis; great improvement; indications for *phosphorus*, *sulphur*, and *drosera*. The vegetable diet.

Interstitial Nephritis.

GENTLEMEN: We have, at present, in our ward for women, (ward 2, room No. 3,) a patient whose case merits our attention. This woman is forty-nine years of age, and has been subject to a diarrhœa during the last twelve or fifteen years. Little by little her constitution has given way, until now she presents all the symptoms of interstitial nephritis. The case in detail is as follows:

CASE XX.—Mrs. Lalouette, aged forty-eight, entered the hospital on the 10th of May. She is greatly emaciated; the complexion is pale and of a grayish hue, and the strength is almost gone. For eight or ten years she has suffered from a diarrhœa, which has resisted all kinds of old-school treatment, and which, little by little, has destroyed her constitution. Notwithstanding this, she has continued to work until last year, when she came to be treated under the service of the lamented Dr. Milcent. A short time after, she left the hospital quite well, and it was this successful resort to homœopathy in her case that has brought her to us again, a year from that time. Her present symptoms are, great emaciation and feebleness; loss of appetite; excessive thirst both day and night; the flow of urine is very abundant, watery, with a specific gravity of 1.010, and albuminous. There is no œdema at present, but at the beginning of the year her face was somewhat bloated. The heart is hypertrophied, and the apex-beat is outside of the line of the nipple. The radial and temporal arteries are

ossified; the respiration is natural, and there is occasionally some diarrhœa.

She reports that the thirst and the copious urination began three years ago.

March 11. I prescribed *arsenicum*, 3d trit., twenty centigrammes in 200 grammes of water; one spoonful every three hours.

March 17. There is less thirst; the urine not so abundant, and the patient feels strong; but still the urine has the same specific gravity.

March 26. There is a general improvement; the urine is the same. *Arsenicum*, 1st trit.

April 1. The patient is better; her strength returns, slowly to be sure, but she has an appetite and drinks less; the urine is less abundant, but of the same specific gravity. *Phosphoric acid*, 3d dil., three drops.

This medicine was continued until the 15th of April, when I left the patient in the care of Dr. Frédault.

You are aware, gentlemen, that besides Bright's disease, or parenchymatous nephritis, there are two other lesions of the kidneys, *id est*, one that is called interstitial nephritis, and which is characterized by a pathological development, or, in the language of the day, a proliferation or hypergenesis of the connective tissue of the kidney. This hypergenesis is followed by atrophy of the glandular tissue, which, in the midst of the morbidly exaggerated production, is compressed, and ends by becoming atrophied. The other lesion to which I have referred is the amyloid degeneration of the kidney. This is rarely found in any but scrofulous or rachitic subjects, and in them only after chronic suppuration.

In the case that now claims our attention the disease is interstitial nephritis, with the following symptoms: excessive thirst; the urine is very abundant, as in diabetes, with considerable albumen in it, more especially during the last few days; absence of œdema, which, considering the length of time since the disease began, excludes the idea of Bright's

disease. As in almost all similar cases, we observe the co-existence of hypertrophy of the heart and of ossification of the arteries.

The treatment in such cases is very difficult, as it always is where there is an organic lesion. However, I prescribed *arsenicum*, which, you know, is very well indicated in albuminuria, and which, in this particular case, corresponded perfectly to the thirst, the debility and the emaciation. In fact, you are aware that in all cases of chronic arsenical poisoning, albumen is found to be present in the urine. When the poisoning is acute, there is not only albumen, but hemato-globuline in the renal secretion. Arsenicum is, for that matter, the remedy that should be called for in albuminuria.

In acute cases that are characterized by bloody urine and pain in the loins, I prefer *belladonna* at the beginning, and afterward *cantharis*. This last medicine is perfectly homœopathic, for every one knows that the application of a fly-blister may cause renal congestion, accompanied by slight albuminuria, by renal pains, and difficult and infrequent, and sometimes bloody, urination. As for chronic nephritis, I combat it with *arsenicum* and *plumbum*. The lead preparations also, in cases of poisoning by them, produce a condition which is very analogous to that of persons who are afflicted with chronic albuminuria, for their urine is often albuminous.

Besides these remedies we venture to suggest the use of *mercurius corrosivus* in the third or the sixth attenuation. There is, we believe, no remedy to compare with it for puerperal albuminuria, and for renal disease that has been caused by the abuse of alcoholic liquors. Bæhr says, very truly, that the renal symptoms in case of poisoning by the *merc. corr.* are almost as characteristic as are its dysenteric symptoms.

Where hypertrophy of the heart coëxists with interstitial nephritis, or, indeed, with either form of renal inflammation, the patient cannot improve while he continues to live in the rarefied air of the mountains and of the higher altitudes. Some of our cases have been wonderfully benefited by a change of locality. In our experience, railroad men and commercial travelers are quite subject to interstitial nephritis.—L.

Certainty in Therapeutics.

A short time ago you saw me prescribe drosera to the patient in No. 2 of the woman's ward, who is a consumptive. This remedy corresponds to the spasmodic cough that is provoked by a tickling in the throat, and which is accompanied by vomiting. It is a precious remedy, not only for the relief that it gives to the sick, but also because it serves to demonstrate what I call *therapeutic certainty*. This term is a double one, and includes the positive knowledge of the disease on the one hand, and the equally positive knowledge of the curative agent on the other. If you are not thus doubly certain, you cannot know what effects to attribute to your remedies.

Now, gentlemen, it is to Hahnemann again that we are indebted for this positive knowledge of therapeutic agents, for he was the true founder of the experimental Materia Medica. Undoubtedly you will find indications of this method before his time, for Pliny, in the days of the ancients, observed the effects of aconite on a healthy man; and Storck, a long time after, followed in the same track.

But all this was only a presentiment, if I may so express myself; and, if you compare their crude attempts with the homœopathic formula, and the pathogeneses of the hundred medicines that we owe to the almost superhuman efforts and patience of Hahnemann, you will at once concede that to him alone is due the honor of this therapeutic reform.

But it is not sufficient to know the positive effects of our remedies. We must also know with what disease we have to contend, and when this is settled we must further know what is the form and the variety of the disease, for without all this our statistics will be of no value. If you are treating the typhoid fever, and wish to prove the effect of a remedy in shortening its duration, you must note the form under which it presents itself to you, for if it is left alone, the milder form of this

disease will cure itself in from fourteen to seventeen days; or the common form in from twenty to twenty-four days; while the protracted type of this fever may run to forty or even to sixty days.

The same distinctions are necessary in cases of pneumonia, which, in spite of the non-dangerous character that some of your teachers have ascribed to it since they have witnessed the marvelous effects of homœopathy in its treatment, still shows in the official statistics of the Paris hospitals, a mortality of from twenty-five to thirty in one hundred.

When you can distinguish the morbid species, their forms and varieties, their epidemic character and their medical constitution, and when you know the positive effects of your remedies on a healthy person, then you may claim to possess the elements of this *therapeutic certainty.* Without this, whether allopathic or homœopathic, your experience will bear the stamp of uncertainty and of deception.

Illusions and uncertainties concerning the action of remedies form that portion of traditional therapeutics which the immortal Bichat has declared in these words, and upon the meaning of which, our opponents would do well to reflect:

"An incoherent assemblage of opinions, themselves incoherent, the Materia Medica is, perhaps, of all the physiological sciences, the one which best portrays the caprices and whims of human nature. What do I say? To a methodical mind it is not a science; it is a mass of unformed and of inexact ideas; of observations that are often puerile; of illusive means; of formulæ that are as oddly conceived as fastidiously gathered together. It is said that the practice of medicine is repulsive. I say more than this, that to the mind of a reasonable man, the principles of the greater part of our Materia Medica are irrational."

Such, gentlemen, was the justly severe language of the celebrated teacher of whom the faculty are very proud; and it is in

the name of the therapeutics which he so ably cauterized, that we are persecuted, when our only object has been to rescue it from the chaos in which it was buried. We have not only had to do battle on scientific, but also on professional, grounds. . . . And these attacks have been conducted by men who know us perfectly well; men who have been our colleagues and rivals in the *concours*, in the faculty and in the hospitals, and who have neither had courage enough to embrace the truth, nor sufficient modesty to keep silence.

Pleurisy, followed by Phthisis.—(Continued from page 34.)

The concluding history of the case of consumption that was preceded by pleurisy in a lying-in woman is as follows:

Case IV.—Under the influence of *arsenicum*, 12th dil., the general condition of this patient improved. Since the 5th of February she has taken *phosphorus*, 30th dil.

February 11. The cough has perceptibly diminished; the fever is still high; it returns about three o'clock. The temperature reaches 103.10° and 104°; in the morning it is 101.30°. The pulse is 88. *Phosphorus*, 6th dil.

February 16. The cough has increased each day since giving the *phosphorus*, 6th dil.; at the same time the morning temperature has raised to 102.20°. We suspect a medicinal aggravation, and suspend the remedy.

February 17. She coughs less often, but the temperature remains the same.

February 18. The patient improves, coughs less, is stronger, and she does not realize that she has the fever, which, as you know, is one of the peculiarities of hectic fever. Return to the *phosphorus*, 30th dil., instead of the 6th.

February 23. Continued improvement; she coughs but little, eats and sleeps well, and, despite a meagre diet, her strength returns; the temperature has fallen three-fourths of a degree. *Phosphorus*, 200th dil.

February 25. The temperature is again 102.20° in the morning, and in the evening 104°; the cough is not increased. I prescribed *sulphur*, 30th dil.

February 27. Notwithstanding the hectic fever, the general improvement continues. The temperature varies slightly; in the morning it is 102.20°, and in the evening 103.64°; but the patient coughs much oftener. I suspend the remedy.

February 28. The cough has diminished, and we return to the *sulphur*.

March 2. The cough has increased and is spasmodic; it is caused by a tickling in the throat. *Drosera*, 3d dil., three times a day.

March 7. She coughs less since taking the *drosera*. The strength, the appetite, the general condition and the flesh return and are improved; the patient no longer thinks herself ill. There is still, however, an abundant expectoration and loud mucous râles in the apex of the right lung, but more especially in that of the left one. The evening temperature varies from 102.20° to 104°.

This patient left on the 14th of March, believing herself cured. I saw her two months later. She was still feeling well, but I could not make a local examination.

I wish to call your especial attention to the aggravation of the cough in this case by *phosphorus*, 6th dil., and also by *sulphur*, in the 30th dil.

You see, gentlemen, that even in the gravest cases, consumption can be arrested without resorting to quinine, to alcohol, to beef-juice, or to any of the so-called tonics that have so multiplied for the relief of a theoretical debility.

We very much regret that the author did not have more to say concerning the puerperal pleurisy, for, even in private practice, we are persuaded that it is more common than is generally supposed. Hervieux, after speaking of the professional indifference to this subject, says, in his *Traité clinique et practique des Maladies Puerpérales suites de couches*, page 901: "This fact is all the more remarkable because, after peritonitis and phlebitis, pleurisy is one of the most important of all the manifestations of the puerperal poisoning,—important from its danger, not less than from its frequency in certain epidemics."

This case in Dr. Jousset's clinic is typical. It illustrates one of the principal dangers from pleurisy in lying-in women. The class of patients which is most likely to have it are those who are predisposed to phthisis, and in whom the development of tubercles has been at a stand-still during gestation. Wheth-

er the drain and strain of labor have so reduced the general strength as to supply the conditions that favor a relapse of the pulmonary trouble, or if the revulsion from the uterus in the early puerperal state is the cause of it, we cannot say. It is certain, however, that pleurisy in this class of puerperal women is very much more serious than when it occurs in the idiopathic form, outside of the lying-in chamber.

In such patients, pleurisy always tends toward the development of acute phthisis. The latter drifts rapidly into the typhoid state, and the patient is an easy victim to a galloping consumption. We are firmly of the opinion that a considerable share of the cases of death reported as from puerperal fever, and from typhoid fever also, during the lying-in, are, and have been, cases of this kind.

The true prophylaxis of pleurisy, pleuro-pneumonia and phthisis in childbed is to see to it that the patient, whether in the hospital or at home, has a plentiful supply of fresh air; that she has good, healthy, nourishing food, and enough of it; that she is not exposed to causes that would produce a chill; and that, if there is the slightest symptom of either of these affections, she has *bryonia*. This remedy is especially useful about the time that the flow of milk is established, or when the patient is passing through the period that is vulgarly known as "milk fever." The *rhus toxicodendron* seems, in general, to be better adapted to puerperal inflammation of the peritoneum than to that of the pleura.—L.

LECTURE IX.

SUMMARY.—Acute articular rheumatism; indications for *chininum sulph.*, *china*, *aconite*, *mercurius* and *bryonia*. Chronic rheumatic endocarditis: *case*. A new example of medicinal aggravation; indications for *cactus* and *aconite*. Indications for *aconite*, *pulsatilla and ipecac.* in rubeola, and for *ipecac.* and *bryonia* in the grave bronchitis of measles. Hysteria and the *bromide of potassium*. Asthma and its treatment by *iodine*. Chronic aortitis: *case*. Indications for *nux vomica*, *bryonia* and the *arseniate of antimony*.

Acute Articular Rheumatism.

CASE XXI.—Marie Maissoneur, aged twenty-four years, a domestic, entered the hospital on the 17th of March, and left it on the 15th of April.

A month ago this patient first felt a pain in the knee, which lasted only one day. She continued to work until the 13th of March, when she was seized with quick, sharp pains in the knee and in the hip joint.

March 17. She has pains in the wrists and elbows, but they are less severe than in the leg; there are no hereditary antecedents; she has been subject to headaches for two or three years. The evening temp. is 102.20° and the pulse 120.

March 18. Morning temp. 99.68°, pulse 80. The pain is principally in the articulations of the legs, but there is neither redness, swelling nor perspiration; the heart-sounds are perfectly normal, but she has headache and loss of appetite. Evening temp. 101.48°, pulse 88. *Chininum sulph.*, 3d trit.

March 19. Morning temp. 100.76°, pulse 84. The hands are a little swollen; the heart continues healthy. Evening temp. 102.20°, pulse 92.

March 20. Morning temp. 100.4°, pulse 72. She has had a good night. *Chininum sulph.*, 3d trit. Evening temp. 101.48°, pulse 100.

March 21. Morning temp. 100.40°, pulse 84. Some diarrhœa, and pains in the extremities between the joints. *Chininum sulph.*, 2d trit. Evening temp. 101.48°, pulse 100.

March 22. Morning temp. 100.40°, pulse 84. Continue the same treatment. Evening temp. 100.76°, pulse 88.

March 23. Morning temp. 101.48°, pulse 72. The patient sleeps well, and suffers much less. The same remedy. Evening temp. 100.40°, pulse 72.

March 24. Morning temp. 100.40°, pulse 68. The evening temperature was the same. The patient is doing very well, and from this time continued to convalesce.

March 27. The patient is up. Although the slight articular pains persist, the general condition is very satisfactory. *Colchicum*, 3d dil.

March 31. She has abdominal pains from over-exercise; the joints are somewhat painful; she is unable to be up very long. *Rhus tox.*, 3d dil.

April 2. Since returning to her bed the patient is much better. *China*, 12th dil., was given, and continued until she left, cured. This was on the 15th of April.

Concerning this patient, I wish to call your attention to the individuality of the case, which presents two clinical peculiarities. The first of these is the slight swelling of the joints, and the second, the absence of the habitually profuse sweats. You know that the progress of acute articular rheumatism is uncertain, and is not cyclical, and that it may last for six weeks as well as for one week. There is no therapeutic certainty by which to judge of the promptness of its cure.

If we were always careful to report only those cases in which the course and duration of the disease have been modified by our treatment, it is very probable that we should not have very much to say of our success in curing rheumatism in any of its forms. The most that we can do is to mitigate its severity, and to abort its sequelæ; for in this affection, as in the eruptive fevers, the complications and the sequelæ are largely, if not entirely, under the control of our remedies; and, all things considered, they really constitute the most serious and troublesome parts of this painful affection.—L.

I prescribed *Chininum sulph.* for this case on account of the remittent type of the fever, as shown by the variations in the temperature and the pulse between morning and night.

You observe in this case that *chininum sulph.* succeeded very well, and that our patient was convalescent on the seventh day of the treatment, which was the ninth or the tenth day of the disease. This convalescence, which in rheumatic patients is so perilous, was passed by her with but very little trouble. However, she walked a little too much in the ward, and I was obliged to send her to bed again. *China* effected the cure, and the patient left the hospital after a stay of less than a month. I do not hesitate to claim that in the duration of the disease, as well as in the convalescence thereof, this case may certainly be considered a success.

The chininum sulph. is the remedy that I habitually prescribe for acute articular rheumatism, and it corresponds as china does to articular pains with swelling and redness, and above all, to an intermittent or remittent type of the accompanying fever.

When this fever is very intense and continuous, the pulse full and strong, the face red, the thirst very great, and the patient anxious, *aconite* is the principal remedy.

Mercurius is best indicated by profuse sweats, paleness of the face, and the aggravation of the pain during the night.

Bryonia is frequently employed by homœopaths in the treatment of acute articular rheumatism, with inflammation of the larger or of the smaller joints, with a pale or red swelling, moderate fever, and aggravation of the pain by the least movement.

China affects the same parts as the chininum sulphuricum. You have seen me prescribe it for this patient when the fever had completely disappeared. This is the time for its administration in acute articular rheumatism. You will often see me prescribe it for the arthritic gout.

Chronic Rheumatic Endocarditis.

Case XXII.— Louise Pommier, thirty-eight years of age, entered the hospital on the 9th of May, and left it on the 18th of the same month.

This girl, who has a wretched constitution, came to us complaining of palpitation and suffocation. She has never had good health, and, during her infancy, had symptoms of scrofula.

From the time that her menses were established, she has had leucorrhœa in the intervals between the periods, and symptoms of chlorosis, *id est*, headache, dizziness and palpitation.

Ten years ago she had an attack of general rheumatism. After that attack, and since that time, she has had very decided palpitation of the heart. Paroxysms of suffocation and of choking have made it impossible for her to do any hard work. She has never had a cough, and the physical examination of the lungs gave a negative result.

Her present condition is as follows: She has palpitation on the least motion, and a very sharp pain at the apex of the heart. There is roughness with the first sound of the heart; a very decided purring tremor at its apex,and the organ is decidedly hypertrophied.

On questioning the patient, we learned that the palpitation and the pains which she had had about the heart before the attack of rheumatism, and which were due to the chlorosis, had been considerably increased by the rheumatism.

The diagnosis is very easy. There is insufficiency of the mitral valve, which is a sequel to the rheumatic endocarditis, and a compensating hypertrophy.

May 9. *Cactus grand.*, 1st dil., ten drops in 200 grammes of water; one spoonful every three hours, with an ordinary diet.

May 11. The patient complains of insomnia, and of sharper pains in the heart. No prescription.

May 12. She is improving. We resume the *cactus*, 1st dil., but four drops only, instead of ten.

May 13. The aggravation is the same as with the ten drops. We suspend all medicine for forty-eight hours. Improvement

followed, with a better night, and a diminution of the pains, the palpitation, and of the suffocation.

May 16. Resume the *cactus*, 1st dil., four drops.

May 18. There is no perceptible aggravation, but, on the whole, the condition of the patient is about the same that it was a week ago. We prescribed *aconite*, 1st dil., and afterward the 30th dil. This last potency calmed the pains and the palpitation; the purring tremor disappeared; the souffle persists, but is less obvious, and the patient left the hospital much improved.

The absence of all the signs of the cardiac cachexia, notwithstanding the gravity and duration of this lesion, makes this case a very interesting one. This woman is really thin and anæmic, but she was so before she had the rheumatism, and owes the relative immunity from which she has already profited to the compensating hypertrophy of the heart. This hypertrophy has made the arterial pressure equal to the venous pressure. But the day on which this equilibrium is lost, the cachexia will make its onset.

You will readily understand that the treatment of this case is very difficult. A valvular lesion of ten years' duration does not offer a chance for a very brilliant success in therapeutics. All that can be done is to try and relieve the general condition of the patient, to wrestle with the valvular lesion, and so to delay the development of the cachectic stage. As for curing the organic trouble, we need not think of it.

I prescribed the *cactus grandiflora*, which is strongly indicated in affections of the heart of a rheumatic nature; and here we have another case of medicinal aggravation from the effect of this same remedy. From the first day that she took it, the patient suffered from palpitation and insomnia. We suspended the remedy, and she improved. In two days more we prescribed it again, and with the same result. I thought it best, however, to persist with the *cactus*, and have, therefore,

given it until within the last few days, when it was replaced by *aconite*, which is a powerful regulator in cardiac affections. As a matter of fact, I have experimented upon rabbits with the *aconite*, and have found that by the injection of the lower potencies, I almost always caused lesions of the mitral valve.

The Remedies in Rubeola.

Regarding the treatment of the young man who has the measles in the common form, and who to-day enters upon the convalescent period of that cyclical disorder, without having presented any other symptoms than a few attacks of bleeding at the nose and a slight diarrhœa, I wish to say a few words concerning the treatment. In such cases it is my habit to prescribe *aconite*, and to continue its use as long as there are no complications. Fever, thirst and redness of the skin are its principal indications, and I usually prescribe it in doses of a few drops of the 3d dil. put into 200 grammes of water, one spoonful to be taken every three hours.

Pulsatilla would be preferable in cases where there is otalgia and no thirst. When the epistaxis is very profuse and recurrent, the tampon may be necessary, but I believe that you can almost always stop the bleeding with *ipecac.* Finally, gentlemen, you are aware of the serious nature of capillary bronchitis, that is incident to this disease, which is called rubeolous pneumonia, and which Trousseau considered as frequently fatal; but, since I began to use homœopathic remedies, and that is a long time ago, I have yet to meet with a failure in these cases. Our treatment is really heroic. It consists in the employment of two remedies, viz., *ipecac.* and *bryonia* alternately every two hours. I always give them in the 12th dil. I will not say that this method is infallible, but I do insist that it is remarkably successful.

Remembering that *cuprum aceticum* is one of the very best remedies for symptoms growing out of a repercussion of the eruption in measles, we have

been in the habit for some years of prescribing it, in bad cases, as a prophylactic of this very condition. We begin with it on the second day of the eruptive stage, and repeat it about three times daily in alternation with whatever remedy is indicated for the incidental symptoms. Our preference is for the 6th dil.—L.

The Bromide of Potassium in Hysteria.

The two hysterical patients in Nos. 3 and 8 of the women's ward will leave the hospital in a few days. I have given them of late the *bromide of potassium*, which presents, in its pathogenetic effects, the absence of reflex nausea, when the finger is introduced into the pharynx, a symptom that most hysterical patients are certain to have. In one of these women (No. 8) the use of the *bromide* in the 3d trit. stopped, at least for the time being, the reflex nausea, which fact affords another illustration of the law of similars.

Asthma.

Our asthmatic patients are less numerous than formerly. The woman in No. 6, who had transitory emphysema, has been cured by *arsenicum*. The man in No. 1 of the men's ward, who was also ill with a transitory emphysema, and whose sputa were frothy and like the beaten white of an egg, indicating *arsenicum*, has also been cured, as you know, by that remedy. In order to hasten his cure I gave him *jodium*, but without any marked result, and we therefore resumed the *arsenicum*. My reason for prescribing the *jodium* in this case was because Trousseau had observed that patients to whom he had given it had a prolonged and sibilant respiration which he attributed to iodism; and I thought that if it caused these symptoms, it should also cure them. Since, however, having read Rilliet over again, I can find no notice of such a result. The remark of Trousseau should, for the present at least, be accepted with some reservation. We must wait until further research has settled the question.

It is only just to say, in this connection, that an American

quack and a French pharmaceutist, M. Aubré, have warmly praised the value of the *iodide of potassium* in large doses in the treatment of asthma. This remedy has been unsuccessful, so far as I have seen and read of it, as all medicines must be for the employment of which we have no positive indications.

Gout — Chronic Aortitis — Emphysema — Hemorrhoids.

Our next patient will need to remain for a longer time in the hospital.

Case XXIII.— Mrs. Renaudin, aged seventy years, entered on the 9th of March and left on the 4th of April.

This woman has had good health. She has borne eight children, and her confinements have never been followed by any of the puerperal diseases.

About seven years ago she commenced to have pains in the right side of the base of the chest, and breathing became less easy and free than natural. For three or four years past she has had hemorrhoids, and the loss of blood, which was sometimes very profuse, brought relief.

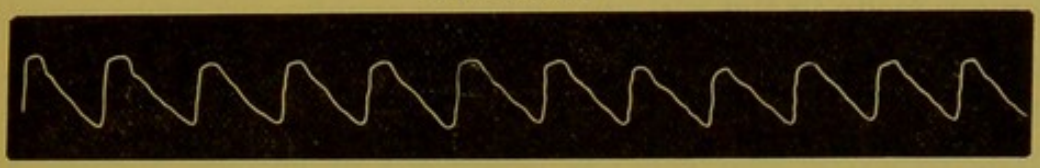
In 1872 she had an attack of acute bronchitis which kept her in bed for five months. At that time the dyspnœa, of which she had already complained, became more intense; the fits of suffocation, that were much more frequent in winter than in summer, came very often, but did not last long; she had some palpitation; she is habitually constipated, and the bowels are never moved except by enemata.

Present condition: The patient has suffered for the last eight days from a pain in the right side of the chest. Since this began she has coughed and raised a great deal. On examination of the chest we find the signs of a transitory emphysema,—exaggerated sonorousness and prolonged expiration, accompanied on both sides by moist râles.

There are no abnormal cardiac sounds, but there is a very marked arching of the chest in front of the sternum (*voussure présternal*). There is a dullness that extends from the right of the sternum on a level with the aorta, and which measures nearly six centimetres. With the second aortic sound, there is

a little murmur; the radial arteries are ossified, and therefore it is not difficult to diagnosticate aortitis with ossification and dilatation of the aorta. The nights are restless. The sphygmographic tracing corresponds with the physical signs; the ascending line is vertical, the horizontal one is very pronounced, and the descending trace is a little oblique, with slight dicrotism.

Trace No. 6.



This woman complains most of the hemorrhoids, which bleed and are very painful, and of a terrible constipation. *Nux vomica*, 12th dil., six drops in 200 grammes of water; one spoonful to be given her every three hours.

March 12. The patient complains a great deal. *Arsenicum*, 12th dil., in the same manner, and an injection of cold water.

March 14. The nights are better; the oppression is diminished, but the hemorrhoidal pains continue. *Nux vomica*, 30th dil., four globules in 125 grammes of water; three spoonfuls during the day.

March 18. The hemorrhoidal suffering has lessened within twenty-four hours, and to-day the pains are almost entirely gone. *Ipecac.*, 3d trit., was prescribed for the catarrhal expectoration.

March 21. The habitual pain in the right shoulder is more intense; the expectoration is less free. *Bryonia*, 3d dil.

March 23. This morning there are signs of gouty arthritis in the fingers of the right hand, and in the right shoulder. *China*, 12th dil., six globules in twelve spoonfuls of water; three doses a day.

March 26. The pain has greatly lessened. We prescribe the *arseniate of antimony*, 2d trit., twenty centigrammes in 200 grammes of water; one spoonful every three hours.

March 31. Great improvement; the patient scarcely coughs at all; the nights are good, and she breathes well, but the pain in the right side persists. *Bryonia*, 3d dil.

The improvement continued, and the patient left the hospital on the 4th of April, in a fair condition of health.

In this case, the existence of the hemorrhoidal tumors complicating the emphysema, led me to prescribe *nux vomica*. The 12th dil., which I first prescribed, had but little effect, and as she complained of violent pains in the anus, I ordered the same remedy in the 30th dil., which was followed by a prompt and decided improvement. She does not suffer any more from the hemorrhoids; but, unfortunately, the fits of suffocation continue to recur, and she has symptoms of chronic aortitis, a disease which, up to this time, has not been very carefully studied, and the characteristic signs of which are those of disease of the heart, with an absence of the physical signs of a lesion of its orifices. Our patient shows an increase of the transverse dullness over the aorta, which now measures between six and seven centimetres, instead of three and a half.

The radial arteries show evident signs of ossification; the nights are restless, and the oppression is very marked; and the sphygmographic tracing shows the characteristic horizontal line of aortitis. In such cases you will frequently observe the breathlessness, the cough and the dysphagia, as well as the albuminuria and the œdema, that are so common in cardiac affections.

We shall return to the subject of chronic aortitis in a subsequent lecture.

See the last part of Lecture XI, for a remarkably interesting and practical discussion of the subject of chronic aortitis, illustrated with several cases.—L.

LECTURE X.

SUMMARY.—Simple ulcer of the stomach, *case;* indications for *nux vomica*, *arsenicum* and *argentum nitricum*. Pneumonia of the apex of the lung, *case; bryonia*, *phosphorus* and *tartar emetic;* treatment of pneumonia. History of the introduction of homœopathy into the Paris hospitals; Tessier and his enemies; the report and the favorable statistics of M. Davaine. The Expectant and the homœopathic treatment of pneumonia. Sciatica, *case;* indications for *bryonia*, *rhus toxicodendron*, *colocynthis*, *arsenicum*, *belladonna* and *chamomilla*, *nux vomica*, *sulphur* and *veratrum*. The common form of phthisis, *case*; indications for *bryonia* and *drosera*. On the choice of the attenuation.

Simple Ulcer of the Stomach.

GENTLEMEN: The following is the history of a patient who for many years has been subject to attacks of vomiting:

CASE XXIV.—M. Martin, a mason, aged thirty-seven years, entered our ward on the 25th of March.

This man, who, during his infancy, was subject to epistaxis, was taken ill about three years ago. After two months of dyspepsia he began to reject his food. Sometimes vomiting would occur immediately after eating, and again not for five or six hours after his meals, but it was always preceded by a violent colic. He usually vomited every second day, but occasionally he would have an interval of a fortnight, during which he would have no attack. He tried the milk diet at the Hospital la Pitié for two months, but without effect.

On pressure, the patient complains of pain below the xiphhoid cartilage; but examination with the hand does not disclose any tumor in the epigastric region. There is no pain in the corresponding portion of the vertebral column.

March 26. *Nux vomica*, 30th dil., four globules in 125 grammes of water, three spoonfuls during the day.

March 27. There was vomiting last night. The same treatment.

March 28. No vomiting. The same treatment.
March 29. Vomiting. *Nux vomica*, 3d dil.
March 30. Vomiting last night. *Arsenicum, met.*, 6th dil.
March 31. Vomiting. *Arsenicum, met.*, 12th dil.
April 1. The patient is not so weak, and has not vomited. *Arsenicum, met.*, 3d trit., and an almost exclusive animal diet.
April 2. No vomiting. The same treatment.
April 3. Slight vomiting. *Arsenicum, met.*, 2d trit.
April 4. No vomiting. The same treatment.
April 5. Excessive vomiting. *Arsenicum, met.*, 1st trit.
April 6. Slight vomiting. The same treatment.
April 7. No vomiting.
April 8. No vomiting.
April 9. Last evening the patient vomited a little several times. His general condition is, however, much improved since he entered the hospital, and he has now passed fifty-six hours without vomiting.
April 11. He vomited again last night. The same treatment.
April 12. *Argentum Nitricum*, 3d trit.
April 13. No vomiting. The same treatment.
April 14. No vomiting.

I wish to call your attention to the fact that this patient is of a hemorrhoidal constitution. He has had the epistaxis, which is common in persons who have this peculiar dyscrasia. Moreover, he has not lost his appetite, which is a negative symptom that is of very great importance in an organic affection of the stomach. On direct examination, we find neither the dilatation with sonorousness that is present in pyloric affections, nor the circumscribed dullness that exists where there is a gastric tumor, nor does palpation discover any such tumor.

It is very doubtful if, in the whole range of our medical literature, there is a more expressive paragraph than this, or one that carries more of meaning in regard to the differential diagnosis of the class of cases to which it refers. The hints contained therein are of the utmost importance wherever they can be used; but they are especially significant in the recognition and treatment of

reflex disorders of the stomach in women. We have treated several cases of so-called ulceration of the stomach, in which, for the lack of this kind of teaching, the most egregious blunders had been made in diagnosis. One of them was declared to be a perforating ulcer of the stomach, and the patient had been given up to die. In each and all of them, however, there was a mild form of metritis, with prolapsus uteri, which soon yielded to appropriate treatment.—L.

The disease has lasted three years without being followed by a cachexia. In brief, therefore, I believe we may give our diagnosis of this case as one of *simple ulcer of the stomach.*

Of this simple ulcer, you know, there are two forms, one of which is hemorrhagic, while in the other the loss of blood is more rare. The fatal termination may come quickly in either of them. Indeed, the ulceration of a vessel in the coats of the stomach will sometimes be followed by a mortal hematemesis, and at other times it will produce a perforation that is followed by peritonitis. This latter mode of termination occurs twelve times in one hundred on the average.

I began the treatment with *nux vomica*, it being indicated by the vomiting of food and of acid matters, by the pains, and by its adaptation to the constipation, and also to the hemorrhoidal diathesis. I prescribed it in the 30th dil., because I have often observed the aggravation produced by this remedy in gastric affections. This attenuation not producing any result, I descended the posological ladder, and then I tried *arsenicum*, and finally the *argentum nitricum*, which have caused a slight amelioration of the symptoms.

Pneumonia at the Apex of the Lung.

I have a few words to say to you of the patient who died the day before yesterday of pneumonia.

Case XXV.—Mrs. Goris, aged fifty years, entered the women's ward on the 20th of March, and died on the 24th of March.

This woman has suffered greatly of late. She was badly

nourished, and being obliged to work to earn her living, she has, she tells us, been losing her strength for some months past.

She still menstruates, and her periods are regular.

In the intervals between them she has suffered from leucorrhœa for the last fifteen months.

March 11. Without premonitory symptoms, and without any known cause, the disease set in with a violent chill, which was followed by a continuous fever. Afterward she had a headache, a pain in the right side under the nipple, and some cough. These were the first symptoms of the attack. The disease was not understood, and she was treated with *aconite* up to the day of her admission to the hospital. She came to us in a very dangerous condition. Her symptoms at that time were oppression, a frequent cough, the tongue was dry and covered with a thick coating, and there were patches of muguet on the cheek and upon the veil of the palate. The expectoration is viscous, transparent and greenish. There is a souffle and bronchophony in the fossæ above and below the clavicle.

The face has a most anxious expression; her strength is very much exhausted; the pulse, which is 116, is soft and small, and the temperature is 104°.

March 21, the eighth day of the disease and the first day of the treatment. She had a wretched night. There is excessive dyspnœa, noisy respiration; the tongue is dry, with great thirst, and scanty expectoration of a yellowish and adhesive mucus. The pulse is 104, and the temp. 103.28°. *Bryonia*, 12th dil., six globules in 200 grammes of water, one spoonful to be taken every two hours.

Evening. There is oppression and delirium, with arrest of the expectoration. The pulse is 120, and the temp. 103.64°. *Phosphorus*, 12th dil., six globules in twelve spoonfuls of water; one spoonful every two hours.

March 22, being the ninth day of the disease and the second day of the treatment. After taking the *phosphorus* the patient began to expectorate; otherwise the night has been very bad, with great unrest, considerable dyspnœa, a general perspiration, and the tongue is a little less dry. The two last symp-

toms, which are comparatively good, lose their value in the presence of the others; the urine is pale; the pectoral lesion extends from the apex of the lung downward. The pulse is 108, the temp. 101.84°, or nearly two degrees lower than it was at the same hour yesterday. *Phosphorus*, 12th dil., was continued. The patient is to be nourished with milk and with broth. At evening the pulse was 124, the temp. 102.92°. By mistake, ipecac., 1st dil., was given to the patient instead of continuing the *phosphorus*.

March 23, or the tenth day of the disease and the third day of the treatment. The fever is still diminishing; the pulse is 108, and the temp. 100.40°, or more than a degree less than it was yesterday at the same hour; but the patient has been delirious during the night, and the dyspnœa is as bad as ever. The expectoration has almost ceased. *Tartar emetic*, 3d trit., twenty centigrammes in 200 grammes of water, one spoonful every two hours.

Evening. The fever, which is higher than this morning, is less intense than it was last evening; it follows a descending scale. The pulse is 104; the temp. 102.20°. The general condition is very serious; the tongue is dry; the lips are black; the pulse is very feeble; the urine is pale, and the ulceration of the mouth is more extensive. Resume the *phosphorus*, 12th dil.

March 24. The eleventh day of her illness, and the fourth day of the treatment. The fever is not so high as it was last evening, but it is higher than it was yesterday morning. She passed a terrible night, with excessive dyspnœa, a feeble pulse, and a progressive debility and prostration. The evening pulse was 108, the temp. 99.5°, with collapse, anxiety, agitation, a very dry tongue, and a complete arrest of the expectoration. *Tartar emetic*, 1st trit., and wine. She died during the night.

You observe, gentlemen, the singular thermometrical variations in this case. You have seen, from the detailed account, that the temperature diminished regularly, which would have been a favorable sign if, at the same time, the dyspnœa and the prostration had not constantly increased. More than this, although it seems almost incredible, we know that the diag-

nosis of pneumonia was not made by the physician who saw this patient seven days before she came into the hospital. In general, I do not find fault with those errors of diagnosis which the difficulty of the case will explain; but there are certain things and certain signs which to ignore is unpardonable. A disease that makes its onset with a chill, with fever, with pain in the side, and a cough, suggests pneumonia at once, and should be treated as such while waiting for the stethoscopic signs to corroborate the diagnosis. Notwithstanding it has been said that pneumonia presents no stethoscopic signs in old people, I believe that by a proper and careful examination they are to be found. It was so in the case of this poor woman, for on auscultation of the right clavicular fossæ we heard a decided though feeble bronchial souffle. But we must not forget that the apex of the lungs expands much less than the inferior lobes, which, of course, makes these sounds weaker than elsewhere.

In this case my prognosis was from the first very grave. There were two unfavorable signs: firstly, the decline of the temperature whilst there was an aggravation of the general symptoms,—a state of things which revealed the ataxic character of the disease; and secondly, the color of the urine, which was pale and without deposit, while in pneumonia it should be red, and sometimes even the color of blood. There was also great oppression and prostration; the tongue was dry; and finally the respiration at times was rattling, which is a very bad symptom, and which indicates great weakness of the bronchial muscles.

À propos of this case, I have something to say of the therapeutics of pneumonia. Tessier formulated a treatment for this disease which to-day is classical. It consists in the administration of *bryonia* during the day, and of *phosphorus* during the night. By the aid of these two remedies the mortality in his hospital service was only three in forty-two cases,

and these three deaths included those of two patients who entered the hospital in a dying condition.

The symptoms that afford the best indications for *bryonia* are the pain and the stitch in the side. *Phosphorus* corresponds more accurately to the dark brown coating of the tongue, to its dry condition, and also to the typhoid state or appearance of the patient.

While we are on this subject, I think it will be profitable to give you the *History of Homœopathy in Paris.* In 1848, Tessier, who was then a physician of the Sainte Marguerite Hospital, which is now the Sainte Eugénie, agreed with two other physicians of the same hospital, Drs. Valleix and Marrotte, to test the homœopathic treatment in pneumonia. When it was discovered that the patients were cured in great numbers by this treatment, those who at first had recommended and tried the experiment, rejected it; and not content with flying from the light themselves, denounced Tessier to the Director of "Public Assistance" for having introduced charlatanism into the hospitals. M. Davaine, who was at that time Director, responded to this denunciation by an examination of the subject, which lasted for three years, and which considered the case of every patient in the three services, or divisions of that hospital. At the end of the three years the superiority of the homœopathic treatment was shown not only in curing, but in shortening the duration of the disease, in a manner so conclusive, that the Director of "Public Assistance" could not but encourage the experiments of Tessier, the results of which were so full of promise, as he loyally said, not only to the sick, but also to science.

I will read you the exact statistics afforded by this examination, and certified to by M. Davaine himself a short time before his death.

During the years 1849, 1850 and 1851, there were treated

by allopathy (Drs. Marrotte and Valleix), 3,724 cases, of which 411 were fatal, which shows a mortality of 11.3 per cent.

During the same period there were treated by homœopathy (Tessier), 4,663 cases, of which 339 were fatal, making a mortality of 8.55 per cent, showing a difference of 3 per cent in favor of homœopathy.

Besides, as the number of beds was practically the same in the two services (100 beds under Tessier, and 99 under Marrotte and Valleix), and as there were three hundred more cases treated in the homœopathic service than in the allopathic, the duration of the disease must have been shorter in the former than it was in the latter.

You understand, gentlemen, that such a result was scandalous, and that some sort of answer must be made to the facts offered, and to the cures that were obtained by *bryonia* and *phosphorus!* Valleix was the first to attempt this. He said that the diagnosis of the cases published by Tessier was erroneous, and that he had been treating capillary bronchitis for pneumonia. This was not only silly but stupid. It was silly, because no one doubted the truth of Tessier's diagnosis, or of his experience; and stupid, because capillary bronchitis is a more serious disease than pneumonia. This argument, therefore, returned upon its author, and the first reply to Tessier's statements was not echoed very loudly.

At about the same time the hospitals of Vienna furnished even more serious evidence of the truth of homœopathy. It was there, indeed, that the expectant method was openly practiced, and that Dietl extolled its use in pneumonia.

In the first year the results were certainly not unfavorable, for the mortality was only 7.4 per cent. In the second year it increased to 9.2 per cent, and the third year to 21.2 per cent. Borde, in 1855, had a mortality of 22 per cent; Schmidt, of 23 per cent; and, finally, Brandes, at Copenhagen, one of 31 per cent. Adding these figures together we find there was an average mortality from this method of 18.8 per cent.

In Paris, Tessier's statistics showed a mortality of not quite 6 per cent; while the Leopolstadt Homœopathic Hospital had a loss of only 5 per cent.

More than this, gentlemen, outside of statistics you may rest assured that the progress of the disease is not the same when treated by the expectant method as when treated by homœopathy. In the former the disease, after running its course, terminates abruptly with defervescence, while, on the contrary, this symptom is very rare in the latter, where the improvement is gradual and constant, and the symptoms grow lighter day by day.

Moreover, there is this difference also, that when the disease has been left to itself, although from the ninth to the eleventh day, the fever has stopped, the physical signs may persist until the twenty-fifth or even the thirtieth day; whereas, under the homœopathic system, the stethoscopic signs will disappear after eight days of treatment.

Sciatica.

After this digression we return to our patients, and I will speak to you directly of the man who is suffering from sciatica, and whom you may have seen lying upon his sound side.

Case XXVI.—M. Large, forty years of age, entered on the 18th of March. He is not hemorrhoidal, and has had neither herpes nor syphilis. He was never ill until about the 10th of March.

On the 16th of March the pain became so violent that he was obliged to stop work. He had a burning pain in the thigh, which extended to the leg, following the course of the sciatic nerve. Pressure between the great trochanter and the sciatic eminence is extremely painful. The pain is continuous, and is aggravated by movement, but it is not more severe at night than during the day; it loses itself in the leg, where it causes a sensation of cold in the calf of the leg especially; there is also insomnia, loss of appetite, and constipation.

March 18. *Rhus tox.*, 3d dil., three drops in 200 grammes of water; one spoonful to be taken every three hours.

March 19. The patient begins to improve. The same treatment.

March 20. The improvement continues. The same treatment.

March 21. He complains of severe constipation. To have an enema, with the same treatment.

March 22. He had a copious stool, and has been able to sleep a little. The same treatment.

March 23. Continued improvement.

March 24. The patient is able to lie for a short time on the affected side. The same treatment.

March 25. The improvement continues. *Rhus tox.*, 3d dil.

March 27. The patient gets up and walks easily. His nights are very good.

March 30. In consequence of a slight imprudence, the pains have returned. *Sulphur*, 30th dil., four globules in 125 grammes of water; three spoonfuls a day.

April 3. The pains do not lessen. *Rhus tox.*, 3d dil.

April 6. The thigh only is painful. *Rhus tox.*, 1st dil.

This remedy was continued until the 15th of April, at which time the patient scarcely suffers at all, and is able to walk.

Now, the pain has left its first location, which was in the thigh and the hip, and has gone to the lower part of the leg, where there is still a sensation of cold. From the beginning of the treatment the case has constantly improved.

The remedies usually given for sciatica are, *Rhus tox.*, *bryonia*, *chamomilla*, *belladonna*, *colocynth*, *sulphur*, *plumbum*, *veratrum*, and *nux vomica*.

Bryonia and *rhus tox.* have several indications in common, but the first is especially useful if the pain is increased by motion, and lessened when the patient lies upon the affected side. The second, on the contrary, is indicated where the pain is increased by repose, or by lying upon the diseased side. It is

also useful when there is a sensation of tingling, or of cold in the affected part. We prescribed the *rhus tox.* for our patient, because of the sensation of numbness and cold, and also because of the increase of pain when he would lie upon the affected side. I once cured a patient who had suffered from sciatica with atrophy of the limb, for eighteen months, with *bryonia*, 2d dil.

At the end of one week the improvement was very obvious, and the patient was well in a few weeks. In six weeks I also cured a case of chronic sciatica, which dated from a year, by *plumbum.* In this case the patient was a gentleman who had been treated by many old-school physicians, each of whom had failed to relieve him. Among these physicians was Beau, the anatomical draughtsman, and author, with Bonamy and Broca, of an atlas which has become classical.

The symptoms that correspond to *arsenicum* are great pain, which increases at night, and a sensation of burning. *Colocynth* is called for when the pain is constrictive in character, and when there is a sensation as of an iron band around the hip; but I have not found it a reliable remedy.

Colocynth is not by any means a specific for sciatica, but, in exceptional cases, more especially where the pains are of a shooting and cutting kind, that run like lightning from the hip to the knee, or even to the heel; and where they come on, or are worse at night, and from motion; where they affect the right side more than the left; and when they occur in one who is subject to neuralgia elsewhere, it is very useful. Only recently I gave one dose of *colocynth*, 2d dil., to a very dear friend, whose attack of sciatica was sudden and very severe, and who, in former years, had suffered prodigiously from it. The relief was complete, and almost instantaneous.—L.

When there is a very sharp pain, with restlessness and continual complaint, you will do well to give *chamomilla* and *belladonna* alternately. The distinctive characteristic which calls for the latter is a sharp pain on the slightest touch. *Sulphur* is successful in cases of chronic sciatica — particularly when the patient is hemorrhoidal. One of the symptoms indicating

this remedy is the increase of the pain at night from the warmth of the bed. *Nux vomica* is also strongly indicated in cases where the patient is hemorrhoidal.

My friend, Dr. Cretin, uses the *veratrum* very often. He gives it in the tincture, and with excellent results. The symptoms which, according to the Materia Medica, indicate the veratrum, are extremely violent pain, with nervous irritability; pains like electric flashes, and tingling pains, occurring principally at night, or about three or four o'clock in the morning.

In one very protracted case, where the suffering was confined to the left leg, and the pain had resisted many remedies, I found the *ledum palustre*, 3d dil., of great service. The pain descended from the hip along the posterior surface of the thigh; was aggravated by the touch, and by the warmth of the bed; there was swelling of the leg and foot; the leg felt cooler than its fellow, and the sole of the foot was very sensitive.

A very interesting collection of cures of sciatica by various remedies, including *arnica*, *bryonia*, *cocculus*, *ignatia*, *mercurius*, *rhus tox.*, *sepia*, *staphysagria*, *sulphur*, etc., may be found in Hoyne's Clinical Therapeutics.—L.

The Common Form of Phthisis.

In conclusion, I wish to speak to you of the unfortunate consumptive in No. 2 of the men's ward. He has the symptom so common in tuberculous cases, of a tickling in the throat which provokes vomiting. This symtom I have arrested in ninty-seven out of one hundred cases, by *drosera*.* In the present case I prescribed it in the third, and afterward in the twelfth, dilution, but without succeeding in checking the spasmodic cough. I then gave it in the mother tincture, and in twenty-four hours the vomiting had stopped. The case of this poor patient, who is doomed to face death very soon, is an interesting one, because it affords an opportunity for studying the real effects of our homœopathic remedies. He has, like most consumptives, the frequent pains in the side that we can cut short with bryonia. But unfortunately, although in such cases

* These cases were published in the Transactions of the Homœopathic Congress of Paris.

we may relieve the symptoms, it is not possible to attack the disease at its root. Still, if we may not always cure it, we can at least relieve it, and that is what we are trying to do in the present case.

In connection with the prescription of drosera for this patient, I cannot let the occasion pass without reminding you of a precept in therapeutics, which is generally admitted to be true, but which is very often neglected in the practice, viz: that when a remedy has been carefully selected, it should not be hastily changed; but the proper attenuation for the particular case should be sought for, without regard to our prejudice. For example: In the case of this patient, drosera was indicated by the experimental Materia Medica, and also by clinical experience, and we could, therefore, depend upon a therapeutic result with certainty. I accordingly persevered in the use of the drosera, and because the third dilution, which I habitually prescribe, was not effectual, I gave the twelfth. This also failing, I resorted to the mother tincture, which was successful.

The detailed account of this case is as follows:

Case XXVII.—M. Leblanc, aged thirty-seven years, entered the hospital on the 7th of March.

The bad effects of living in a dark and illy-ventilated room are well shown in the case of this patient, who, born of strong parents, has always had good health heretofore. For the last four years he has occupied a room that was situated in a court into which the fresh air seldom penetrates.

In July, 1873, he had a dry cough, which was also frequent, and which provoked vomiting. About the month of December he had hemoptysis. He has become greatly emaciated, and has lost his strength.

On examination of the chest, loud humid râles are heard in the apex of the right lung, and over the remainder of the chest there are the râles of bronchitis. He also has a pain in the side. *Bryonia*, 3d dil., three drops in 200

grammes of water, one spoonful to be taken every three hours. He is also to have the vegetable diet.

March 10. The cough is less frequent; there is a slight expectoration; the pain in the side has disappeared; there is slight vomiting after the cough. *Drosera*, 3d dil.

March 11. The pain in the side has returned; there are night sweats, but the patient coughs less. *Bryonia*, 3d dil.

March 12. The pain in the side persists; there is the same general condition. *Bryonia*, 6th dil.

March 13. The pain in the side is gone. The same treatment.

March 16. The cough is better, but still produces vomiting. *Drosera*, 3d dil.

March 18. The vomiting continues. *Drosera*, 12th dil.

March 19. The same condition. *Drosera*, in the mother tincture, three drops.

March 20. No more vomiting; has had a very good night, and but little cough. The same treatment.

March 26. His condition is unchanged. There is no vomiting. *Arsenicum*, 3d trit.

March 28. The same. *Kermes'*, 1st trit.

April 6. The patient's condition is very satisfactory, and he wishes to leave the hospital. *Phosphorus*, 12th dil.

April 10. The pain in the side has returned. *Bryonia*, 3d dil. This pain afterward disappeared, and the same remedy was continued until April 15.

The influence of bryonia over the pain in the side, and of drosera over the spasmodic cough and the vomiting of the food, was very marked and evident in this case.

LECTURE XI.

SUMMARY.— Typhoid fever; indications for *arsenicum*. Phthisis and chlorosis; indications for *bryonia* and *sepia*. Of the use of iron in phthisis. Sea-baths in ditto. Chronic aortitis; the common and the painful forms of *angina pectoris;* description of chronic aortitis; *cases — angina pectoris; case.*

Typhoid Fever, alias Acute Phthisis.

GENTLEMEN: The diagnosis of the case in No. 4 of ward 11 is somewhat difficult. The woman's symptoms are: fever, which has lasted for twelve days, with morning remissions and evening exacerbations, the morning temperature being 101.84°, and the evening temp. 104°; debility, bronchitis and some stupor, which symptoms certainly resemble those of typhoid fever. But there is another morbid condition which so strikingly resembles this disease, that the most skillful physicians have hesitated in its diagnosis. I allude to the acute, or galloping phthisis of Trousseau, which may present itself in two forms. In one of these forms of phthisis the affection is very like capillary bronchitis, because the dyspnœa is so very marked; the other is of a typhoid type, which may be, and has often been, mistaken for typhoid fever.

The case of our patient is all the more perplexing, because the abdominal symptoms are lacking entirely. On account of the adynamia, and the duration and the violence of the fever, the prognosis in these cases is always very grave.

I prescribed *arsenicum* in a low trituration, which appeared to me to be indicated by the pale face, the prostration, the sleeplessness with great agitation, and the intense thirst, which are pathogenetic symptoms of arsenicum. As to alimentation, I try to preserve a proper medium, giving such strengthening

food as the feebleness of the patient, and the duration of her disease, require, and at the same time that which is not so substantial as to increase the fever. I will speak of this case again in our next lecture.

Phthisis and Chlorosis.

In No. 1 of this same ward for women, there was, you recollect, a patient who presented the symptoms of two diseases, which are frequently observed in the same person, viz, phthisis and chlorosis. This woman, who has coughed for a long time, has in fact a pretty well-marked dullness in the right side. Upon auscultation, the expiration was found to be harsh and prolonged, and there was also bronchophony. At the same time she suffered from neuralgia in the superior intercostal spaces. The leucorrhœa, breathlessness, and a carotid souffle, show a well-defined state of chlorosis existing independently, I believe, of the phthisis.

I first prescribed *bryonia*, which was indicated by the pain in the first intercostal spaces. I did not put her on the vegetable diet, as is my custom in consumptive cases, the chlorosis being a clear and well-defined counter-indication for such an aliment; but I prescribed a more nourishing diet instead.

The improvement of the respiration being prompt, I stopped the use of bryonia and prescribed *sepia*, which was imperatively called for by the leucorrhœa. Ought we, gentlemen, in similar cases, to make use of the heroic remedies? I certainly do not pretend to deny that iron is the principal remedy in chlorosis, but I do consider it a very dangerous one when consumption makes its onset, and is complicated with the insidious symptoms of chlorosis. And in this opinion I am happy to have the indorsement of one of our most illustrious teachers, Trousseau, who reproached himself during the last years of his teaching, for the freedom with which he had prescribed iron during the first period of his medical practice. He confessed this with

the sincerity of one who deserves to be great as a medical authority, and whose reputation will not be damaged by his early mistakes; for he charged himself with the death of several women in whom consumption was the consequence of the use of iron, given for the cure of a real, or of a suspected, chlorosis.

The celebrated Dr. Graves, of Dublin, once expressed a wish that the sentence, "He fed fevers," might be engraved on his tombstone. Trousseau and Graves were great friends, as well as great teachers in the department of Clinical Medicine. And in view of the fact just cited by our author, we have sometimes thought that an equally creditable and suggestive epitaph might be written for Trousseau : He Proscribed Iron in Tuberculosis.—L.

Independent of clinical experience, the physiological action of iron is sufficient to put us on our guard. We know that it congests the lung, produces a dry and frequent cough, and sometimes, also, hemoptysis, and therefore, that it should never be given except in homœopathic doses to a patient in whose case the existence of tubercles is even suspected.

In the case of this patient I prescribed the *acetate of iron* in the 1st trit., for two reasons, namely, first, because she has not coughed for two weeks, and because, by careful auscultation I do not find that there has been any advancement of the pulmonary lesion for the last six weeks. The second reason is, that her social condition does not permit of her taking the treatment that I should greatly prefer for her — I mean the fresh air, exercise and sea-bathing. I intend, however, to watch her very carefully, and shall suspend the use of the remedy the moment there are signs of an aggravation.

It may surprise you to hear me speak of sea-bathing in connection with consumption. Our great Laennec had unbounded confidence in the sea-air for the cure of phthisis. He sent these patients to the seaside, and had sea-weeds placed in the consumptive wards of the hospital. Of late,

there has been a reaction against this order of things. It has been shown, in a certain number of cases, that the sea-air was unfavorable, and the doctors, like Luther's drunken countryman on horseback, who fell on the right side when lifted up on the left, have proscribed sea-bathing and sea-air in the treatment of tuberculosis with the same unanimity and enthusiasm with which they formerly advised their employment.

However, this question should depend, not upon fashion, nor upon caprice, but upon the real indications. Consumptives with hemoptysis, or with fever, should avoid the salt water, while those who are not thus affected may derive benefit from a sojourn on the southern coast of Brittany or somewhere along the Gulf of Gascony. Not only the sea-air, but short baths of, say, from five to ten minutes' duration, taken with moderation and care, will prove beneficial.

It is a great mistake to suppose that one climate, or one set of surroundings, will be the best for any class of invalids whatever. The most careful rules, and the most encouraging analyses of wind and weather, of dryness and moisture, of heat and cold, of soil and water, are worth but little unless the patient's organism is *en rapport* with the "health resort," wherever it may be. We prefer to choose a climate, just as we would a diet, for a sick person, *id est*, to suit his tastes and idiosyncrasies, and, as nearly as possible, to make his experience the rule for its continuance or for its rejection.—L.

Chronic Aortitis.

An old woman, gouty and hemorrhoidal, in No. 1, ward 2, furnishes me an opportunity of speaking to you of *chronic aortitis*. You have heard me several times, both in the wards and at the consultations, make a diagnosis of chronic aortitis. I am aware that such a term may have appeared strange, and it is better that I should give you some information concerning this affection; for all, or a great part, of that which you may find in contemporary medical literature is erroneous. The history of inflammation of the aorta

is very brief. Up to the time of Bizot, nothing but theories regarding the inflammation of the internal membrane of the aorta and of the arteries existed. Pinel, of whom they tried to make a great authority, and who was really but the caricature of a philosopher, had founded angiotenic fever upon the existence of acute inflammation of the arteries, but this inflammation was and is an hypothesis, and we have, therefore, nothing to do with it now.

This *angiotenic* fever was a name offered by Pinel as a substitute for the *inflammatory* fever of Huxham and Stoll, the *synocha* of Cullen and Hoffman, and the *continuous* but non-putrid fever of Bœrhaave.—L.

Bizot published an account of three cases, which he called acute aortitis. In these cases the disease was characterized by intense and continued fever, an increasing dyspnœa, and œdema. At the autopsy, one could distinguish inflammatory redness, and pseudo-membranous deposits were found on the surface of the lining membrane of the artery. In one of the cases an atrophy of the kidneys cast a doubt upon the value of Bizot's reports.

At this time (1833) Bright's disease was but little known in France, and the kidneys of patients troubled with attacks of aortitis were very superficially examined. In Bizot's cases it is, therefore, difficult to separate that which belongs to aortitis from that which belongs to parenchymatous nephritis, or possibly to interstitial nephritis.

In 1859 Tessier traced, in *L'Art Médical*, the prominent features of chronic aortitis. This description was founded upon the cases, including the autopsies, of two men, who were equally distinguished in their several ways—Dupuytren and Saint Arnaud. Thanks to the silence which envelops and tries to stifle all works that come from the pen of a disciple of Hahnemann, this production has remained without an echo, but has not been without an effect; for it is impossible not to

recognize in many points the influence of J.-P. Tessier in the writings of Peters, on the painful form of chronic aortitis or angina pectoris. It was a singular destiny, that of this man, whom they would consign to oblivion because he placed the truths of therapeutics above the prejudices of his professional neighbors; above his own interests, and above all personal considerations, but whose influence is felt at every step in the progress of contemporary medicine.*

Chronic aortitis occurs in two forms, one of which is extremely painful, and which, for a long time, has been known as angina of the thorax, or angina pectoris. The other form, which is almost painless, is little known, notwithstanding its frequency. The latter is what I call the *common* form of chronic aortitis.

Between these two forms there are intermediate cases, in which you will find the rudiments, or echoes of angina pectoris. These cases are frequently met with in practice, and you have seen several of them in our hospital.

Chronic aortitis is generally found in persons between forty and fifty years of age. In every case that I have seen there were unmistakable symptoms of gout, and especially of hemorrhoids. The abuse of coffee, tobacco, and, above all, of alcohol, in some form, have been noticed by all authors as "occasional causes" of thoracic angina, and of ossification of the aorta. In other words, you will find these etiological conditions to have existed in nearly all cases of chronic aortitis. Finding that the same morbid conditions and the same causes that determine organic affections of the heart are present, we observe that it is not infrequent to discover that the same person may have a chronic inflammation of the aorta, coincidently, with a chronic inflammation of the endocardium. The cardo-aortitis is a frequent affection, and it is often difficult

* See *L'Art Médical* for January and March, 1874; article, *Angine de Poitrine*.

to tell which of these lesions preceded the other. Moreover, they may cöexist.

In the case of Count B., aortitis had continued in an uncomplicated form for more than a year. The heart, which was examined each day by the consulting physicians and by myself, presented absolutely no abnormal sounds; but near the termination of the disease, or about three months before his death, we discovered a perfectly well-defined mitral insufficiency.

Endocarditis may become complicated with chronic aortitis, as aortic inflammation often is complicated with endocarditis, and cardo-aortitis is a frequent affection. The subject of Case III, who was attacked with rheumatic endo-pericarditis, had, for some time, signs of intercurrent aortitis, as shown by the sphygmographic tracings, in which we found the range that is characteristic of the aortitis.

Not having any morbid specimens of it to show you, I will not dwell upon the pathological anatomy of chronic aortitis. This part of the subject, for that matter, is better understood than the history of its symptoms. Broussais has shown that the bony and cartilaginous deposits, as well as the atheromata of the aorta, are the product of a chronic inflammation; and Virchow, by histological examination, has confirmed the opinion of Broussais.

The autopsy of Dupuytren may serve as a type of the lesions of chronic aortitis: "The heart was hypertrophied, but its internal membrane was healthy. The valves, right and left, were flexible, mobile, and well-formed; and the orifices to which they were adapted were perfectly free. . . . The internal surface of the aorta and of the large arteries, which originally was a little rough, is slightly rugous, with small yellow points and patches scattered over it,—these patches being fibrous, or fibro-cartilaginous, but not yet bony or calcareous. The walls of the arteries were thick, as though hypertrophied like the heart itself." (See *L'Art Médical*, t. x, p. 419).

Thus, as demonstrated by the autopsy, the heart of Dupuytren was perfectly healthy, notwithstanding he died of dyspnœa, and with the œdema of the cardiac cachexia. Recollect this, gentlemen, and when you find a patient having all the rational signs of an affection of the heart, but in whom, by attentive auscultation, the integrity of the cardiac orifices is made evident, think at once of chronic aortitis, and a careful examination will often give you a certain diagnosis.

And what is there astonishing in this resemblance between the symptoms of aortitis and those of chronic carditis? Is it not the immediate effect of chronic inflammation that there should be a loss of elasticity in the arterial tunics, and, consequently, a narrowing from defective dilatation? You remember, in your physiology, that the channels of the human body, such as the trachea for conducting the air, the urethra and the bile ducts for the escape of the excretions, and the channels for the blood, like the aorta, are all essentially dilatable, and that they do dilate every time they perform their functions. But when there is chronic or acute inflammation in these channels, they become, wherever they are diseased, non-dilatable tubes. In default of dilatation, there is narrowing; whence, in trachitis, we have dyspnœa; in angiocholitis, the more or less complete retention of the bile; of the urine in urethritis; and in aortitis, the symptoms of aortic contraction.

But when the disease is more advanced the lesion becomes more complicated; the wall of the artery is attacked in its whole thickness, and loses its physiological properties. Awhile ago it was its dilatability only that was impaired; now, its elasticity is more or less lost, and the walls, to a certain extent only, yield to the pressure of the blood-current. From this comes the consecutive dilatation of the aorta, and all of its morbid consequences.

In the normal state, the expansible and elastic aorta gives way to the flow of blood, and then reacts upon itself,—a con-

dition that is eminently favorable to the circulation. But when the arterial wall is attacked in all of its coats, it becomes an almost inert tube, incapable of yielding to the sanguinary wave, and incapable also of contracting after it, or of assisting the progress of the blood-column, from which come, very soon, the disorders analogous to those produced by the contraction and insufficiency of the aortic valves, viz: the diminution of arterial pressure, the increase of venous pressure, albuminuria, œdema, dropsy, and all the signs of a cachexia that depends upon a failure of hematosis and of nutrition. Whence the sphygmographic signs that are so characteristic of chronic aortitis, the level tracing and absence of dicrotism, due to the diminution and loss of the action of the elasticity of the aorta in the circulation of the blood.

The disease always commences with dyspnœa. This dyspnœa, which is very moderate in a state of rest, is soon accompanied by paroxysms that frighten and depress the patient. They are brought on by exercise or emotion, and are more frequent after eating. In the case of one lady, the first paroxysm occurred while dancing. In general, these patients suffer less when the stomach is empty, and are almost always most oppressed after dinner.

In the case of Count B——, of whom I have spoken to you, the attacks of dyspnœa occurred in the night, like those of asthma.

This dyspnœa is sometimes associated with a catarrh, which is not very serious; but from the beginning these patients lose strength rapidly, and their nights are often troubled by dreams, nightmare and unrest.

The progress of the disease is more or less rapid, but it is never really arrested; the habitual dyspnœa becomes more pronounced day by day, and then follow the terrible paroxysms, causing fear of death by suffocation or by syncope. These paroxysms are in fact characteristic of the cardiac dyspnœa;

the pulse is accelerated, and at the same time it grows smaller, and finally disappears; the skin is cold, and bathed with a cold sweat; the face is pale, with most pronounced syncope. In some cases there is an entire loss of consciousness during the worst paroxysms. The expiration is habitually convulsive during the paroxysms, as in asthma. Some patients relieve themselves decidedly by exaggerating this expiration into a prolonged and plaintive moaning cry.

In the cases of M. Beaur and of Mrs. Broq, the detailed accounts of which I have given you, the diaphragm was seized by clonic convulsions, producing a sub-costal throbbing, which was worse on the left than on the right side. A strong pressure, which prevented the throbbing in the sides, relieved them very much.

Some patients are subject, at intervals, to a silent dyspnœa, which is characterized by an extremely slow and prolonged inspiration, that is made with the mouth widely opened. The loss of strength, and the anæmia make incessant progress; the appetite is retained for a greater or less length of time, but many patients will not eat, from the fear of bringing on the attacks of dyspnœa.

Sleep becomes more and more troubled, and the albuminuria appears very promptly.

I have known patients to go for months, and even for years, without developing a cachexia, in spite of habitual albuminuria and some paroxysms, with considerable time between them, of cardiac dyspnœa. The Duchess of —— is an example of this (see Case XXXI), but in most cases the presence of albumen in the urine denotes the advent of the cachexia.

The Cachexia.—Œdema is usually the first symptom. It increases more or less rapidly, or more or less slowly; but it increases, reaching the scrotum and the loins. It makes its appearance also in the superior extremities and in the face;

the appetite diminishes and disappears, and, if the patient be forced to eat, when the stomach is no longer able to digest food, vomiting or diarrhœa ensues. Insomnia now becomes a cruel evil, an enemy that is more terrible than thrist or hunger. "It is a lamentable sight, that of a victim to this form of the disease. No sooner is he in his bed than he springs from it precipitately, rushes about his chamber as though insane; sits down and then gets up again; he is afraid of the heat, because it increases his dyspnœa; afraid of the cold, because of his dropsy. Around the patient all the anxious family are also awake, each one trying to find a comfortable position for him: this one for his feet, that one for his head; one for his back and another for his arms; and yet another for his loins and his hips. And so the whole night passes in these fruitless attempts to make him comfortable" (J.-P. Tessier, *L'Art Médical*, t. x, p. 413).

M. Beaur presented a type of this kind of insomnia.

The delirium and stupor appear in the very last stage. I have often observed a delirium with symptoms approaching those of insanity.

During the last weeks of the disease the fits of suffocation usually disappear. In some cases, even the dyspnœa is so relieved that the patient and his friends begin to hope for his recovery.

The death, which follows, results from different mechanical causes. It is most frequently occasioned by the accidents which are usually observed at the termination of cardiac affections. The great anasarca, the œdema of the lungs and of the brain, produce a slow asphyxia, which kills the patient after an agony which is most painful to those about him, for he himself is almost unconscious.

The symptoms of albuminuria, and of the different varieties of uræmia that succeed it, often modify the death by asphyxia, and then the patient passes into a state of coma.

The convulsive symptoms must be very rare, for I have never seen them. Sometimes death comes by syncope, as in angina pectoris.

The inflammation of the endangium extends more or less rapidly until it gains the external sheath of the aorta; some of the painful symptoms of thoracic angina follow, and death, by syncope, results when the cardiac plexus is involved in the inflammatory process.

For the sake of convenience in the description, I have deferred speaking of the accessory symptoms until now. These symptoms are none the less important because, if not well understood, they may impair the diagnosis.

Some patients suffer greatly from difficulty of deglutition (see the case of Madame, the duchess of P.) This difficulty compares perfectly, in its character and symptoms, with that which accompanies aneurism of the arch of the aorta. In both cases this dysphagia is of the paralytic form, and arises either from pneumo-gastric compression, or from the extension of the inflammation to this nerve. You know that the muscles of the œsophagus are supplied by the nerves which come from the pneumo-gastric.

I have sometimes observed a pain in the throat, with constriction. This pain is extremely persistent, troubling the patient, who begs his physician to cure him of an angina, which absolutely does not exist.

The extension of the inflammation of the endangium to the external tunic of the aorta produces, when it attacks the nerves that surround these vessels, certain special symptoms, which give the patient a peculiar expression of the face. First of these are the pains which radiate in different directions, as along the jaws to the neck, the shoulders and the epigastrium. The cases in which the pains are slight form a connecting link between the common variety of chronic aortitis and angina pectoris. Painful spots may frequently

be found by pressure upon the first bone of the sternum, and in the superior intercostal spaces. The spasms of the diaphragm, and the pains along the scalenus muscle, may be explained by the inflammation of the phrenic nerves; just as the peculiar character of the expiration, noted in many cases, shows an excitation of the pneumo-gastric by the extension of the inflammation.

Let us return to the physical signs which permit us to make a precise diagnosis in chronic aortitis:

1st. There is often a sub-sternal pain, that is increased by pressure upon the first joint of the sternum, and also in the neighboring intercostal spaces.

2d. There is, but not always, a dull sound on percussion over the aorta, which dullness predominates habitually on the right side of the sternum, between the right border of this bone and the sterno-clavicular articulation.

3d. In the onset, the aortic sounds have seemed to us to be more distinct; later they became dull; and sometimes there was a veritable *bruit de souffle*.

4th. The pulse is generally small and feeble, but it may be irregular, as it was in the case of Madame Broq, but, on examination with the sphygmograph, it always shows the feature which Marey attributes to senile atheroma. This symptom has never failed us. We shall show you several drawings in which it may be seen.

Finally, the superficial arteries are often ossified, and some patients present the senile circle of the cornea.

Case XXVIII.—Mr. B., whose present age is fifty-two, is a man of vigorous constitution. His mother was gouty, and he has himself been subject to periodical headaches, that recur about once a month. He has for a long time used tobacco to excess, drinks wine and coffee freely, and is a high liver. His occupation is sedentary.

At about the age of forty he suffered from hemoptysis, for which trouble he was sent to the Pyrenees. Several years later I saw this patient for the first time, and, upon examination, was unable to find any lesion, either pulmonary or cardiac, connected with this hemorrhage.

Mr. B. has complained of his throat for a long time; he suffers from dryness, with strangulation, pain in swallowing, and incessant coughing from the throat; the voice is nasal. A local examination of the throat showed a general redness, a very irregular swelling of the tonsils, and some granulations in the pharynx. However, in 1870 and 1871 his general health was sufficiently good to permit him, in spite of his age (forty-nine), to serve in the marching battalions of the National Guard. From 1872 his breathing became difficult, and his dyspnœa was always connected with his sore throat.

Toward the commencement of the year 1873, tormented by the idea of chronic angina, he consulted a specialist, whose diagnosis was *anæmia*, and who advised a resort to hydropathy. This treatment induced certain cerebral symptoms; a congestion of the retina of the right eye, with diminution of sight; a certain difficulty of speech, and a noticeable failing of the intellectual faculties. By my advice, he stopped this treatment and took *belladonna*, which gave him some relief.

On the 12th of May, 1873, Mr. B. had his first attack of suffocation. The paroxysm lasted one hour and a-half, and was very alarming. One of our college professors was consulted, and he attributed the paroxysm and the habitual dyspnœa to an imperfectly developed angina pectoris of a gouty nature. On auscultation, he found that the sounds of the heart were very tumultuous, especially at the orifice of the aorta, which led him to admit the existence of a parchment-like condition of the endocardium and of the endangium.

From this time, I had no doubt that the disease was chronic aortitis. The habitual dyspnœa, the attacks of suffocation,

which were frequently repeated, the commencing anæmia, the absence of the signs which characterize the lesions of the cardiac orifice, and the absence of the usual pains of angina pectoris, made it impossible to hesitate regarding a diagnosis that was soon to be confirmed by the character of the dyspnœa, the restless insomnia, the presence of albumen in the urine, the œdema, the dullness in the aortic region, and the succession of all the symptoms which characterize the cardiac cachexia, without any of the signs of a lesion of the cardiac orifices.

Pilules of arsenic were prescribed by the physician to whom my patient had applied, but notwithstanding their use the spasms of suffocation were frequent. *Nux vomica*, in the 30th dil., which was prescribed on the 4th of June, stopped the paroxysms for some time. The patient, who was in the country, passed several days at the sea-side; then he spent a season at Royat, and returned much relieved, although he had one violent attack after an immersion in the waters of Royat.

During the autumn he was comparatively better, but the dyspnœa continued to return, and he was obliged to walk, and especially to go up-stairs, with the greatest care, as he always felt himself at such times on the verge of an attack.

The severe paroxysms of suffocation returned in the month of December, and in consequence of his having called another physician during one of these spasms, and then remaining under his care, I lost sight of him for some weeks.

About February, 1874, I was recalled, and then his condition was as follows: The complexion is yellow and cachectic; there is swelling of the face; œdema of the legs; the urine is albuminous; there is complete insomnia, accompanied by an unrest that causes him to rise, to change his position, and to walk and talk incessantly, and there is dyspnœa with spasmodic efforts at respiration, and a moaning cry. The dyspnœa

is worse at intervals, and is accompanied by a throbbing in the side that is quite perceptible to view, and which is caused by the convulsive action of the diaphragm. From time to time these attacks were accompanied by faintness, and a threatened syncope. The pulse is small and feeble, varies from 88 to 112, and gives a characteristic sphygmographic trace, a straight ascending line, a very marked level one, and a descending line that is very oblique without dicrotism.

Trace No. 7.

The patient is, therefore, in the cachectic stage, and his condition becomes worse progressively. He is unable to lie down. The insomnia and suffocation are agonizing, and they pursue him to his arm-chair; and for several weeks his wife, his son, and the nurse, were exhausted in useless attempts to make him more comfortable. Overpowered by fatigue, he is scarcely asleep when he awakens suffocating, and anxious, until at length he is afraid to sleep, and resists it with all his strength, imploring those about him not to let him fall asleep again. It seems as though respiration could not go on automatically, but needed a voluntary effort to make it complete. The nights pass in this unceasing struggle, the patient rising, changing his chair, tries to eat, talks a great deal, and after a time becomes delirious. His days are a little more tranquil.

Aconite and *spigelia*, in the mother tincture, and in the 6th dil., relieved the violent attacks of suffocation, but were powerless against the habitual dyspnœa, and the increasing cachexia. It was the same with the *cactus grandiflora*, *lachesis*, *digitalis*, and *secale cornutum*. The *arseniate* of *antimony*, in the form of granules,—advised by Doctor Crétin,—was productive of

calmer nights and several hours' sleep; but this remedy soon lost its power, and when I resumed its use after a suspension of several days, it was ineffectual.

At the end of April the insomnia returned. The patient no longer suffers from suffocation, but the dyspnœa, which has become habitual, is intense at times. The œdema has made great progress. The patient is delirious every night. His speech is so embarrassed that it is very difficult to understand him. The appetite is gone, and his physical strength is so reduced that he cannot take a step. At this juncture I prescribed *carbo vegetabilis*, 12th dil., which gave him a little quiet; but it was *cuprum*, 12th dil., that produced a veritable revolution in our patient's case. The dyspnœa ceased, the appetite and the sleep returned, and at the same time the pulse, which had been between 96 and 120, fell to 80, and also became less feeble.

At the end of two weeks his strength had increased considerably; the unrest and anxiety had disappeared; he spoke distinctly; could walk a little, and believed himself convalescent. But this improvement was not lasting; his strength failed again; the œdema increased; the somnolence became more and more pronounced, and the patient finally passed away quietly without a return of the dyspnœa or of the agitation, which had marked the beginning of the cachexia.

Case XXIX.—Mrs. B——, aged forty-five years, still has her menses. This patient is hemorrhoidal, and has had several attacks of bilious colic. In November, of 1872, more than a year ago, she was seized with an attack of dyspnœa while dancing after dinner. The paroxysm was short, and it apparently left her in good health, but there was a return of it at brief intervals, sometimes when walking fast, or on mounting the stairs. These paroxysms finally became very frequent, and were accompanied by an habitual dyspnœa. Eat-

ing had more and more influence in causing a return of these paroxysms, and when we saw the patient at the end of February, 1874, she had not dared to eat solid food for more than a month, each attempt at doing so provoking an attack of dyspnœa.

At the same time that the dyspnœa became habitual the strength failed; the anæmia became more and more pronounced, and the appetite was completely lost. The opinions of the physicians who were consulted before I was called varied, for some of them thought the disease to be seated in the heart, although they could not discover any abnormal murmurs; others considered it a nervous affection.

The Present Condition.—The patient is lying, or rather sitting, in bed, and bolstered up by numerous pillows. She is extremely pale, with the yellowish tint common to cardiac affections; there is œdema of the eyelids; the respiration, which is manifestly accelerated when the patient is in repose, becomes a perfect breathlessness when she tries to speak; with œdema of the inferior members; the urine contains albumen. She experiences a feeling of constriction, and of distress in the epigastrium, which is not absolutely painful. For the reason that the eating of solid food induces a paroxysm, she takes for nourishment but a single cup of coffee and a little broth each day. These spasms are characterized by dyspnœa, which is really orthopnœa, with throbbing in the epigastrium that raise the abdomen violently, and which are apparently caused by the convulsions of the diaphragm. The pulse becomes small, obscure, and disappears. There is prolonged lipothymia, with cold sweats. The paroxysms, which are so terrible for the patient and so frightful to those about her, come at irregular intervals, several days apart, but are sure to be provoked by eating solid food, and by unusual exercise or emotions. The sleep is agitated, and sometimes she does not sleep at all at night. There is some degree of somnolence during the day.

The heart is large, but auscultation does not show any abnormal sounds either at its apex or at its base. The aortic dullness measures six centimetres; the aortic sounds are intense, and the sphygmographic trace shows the ascending line very short and oblique, the level one, followed almost without transition by a descending line that is oblique, almost straight, and without dicrotism. The pulse is very irrregular.

TRACE NO. 8.

The pulse, which usually was feeble and irregular, varied from 90 to 100.

Aconite and *arsenicum* were successively administered in various potencies; the tincture of the former, and triturations of the latter, and dilutions also from the 6th to the 30th, all of which were powerless to modify the morbid condition.

The œdema and feebleness increased daily. The patient had alternations of excitation and somnolence. But a short time after the persevering use of *carbo vegetabilis*, in from the 6th to the 30th dil., the attacks of suffocation ceased, and did not return.

Toward the middle of March the symptoms of uræmia appeared abruptly; there was a considerable weakness of vision, especially in the left eye; aphasia, characterized by the impossibility of finding the proper word, and the use of words belonging to no language at all; divagation and irritability. These symptoms were much relieved through the influence of *belladonna*.

The sphygmographic trace, made at this time, shows signs of asystolie. The urine continues albuminous. The œdema of the superior extremities has become very excessive. The ap-

petite has completely failed, and at different times she has had attacks of nausea and vomiting, and some diarrhœa. *Ipecac.* caused these symptoms to disappear, but the debility and the œdema are worse each day. She is delirious, lucid and somnolent alternately.

The patient finally died in the month of April, having been perfectly rational for several days previous. It is to be remarked that for several weeks she had not had a paroxysm of suffocation, and that the habitual dyspnœa was greatly lessened.

Case XXX.—Madame de R., aged thirty-six years, of gouty parentage, has suffered from arthritic pains and hemorrhoids. Some years ago she drank tea to great excess to arrest an *embonpoint.* This patient has been through pregnancy several times, the first being followed by phlegmasia alba dolens, which left behind an incurable œdema of the left leg. She has for eighteen months been subject to a slight want of breath, and during the summer of 1873 her physician, struck by her palor and her bloated condition, examined her urine, which he found contained a considerable quantity of albumen.

The first attack of suffocation occurred in July, 1873, at Pouliguen, on the coast; it came on during the night, and was occasioned by the going out of the oil-lamp. She attributed it more to the darkness than to the odor of the burnt oil. The second paroxysm occurred a few weeks later, and was neither violent nor of long duration. It was not so with the attack of the 22d of November, which lasted between ten and eleven hours. This came on about ten or eleven o'clock, after the patient had gone to bed, and after a day during which the asthmatic breathing had been very bad. This paroxysm was so violent that the patient lost consciousness. She had scarcely time to call for help and throw herself down near an open

window, when she sank unconsciously in the arms of her husband. The respiration was apparently suspended; the mouth was wide open; the face pale and cyanotic; the lips were blue; the eyes were fixed; the pulse was regular, feeble and hard. The patient was bled, after which the breathing became slower, and consciousness returned. She expectorated a frothy, bloody substance, and upon auscultation very fine subcrepitant râles were detected. The night following was quiet, and the patient recovered rapidly. This was, therefore, a well marked attack of pulmonary congestion.

In February, 1874, the third attack was occasioned by mental excitement, and was similar to the first. The physicians who cared for her found no signs of cardiac affection, and their diagnosis was aortitis, with an extension of the inflammation to the pneumo-gastric, and consequent disorder of this nerve.

Actual Condition.—The patient suffers from habitual dyspnœa, characterized by a slight increase of the symptoms, and spasmodic expiration. She is pale and anæmic; the mucous membranes are almost colorless; the vascular souffles are obvious, and œdema has commenced in the legs and in the hands; she has thirst; the urine is sometimes very abundant and pale, and sometimes darker and less in quantity than natural, containing albumen generally, though not always, and in variable quantities. The urine, however, takes the characteristic odor from the use of asparagus. There is but little appetite and great debility. The menses still appear regularly. The patient is subject to terrible attacks of suffocation, which come at irregular intervals, several days apart, and at any hour in the day.

She sleeps very poorly, sometimes passing the entire night in an arm-chair, because she breathes more easily, and dreads the spasms of suffocation. After sleeping a short time, perhaps a quarter or half an hour, she awakens in such agony

that she is afraid to go to sleep again, and struggles against the inclination to do so. When she cannot sleep, which is oftener the case, she is extremely agitated, and one position is as uncomfortable as another.

Two weeks ago she took cold while driving in an open carriage, which resulted in an attack of pleurisy, limited to the inferior third of the left pleura. This pleurisy is still far from being entirely cured. Auscultation and percussion of the lung revealed no lesion; there is no pulmonary emphysema, a fact which causes us to reject the idea of asthma, notwithstanding the expiration is, as we have said, sometimes spasmodic and very difficult.

The heart presents no abnormal murmurs; both of its sounds are distinct, but a little harsh in tone. The apex of the heart beats in the line of the nipple. The aorta presents a transverse dullness of four and a half centimetres. The aortic sounds are dull. The pulse is frequent, but so small and so feeble that it is impossible to take the sphygmographic trace of it.

Under the influence of *carbo vegetabilis*, 30th dil., and then of *arsenicum*, 12th dil., the dyspnœa was greatly relieved; the nights became more calm; the effusion was reabsorbed, and the appetite returned; but the œdema and the albuminuria increased constantly. Following a fresh cold, which was chargeable to the coolness of the weather, the pleurisy was lighted up again, the dullness increased to three fingers' breadth, with absence of the respiratory murmur, which is replaced by an abnormal souffle. *Cantharis*, 3d dil., and *bryonia*, 3d dil, were of little benefit, and at the end of thirty-six hours I was obliged, on account of the dyspnœa, to return to *carbo vegetabilis*, 12th dil., which speedily relieved this symptom. During the day I gave several spoonfuls of *cantharis*, 3d dil. Under the influence of this treatment the effusion decreased again.

During this relapse of the pleurisy, the pulse was raised, and varied from 104 to 116, growing stronger also, meanwhile.

A complication of pultaceous angina occurred during this febrile relapse. I treated it locally by painting it with glycerine and *mercurius cor.*, 1st dil. (twenty grammes of glycerine to twenty drops of the mercurius cor., 1st dil.)

We took advantage of the slight improvement in the patient's condition, caused by this treatment, to send her back to her family, where she died a month after, with considerable anasarca.

The premature appearance of the albuminuria, the variableness of its proportions, and even its non-existence occasionally; the thirst, and the quantity of urine, which was often large, caused it to resemble a case of interstitial nephritis.

For, is not interstitial nephritis always associated with an arterial affection and ossification of the arteries, and is it not often, like chronic aortitis, a gouty affection?

Case XXXI.—Madame de ——, the Duchess of ——, is a woman of forty-eight years, and of a fine constitution. Heart diseases are hereditary in her family, and she has herself shown symptoms of gout. Subsequent to a labor, 22 years ago, the menses became deranged and she was attacked with phlebitis, which left her with œdema of both legs. Her disease commenced by oppression of breath when walking, in 1871, or about three years ago. It was at first observable only when climbing the stairs, but it progressed steadily and was attributed to anæmia. Joined to this suffering there soon appeared another, and a characteristic symptom, which still exists, viz: great difficulty in the deglutition of solids. Besides this, the patient is subject to palpitation.

Her condition is shown in the following symptoms:

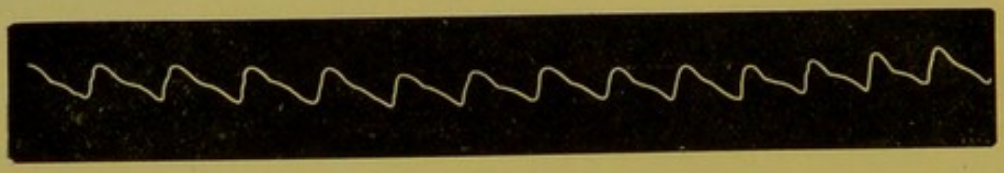
There is an habitual breathlessness which makes walking very painful; she has palpitation, and a short, dry,

laryngeal cough, and choking while eating; the pulse is regular, small and frequent, varying from 96 to 104, and there is a considerable quantity of albumen in the urine.

A short time after this the patient was seized, when about to retire, with a violent fit of suffocation, which lasted for several hours, and which greatly alarmed her family. I found her the next morning much more oppressed than usual, very anxious, and with a pulse of 120. *Aconite*, in the mother tincture, twenty drops in 200 grammes of water, one spoonful every two hours, gave her relief.

A careful examination showed her condition to be as follows: There is no lesion of the lungs; the heart-sounds are well marked, and normal; the aortic dullness extends over a little more than four centimetres, and this dullness is more pronounced at the left of the sternum; there are no murmurs in the vessels. The pulse, examined by the sphygmograph, gives the ascending line as perpendicular, the level very marked and the descending line very oblique, with noticeable dicrotism.

Trace No. 9.



The results of this examination being confirmed by one of our most distinguished hospital physicians, I no longer hesitated in my diagnosis of chronic aortitis.

Fifteen days later this patient had another terrible attack of suffocation, but since then, thanks to an almost absolute state of repose, and the use of *digitalis*, of *lachesis* and of *aconite*, these paroxysms have not returned; the cough has left; the asthmatic breathing is lessened, and the pulse has fallen to 84; but the continued presence of

albumen in the urine, and the persistence of the dysphagia clearly show that the disease is not cured.

The details which follow will illustrate to you the analogies and the differences between the common form of chronic aortitis and the painful form, or angina pectoris.

Chronic Aortitis with Angina Pectoris.

Case XXXII.—Mr. Etienne, sixty-one years of age, entered the hospital on the 26th of January, and left it on the 31st of January.

This man has never had a serious illness, excepting an attack of cramps of the stomach, which occurred five years ago, and which lasted about a fortnight. His health had been good up to the month of October, 1873. At that time his appetite began to fail, and his sleep, hitherto always calm, to be interrupted by pains in the pit of the stomach and in the legs. These pains ascended to the side of the chest, producing violent dyspnœa, and forcing the patient to get up.

The paroxysms were very frequent at night, but he rarely suffered during the day. A physical examination of the patient showed no morbid sounds in the vessels of the neck, but on the level of the aorta a harsh sound was perceptible by auscultation. By percussion, we found a dullness which was much greater than normal. The movement of the heart is irregular, but there is no souffle either at its apex or its base.

January 26. *Nux vomica*, 12th dil.

January 27. The paroxysms have recurred, but they are very short and very frequent. The same treatment.

January 28. No improvement. We find that the arteries are ossified. The sounds of the heart are dull. The same treatment.

January 29. Slight improvement; the attacks have been less frequent, and the night a satisfactory one. *Nux vomica*, 12th dil.

January 30. The patient wants to leave, being, in fact, but slightly improved. He died at his home a few days after.

Case XXXIII.—Mrs. Duplessis, aged forty-nine years, entered on the 1st of April, and left on the 3d of April.

The general health of this patient has been good. Her menses were established at the age of seventeen, and ceased at forty-two. She has had hemorrhoids for the past fifteen years, which at times are very painful. The affection for which she has come to us is of a year's duration, but long before she had felt a formication in the region of the left scapula. This present illness began with a constant pain in the back, which was so severe as to cause her to stop sometimes in the midst of her work. She says that it seemed to her as though some creatures were gnawing her flesh.

For two or three months she complained of fits of suffocation which were of short duration, and which came on generally while she was walking.

Since that time, also, she has suffered from sub-sternal pain and a numbness in the left arm, which extended to the fingers.

An examination of the patient reveals an absence of abnormal aortic dullness, a souffle in both carotids, and absence of the aortic valvular click, which is replaced by dull murmurs.

There is a pain at the top of the sternum, which is increased by pressure, and especially by walking; pain in the diaphragm, that is also excited by pressure on the level of the left scalenus muscle; habitual dyspnœa, and insomnia. The patient is often obliged to stop while walking, on account of the sub-sternal pain, which extends in the form of numbness to the left arm. The sphygmograph gives a pulse that is pretty regular; the ascending branch is short and a little oblique; the level line very marked at certain pulsations, and the descending line long and oblique, with very feeble undulation. This patient only

came to the hospital for examination. She was prescribed for regularly at the dispensary. *Spigelia*, in the mother tincture, almost entirely stopped the sub-sternal pains.

Among the cases of chronic aortitis that I have seen in the consultations, and which I have received into our wards simply to make an examination of the pulse, is that of Mrs. Clery, aged sixty-five, and who occupied No. 3 of the second ward, from the 21st to the 24th of January. This woman bears the appearance of advanced age; she is hemorrhoidal; the cornea presents the senile circle; the superficial arteries are ossified; the sphygmograph showed the typical level tracing; the state of the heart is normal. She complained especially of dyspnœa and of insomnia, and was treated by *arsenicum*, 12th dil., and did not return to the consultations.

Mr. Cartier, aged sixty-five. He has dyspnœa and sub-sternal pains, which radiate to the epigastrium; insomnia, and ossification of the superficial arteries. The sphygmographic trace is characteristic. *Spigelia*, 3d and 6th dils., gave great relief to the pains and the oppression.

LECTURE XII.

SUMMARY.—Typhoid fever, *case*. Asthma, *case;* indications for *bryonia*. Asthma and trifacial neuralgia, *case*. On the choice of the attenuation.

Typhoid Fever.

GENTLEMEN: A week ago you may have seen in our wards a woman for whom, and with some reservations, I made the diagnosis of typhoid fever. I told you that I had but faint hopes of her recovery. My fears have been realized in her death, which occurred two days ago. The temperature of this patient increased constantly; there was a complete absence of alvine discharges and of urine, both of which are very bad prognostic signs. The remedies that I used in this case were *arsenicum*, *carbo-vegetabilis*, and, as a last resort, *stramonium*, in the third dilution. The medicines were alike ineffectual in retarding the progress of the disease.

CASE XXXIV.—Mrs. Charpentier, aged thirty-five, entered on the 1st of April, and died on the 6th of April.

This patient came to us on the twelfth day of her illness, which commenced, as we learned from her relatives, with headache and vomiting. There was no epistaxis. The stools were frequent, but they had been provoked by a purgative given during the first days of the disease; from that time there has been constipation. The patient was completely prostrated. She complains of headache, and says that since she has been ill she does not hear distinctly.

The abdomen is sensitive, especially in the right iliac fossa, but there are no spots on the skin. The pulse is frequent and small; the tongue whitish, a little red at the tip and on the sides. An examination of the chest reveals nothing. No râles are to be heard, although there is dyspnœa and a frequent cough.

April 1. Evening temp. 104°, pulse 120.

April 2. Morning temp. 101.8°, pulse 120. *Arsenicum met.* in the 3d trit. Evening temp. 104.36°, pulse 120.

April 3. Morning temp. 104°, pulse 120. *Carbo-vegetabilis*, 12th dil. Evening temp. 104.72°, pulse 128.

April 4. Morning temp. 103.28°, pulse 116. *Stramonium*, 3d dil. Evening temp. 104.36°, pulse 128.

April 5. Morning temp. 102.56°, pulse 120. *Stramonium*, 3d dil. Evening temp. 105.44°, pulse 136.

April 6. Morning temp. 102.20°, pulse 128. *Stramonium*, in the mother tincture, one drop. Evening temp. 106.88°, pulse 168. Death.

From the 2d to the 6th of April, the prostration and adynamia increased. The patient has had no alvine evacuations at all, and during the last days no urinary discharge; not because of retention of the urine, but from absence of the secretion. She is agitated and delirious, particularly at night; the face is pale, and there is considerable emaciation.

Asthma.

The patient in No. 3 is a woman, ill with transitory emphysema and asthma. Her case, although of slight interest from a pathological point of view, is of great therapeutic importance. You recollect that this patient left us some time ago, after having been treated with *arsenicum*, and that when she left she showed, upon auscultation, that there were no remaining symptoms of emphysema. She returned to us in a few days with a most violent attack, for which we again prescribed *arsenicum*. She was again relieved, although she complained of a constant difficulty in breathing. We then gave her *cuprum*, which seemed indicated by another attack, and which was accompanied with vomiting, but we completely failed to relieve her. I then made a more thorough examination of her symptoms, and found that she suffered from a pain in her side, which was increased by respiration. I

prescribed *bryonia*, under the influence of which remedy she is being rapidly cured.

This indication for bryonia in asthma is not really a classical one. Hahnemann names asthma as being within the sphere of bryonia, but in the history of the remedy he gives few homœopathic symptoms of this affection. Jahr mentions more of them, as *difficult respiration, the need of a deep inspiration, constriction of the chest, and anxious breathing.* I find bryonia strongly indicated in asthma when it is accompanied by vomiting and pain in the side. In fact, a goodly number of homœopathic physicians are in the habit of using it in similar cases, and with decided benefit. Here are the full notes of this patient's case.

Case XXXV.—Mrs. Rouel, aged forty-six years, entered the hospital, for the first time, on the 4th of March, and left on the 19th of March, and rëentered on the 21st of March.

This patient has neither suffered from hemorrhoids, cutaneous diseases, nor from articular gout. For a long time she has been subject to pains in the stomach with cramps. She has had bronchitis quite frequently for three years, and since the 1st of January last has suffered from attacks of suffocation with oppression, which often oblige her to rest. She adds that from that time she has heard a whistling sound in her chest; but the fits of a suffocating dyspnœa, which are as apt to come during the day as at night, are the cause of her coming to the hospital. These paroxysms are usually of short duration.

The examination of the chest, on her entrance, showed the whole left side to be the seat of sibilant râles; there is a prolonged and very emphatic expiration, which is really double. She has been in the hospital since yesterday, but as we have not yet seen her during the paroxysm, we have not made a prescription.

March 5. The paroxysms have not returned. No remedy.

March 6. No paroxysms; frothy expectoration; the expiration is very prolonged, and the whistling more marked than it was yesterday. *Arsenicum*, 3d trit., twenty centigrammes in 200 grammes of water, one spoonful every two hours.

March 7. Improvement; there was less suffocation during the night. The same treatment.

March 9. The râles have considerably diminished; the prolonged expiration is not heard except in the apex of the left lung. The same treatment.

March 11. The suffocation has almost disappeared. The same treatment.

March 12. The emphysema has disappeared.

March 13. There is still slight suffocation. *Arsenicum*, 2d trit.

March 14. No suffocation. Same treatment.

March 16. The patient is cured, and leaves the hospital.

From the day of her leaving us the attacks of suffocation recommenced. On the night of the 16th she had a severe dyspnœa, which prevented her from sleeping, but she has had no paroxysm nor cough. The day of the 17th was not bad, but during the night the suffocation returned and was more severe than the night before.

March 19. The patient continues to grow worse, and reenters the hospital on the 21st.

March 22. She has had four successive paroxysms this afternoon. These paroxysms present this especial characteristic, that they are accompanied by stiffness of the limbs and a loss of consciousness, with cyanosis of the face. Each paroxysm terminates with a profuse sweat. On examination of the chest, we find whistling respiration, prolonged expiration, and moist râles on both sides of the chest. *Arsenicum*, 3d trit.

March 24. The râles have diminished; the expiration is a little less prolonged, and there is less suffocation.

March 25. She has an abundant expectoration; great improvement. *Arsenicum*, 2d trit.

March 26. Less expectoration and suffocation. *Arsenicum*, 2d trit.

March 28. The patient had a high fever last evening, and we feared another paroxysm; the pulse was 120, and the temperature increased to 102.5°. These symptoms grew rapidly better. The same treatment.

April 1. The same condition, but no diminution of the dyspnœa. *Cuprum*, 6th dil.

April 2. No fever in the evening, but the night was very bad.

April 3. There is very great dyspnœa, with frequent cough, and the signs of emphysema persist on the right side. Last evening the pulse was 120, and the temp. 102.74°. She vomited several times during the night, and had pains in the side when she coughed. *Bryonia*, 3d dil.

April 4. No fever last evening, and there is almost no suffocation.

By auscultation, it was difficult to find traces of emphysema, and there is almost no prolonged expiration.

Convalescence was established, and she left us on the 9th of April.

No. 3, of ward 2, is also occupied by a woman, whose paroxysms of asthma alternate with trifacial neuralgia. *Arsenicum* cured the asthmatic paroxysms; *nux vomica*, and then *belladonna*, have been given for the neuralgia, which is principally seated in the branches of the sub-orbital nerve.

Case XXXVI.— Mrs. Casal, forty-five years of age, entered the wards on the 30th of March, and left on the 14th of April.

This patient still menstruates regularly. For five years she has had hemorrhoids, and when these began she first noticed that she lost some blood at stool.

Nine years ago she was attacked with bronchitis, which was brought on by a cold, and followed by a cough that lasted two years. This cough, which was loose, and as frequent in summer as in winter, did not at first impede a free respiration.

The attacks of suffocation, of which she complains, began

six or seven years ago. The paroxysms occurred every eight or ten days, as often in summer as in winter, and were usually of short duration.

During these paroxysms her body would be bathed in a cold sweat. She retained her appetite up to the time of the fit, which is always preceded by dryness of the nose, although ordinarily, when the patient is well, the nose secretes a great deal of mucus.

Auscultation and percussion showed the existence of a universal transitory emphysema; the expiration is prolonged and whistling, and the sonorousness of the thorax is increased.

This woman is subject to neuralgia of the sub-orbital branches of the right trifacial nerve, and this neuralgia alternates with the paroxysms of asthma.

March 31. *Arsenicum*, 3d trit., twenty centigrammes in 200 grammes water. Three spoonfuls daily.

April 6. The patient is better in respect to the paroxysms of suffocation, but the neuralgia is worse. *Nux vomica*, 3d trit.

April 9. The neuralgia persists. I prescribed *belladonna*, 3d dil. The patient, frightened by the admission of a case of erysipelas of the face, asks to leave the hospital.

I will call your attention to two other cases of asthma, in order to familiarize you with the treatment of this disease. The first is a case that was cured by *ipecac.* in the third trituration, followed by *arsenicum* in the same potency.

A point that has not been made by the author is, that in cases like this it is sometimes a very delicate and difficult thing to bring the patient safely through the climacteric period. For, with a strong liability to asthmatic affections existing at this time, the critical age often increases the difficulty instead of curing it by limitation. The prognosis in a woman who is forty-five years of age, and who still continues to menstruate, should be very guarded. It is fortunate, however, for women at the menopause, that asthma is twice as common with men as it is with women at any time of life.—L.

Case XXXVII.—Mrs. Hédoin, thirty-five years of age, entered on the 6th of April and left on the 19th of April.

This patient has never had hemorrhoids nor any cutaneous disease. She has been troubled in her respiration for the past

eighteen months. For that time, also, the menstruation has been very irregular, the flow slight and accompanied by pains in the region of the loins.

The attacks of suffocation, of which she complains, have been more severe and frequent since she had the bronchitis last December.

The paroxysms of dyspnœa come usually at night, and the days are generally calm. The sputa are sometimes streaked with blood. On auscultation, whistling râles both on inspiration and expiration may be heard. The expiration is prolonged. Percussion shows an increased resonance in the lower part of the lungs.

April 7. *Ipecac.*, 3d dil., every three hours.

April 8. The night has been very good; the patient has coughed but little; there is less oppression, and on examination we find the râles diminished. The same treatment.

April 11. The cough has diminished considerably; she complains of pains in the abdomen, and has a slight diarrhœa. *Arsenicum*, 3d trit., three times daily.

April 13. No more enteralgia, but she has slight leucorrhœa. *Sepia*, 3d trit., three spoonfuls a day.

April 15. The patient is greatly improved, and leaves the hospital a few days later with no signs of emphysema.

In the case that follows we owe the cure of our patient to the combined effect of *bryonia* and *ipecac.* Ipecac. alone, in the third trituration, was given for three days without effect. A few days later, it is true that ipecac. arrested a return of the paroxysms in twenty-four hours, but then it was given in the first dilution.

Case XXXVIII.—Mrs. Arnoult, fifty-nine years of age, a domestic, entered on the 7th of February, and left on the 4th of March.

This woman has formerly had good health, and menstruated up to the age of fifty-seven, since which time she has had a dry cough, that is more frequent at night than during the day, and that is always preceded by tickling in the throat.

She also suffers from paroxysms of suffocation, which are more frequent in summer than in winter.

February 9. On examination of the lungs, percussion reveals a sonorousness over the whole chest. By auscultation, we find a very prolonged expiration in the upper third, and diminution of the vesicular murmur in the lower two-thirds. These signs are more strongly marked on the right side. The chest, therefore, presents all the symptoms of the two varieties of emphysema — the transitory and the confirmed emphysema.

The patient has attacks of asthma several times during the night, but there is no fever. *Ipecac.*, 3d trit., twenty centigrammes in 200 grammes of water, one spoonful every three hours.

February 10. The oppression continues as great as before.

February 11. Her condition is the same. The same treatment.

February 12. The oppression continues. The right side, which was less involved in the emphysema, is now attacked, and loud râles are heard in the left side. *Ipecac.*, 3d trit., thirty centigrammes.

February 13. The expectoration, which was scanty, has become very abundant, and is that of bronchitis. There are moist râles throughout the chest. *Ipecac.*, 3d dil., and *bryonia*, 3d dil., alternately. One spoonful every two hours.

February 14. The dyspnœa is much less severe. The same treatment.

February 16. Great improvement in the local and general state of the patient. *Arsenicum*, 3d trit., three times a day.

February 17. The paroxysms have ceased; there is much less expectoration. The same treatment.

February 18. Continued improvement.

February 19. Same condition. *Arseniate of antimony*, 2d trit., three times a day.

February 20. There is a considerable diminution of the cough.

February 24. The patient has had another paroxysm. *Ipecac.*, 1st trit.

February 25. The paroxysms have not returned. *Nux vomica*, 3d trit.

The improvement was very rapid and uninterrupted until the patient left the hospital, which was on the 4th of March.

This was a case of what we should call *post-climacteric* asthma, and the remedy that we have found most useful for it is the *sanguinaria canadensis*, in the third or the sixth attenuation. Apart from the general indication furnished in diseases affecting the bronchial tubes at and after the change of life, this remedy is called for in case of severe dyspnœa, with a teasing, hacking cough, with dryness in the throat, and an inclination to take a deep inspiration during the paroxysm.

In a few cases of this form of asthma we have found the *apis mellifica*, 3d trit., of great service. It has a wider range of use at the menopause than is generally supposed. The symptoms upon which we have prescribed it, after a careful diagnosis of the case, are inability to lie on the left side; hurried and difficult breathing, with a feeling of suffocation, fever and headache, and an aggravation of the cough by lying down, or by sleeping. In one case these symptoms were post-puerperal, and were accompanied by swelling and pain in the right ovary, and tenderness over the uterine region.—L.

Of the Choice of the Attenuation.

Apropos of these cases, gentlemen, I wish to say a word to you regarding the *choice of the attenuation*. I shall not speak now of *palliative medication*, nor of those cases in which the physician desires to obtain the physiological effects of a remedy, as, for example, where it may be necessary to produce vomiting, or purgation, in order to evacuate a poison, or to stimulate the uterus to contract in aid of delivery. In such very simple cases, every one knows that a dose must be given which is in accordance with the effect that we wish to obtain, and that, in such cases, the dose has long been settled by general experience.

The question that concerns us at present is a much more difficult one, *id est*, to determine the dose in the homœopathic treatment.

We might say, as in the time of Hartmann, that this is an arbitrary matter, and that it is optional with the physician, and that each doctor must be governed by his own experience, in order to be able to justify such very opposite precepts.

Some have taught the giving of high dilutions in chronic diseases, reserving the lower ones for the treatment of acute affections.*

This precept is much too absolute to be true, as may be shown by citing the use of arsenic in chronic diarrhœa, of iron in chlorosis, of mercury and the iodide of potassium in syphilis, all of which are given in strong doses for chronic diseases. Some physicians are in the habit of prescribing the mineral remedies in the higher potencies, as the 30th dilution, for example, and the vegetable remedies in from the sixth to the twelfth potencies. You have observed that this pretended rule is successfully broken by us every day.

Other physicians have contended, and with more show of reason, that substances which, of themselves, are inert, such as carbo-vegetabilis, silicea and lycopodium, need extreme trituration and dilution, in order to develop their curative properties, and that in consequence, the higher dilutions, from the twelfth upward, are preferable for these substances.

There are yet others who accept, as pure gold, the theory of *dynamization*, and who, believing firmly that each new dilution develops an additional power in the remedy, conclude that it has no limit. The believers in this theory have left the 30th dilution, which Hahnemann was accustomed to use, far behind, and they have successively adopted the 60th, 100th, 1000th and 1500th. With no rule to guide them, these physicians have reached the 40000th dilution, and have indorsed the action of the contact potencies, *id est*, it suffices for them that one globule, saturated with a medicinal substance, be placed in contact with some inert and unmedicated globules, for the latter to acquire, in a high degree, this medicinal power!

* Mure, of Geneva.

Certainly the greatest enemies of homœopathy are not in the old school; and we may well say, with Hartmann, that since the death of Hahnemann these ideas have been pushed to the very limit of extravagance.

Clinical experience they reply to us is, you say, your only rule for determining the dose and the strength of your remedies; but clinical experience has proved the effect of remedies in the highest and most extreme dilutions, and has fully justified what you call extravagance.

If clinical experience *had* so pronounced in their favor, I should submit to its sovereign decision, because there is no absolute certainty in therapeutics, and, consequently, no science apart from the bed-side.

But what the partisans of extremely high dilutions call clinical experience, is limited to the most shameless and utterly truthless affirmations, or to the publication of cases without a diagnosis, and without even sufficient details to make it possible to examine them, and, for the most part, so ridiculous that the Homœopathic Society of Paris would not permit their publication.

Do we, then, intend to fix the 30th dilution as the extreme limit of the action of a remedy? Certainly we have no right to fix any such limit. But we do protest that none should venture very far on this perilous ground, except he be a true clinical physician, and, I will add, unless he is gifted with enough good sense and discernment to keep clear of all illusions.

In the face of such an extravagance as this, it is not astonishing that a great many physicians have adopted the use of ponderous doses in their practice,—doses that approach the mother tincture, such as the first, second and third dilutions. Shall we say, as some do, that the important thing in the homœopathic treatment is the choice of the remedy, and that the attenuation is of little account?

This would be a convenient way of getting out of the difficulty, but it would not solve the question. To cite only those examples which you cannot have forgotten, the hemorrhoidal patient to whom you remember we gave *nux vomica*, 12th trit., without effect, and who was afterward greatly relieved by *nux vomica*, 30th trit. (Case XXIII), and the patient with phthisis, with whom you recollect *drosera* failed in the third and twelfth dilutions, but was entirely successful when given in the mother tincture (Case XXVII).

In each of these cases the medicine was well chosen, but it was effective of good only when it was given in the dose that was most appropriate to each particular case. The potency is, therefore, of great importance.

If no one has already made an unvarying rule for determining the choice of the attenuation, it must be because such a rule is not yet possible, and because we do not yet possess the necessary evidence for the solution of this very difficult question. It seems to me that there is no better way of helping to settle this question than by summing up the facts, which are known to be unquestionable. For example:

1st. The efficacy of different potencies of the same medicine varies with the diseases in the treatment of which they are indicated; thus, quinine should be used when indicated by the totality of the symptoms in the treatment of intermittent fevers and of chronic diarrhœa. The potency that is most successful, and which is consequently the most strongly indicated, in intermittent fever is the strong one. On the contrary, that which is most efficacious in the treatment of chronic diarrhœa is of a medium dilution, or, say, the sixth to the twelfth dilution.

2d. In the treatment of the same disease the attenuations vary with the different remedies; for example, in the treatment of intermittent fever, if quinine is indicated, it should

be given in strong doses; but when nux vomica or arsenicum are indicated, the higher dilutions, from the twelfth to the thirtieth, are of greater benefit.

From these two undoubted facts we may, therefore, conclude that neither the nature of the remedy nor the kind of the disease can serve as the basis for the choice of the potencies, inasmuch as the *most appropriate doses* vary with the diseases and with the remedies.

The faculty of feeling the influence of external causes, and consequently that of a medicine, which is nothing else, and which is a foreign agent to the organism, varies with each person, and this individual susceptibility, this idiosyncrasy, is the cause of the necessary variation of the attenuations. This element of uncertainty is a part of the very nature of man; we cannot, therefore, hope to eliminate it, but must accept the fact that there is always something *unknown* in this question of the dose and the potency, and that the answer differs with the individual.

There is another modifying element that sometimes influences our success, or our failure, with the medium and the higher attenuations especially. Whether it is the faith *of* the doctor, or the faith that the patient has *in* him, that causes him to succeed with an exclusive potency where others would fail with it, we cannot say; but it is morally certain that some unrecognized influence of this kind, which never came from the pharmacy, or from the medicine case, puts a peculiar emphasis upon much of our experience without getting the proper credit for it. If the scales were balanced, we should find that in many cases, and sometimes in whole communities, the physician's manner and the patient's confidence and impressibility have quite as much to do with the cure as the mere choice of the attenuation after the remedy had been selected. This fact, which is a matter of daily observation, makes it impossible for the members of our school of practice ever to agree upon the comparative efficacy of any range or class of potencies whatever. Taking all the conditions and circumstances into account, each one must settle this question for himself.—L.

But what should be the course of the practitioner in the presence of such a difficulty? For those remedies which are known, and for the use of which we possess positive

clinical indications, we should employ the dose that experience has settled upon. If this fails, whilst the remedy is suited to the particular case, we should change the dilution instead of changing the remedy.

When a medicine is not well understood, and the choice of the potency has not been determined by clinical experience, it is best to commence with the lower potencies, because the positive indications for the newer remedies not being well defined, the chance for an appreciable effect is greater from them. For in general, the more strictly homœopathic the indication, the less the need for the stronger dose.

Those of our readers who desire to have the latest views of Dr. Jousset (for he is a progressive man) upon this subject, will find them in the Transactions of the International Homœopathic Congress, held in Paris, in August, 1878, page 15 *et seq.*—L.

LECTURE XIII.

SUMMARY.—Croup; indications for tracheotomy; *case*. The cure of phthisis; *case;* the vegetable diet in phthisis. Rule for the choice of remedies. Individualization.

Croup.

GENTLEMEN: I will first call your attention to the patient who has successfully passed through the operation of tracheotomy for the croup. The case is as follows:

CASE XXX.— Brassard, a butcher boy of fifteen and a-half years, entered the hospital on the 8th of April.

We learn from the patient, and from the relative who brought him to us, that his ill-health began three months ago with a dry cough, which at times was accompanied by an expectoration that was streaked with blood. His general health remained good, and the boy continued his occupation until the 25th of March. At this time the disease passed into the acute stage. There was a continuous fever, and the patient was confined to his bed or room with dyspnœa, a painful cough, hoarseness and emaciation. The boy adds that eight days ago he expectorated a bit of false membrane, a fact the importance of which we did not at first appreciate.

April 9. He has a high fever. Last evening the temperature was 102.20°, and the pulse 100. There is complete aphonia, with a dull, hoarse and painful cough; dyspnœa, which is worse in paroxysms. During these paroxysms, both inspiration and expiration are whistling; but when the patient is calm, the respiration is calm and quiet. There is no perceptible œdema of the folds of arytheno-epiglottis. On auscultation, we find the respiratory murmur obscure, and an echoing of the laryngeal sounds; some scattered sibilant râles; the relative dullness at the apex of the right lung; the fever is lower than it was last evening; the temp. is 100.76°, and the pulse 96. *Phos-*

phorus, 12th dil., six globules in 200 grammes of water, and one spoonful every two hours.

April 10. Last evening the temperature was only 101.12°, and the pulse 100. This morning the fever is much higher, the temperature being 102.92°, and the pulse 112. The patient is red, perspires profusely, and the dyspnœa is worse. *Aconite* in the mother tincture, twenty drops in 200 grammes of water, one spoonful every two hours.

April 11. The fever has subsided since last evening; the temp. is 102.56°, and the pulse 108. This morning the temperature is again lower, being 101.84°, although the pulse has increased to 112. The patient is much calmer, and the dyspnœa less. The same treatment. Toward noon the dyspnœa increased very much, and the patient has had fits of suffocation, during which the face became purple. Tracheotomy was decided upon, and the operation was performed by Dr. J.-P. Tessier, assisted by Dr. Guérin and by the interne, M. Scheffer.

April 12. Morning. The patient is much relieved; he has thrown up three false membranes through the canula. The respiration is still rapid; the temp. is 102.20°, and the pulse 116. He takes *bryonia*, 12th dil.; with milk for drink and for nourishment.

Evening. Increased fever; temp. 103.28°, the pulse 140; the dyspnœa is more pronounced, and there is great restlessness. *Cyanide of mercury*, 2d trit., twenty centigrammes in 200 grammes of water, one spoonful every hour.

April 13. Improved; the fever has decreased; the temp. is 102.56°, and the pulse 120. Evening. Temp. 102.20°, pulse 124. The patient has no appetite yet, although he drinks milk, some drops of which pass through the canula. The same treatment.

April 14. He slept last night, the fever decreasing. Morning temp. 100.76°; evening temp. 101.12°; the pulse in the morning was 112, and in the evening 108. The respiration is easy, and the patient expectorates mucus freely by the canula. He still takes milk. The canula is changed. The same treatment.

April 15. He is convalescent; the fever is entirely gone. Morning temp. 98.96°, pulse 88; slight increase in some of

the symptoms. Evening temp. 100.76°, the pulse, on the contrary, dropped to 84. The patient sleeps well, has a little appetite, is cheerful, and breathes easily. The same treatment.

I left the patient at this time in the care of Dr. Frédault. The febrile movement stopped entirely on the 16th, and the temperature fell to 99.32°. The canula was removed a few days later, and the cure was complete in a short time.

The erroneous statements made by the relatives of this patient, concerning the onset of the disease, which they fixed at three months previous to his coming to us, his age, and the absence of false membranes in the pharynx, misled us for a short time in our diagnosis. However, the aphonia, the hoarse, dull and painful cough, the dyspnœa, coming in paroxysms, with the symptoms on inspiration, made it impossible for us to doubt the seat of the lesion. Beyond a doubt, the affection was laryngeal. The laryngeal whistling during expiration, as well as during inspiration; the absence of œdema of the folds of the glottis, that was perceptible to the touch, excludes the possibility of the affection that is improperly styled *œdema of the glottis.* I confess that I did not think of croup in a patient who was fifteen years old, where there was no diphtheria of the pharynx, and where the disease had already lasted for three months. This last circumstance caused me to make the diagnosis of *acute tuberculosis of the larynx.*

In the progress of this disease, I could not but admire the precept of Hippocrates: "An error in diagnosis is sometimes the fault of the physician, often of the patient, and oftener still of those about him."

In this case I was, beyond a doubt, the victim of the *error ab astantibus*, and the three months' duration, which was falsely attributed to a disease that had begun but a few days before, had totally changed the aspect and signification of the pathological picture.

In no single respect is the author's sincerity and merit more pronounced than in this frank avowal of an error in diagnosis. We can trust him to the verge of the incredible if he tells the truth when he has blundered. Every man, woman and child, who drives a horse and carriage down the street, thinks himself or herself capable of doing it more skillfully and adroitly than anybody else; and almost every doctor, who prescribes for a patient, supposes himself or herself to be equally skilled, and quite as infallible in the art of diagnosis.—L.

The dyspnœa, increasing hourly, with threatened asphyxia, were the clearly constituted indications for tracheotomy. There was, as expressed by Galen, "the evident necessity of a fixed course of action," and Dr. Tessier, in whose charge I had placed the patient, did not hesitate to act.

The effect of the *cyanide of mercury*, prescribed after the operation, was eminently favorable in arresting the progress of the disease, and in contributing to its cure. As for the tracheotomy, it removed but one cause of the disease; and here we repeat what we wrote in 1844 (in the *Archives de Médecine*), while we were yet an interne of the *Hôpital des Enfants:* "Tracheotomy does not comprise the whole treatment for croup, as Trousseau teaches, but the treatment of one cause of the disease only — suffocation from obliteration of the larynx. This operation is indicated whenever the paroxysms of dyspnœa increase regularly, threatening the patient with death by asphyxia."

The Vegetable Diet in Phthisis.*

In No. 1 of the first ward is a very interesting case as regards the influence of the vegetable diet in phthisis. Here is an abridged history of the case:

Case XXXI.—Françoise Degage, aged twenty-eight years, entered the hospital on the 2d of April, and left on the 14th of April.

Ten years ago this patient was prescribed for at the dispensary in Rue de Verneuil, and now she enters our hospital for

* We have styled this the *Vegetable Diet*, for lack of a better name.—L.

the third time. At its beginning, ten years ago, her disease presented all the symptoms of phthisis,—incessant cough, emaciation, hemoptysis and fever, with night-sweats and mucous râles at the apices of the lungs.

She has been on the vegetable diet, almost without interruption, for several years, and has greatly improved.

April 3. Her present symptoms are: a comparative dullness in the apex of each lung, but particularly of the right one; moist râles, but which are very rare in the apices of the lungs; the expiration is long, and whistling in both lungs; dyspnœa; frequent cough; mucous expectoration, but she has some appetite and strength. *Phosphorus*, 12th dil.

April 5. Having no result from the *phosphorus*, I prescribed *ipecac.*, 12th dil., and *bryonia*, 12th dil.

April 10. Great improvement in the cough and the dyspnœa. The menses appear unexpectedly, and are accompanied by diarrhœa.

April 14. She left the hospital greatly improved.

When this patient came to the dispensary, in the Rue de Verneuil, now some six years ago, she presented all the characteristic signs of phthisis, with softening of the tubercles of the apices of the lungs. The same positive signs are to be found there to-day,—dullness of the apex of each lung, but especially of the right one, and some mucous râles in the same location; but the other portions of the lungs show the certain signs of emphysema in the prolonged and whistling expiration. There are, therefore, two lesions, of which the latter, or the emphysema, seems to have completely arrested the progress of the former, or the tuberculosis.

At the same time that we observed this fortunate development of the lesion, the patient began to gain flesh, her strength returned, and she entirely lost the appearance of a consumptive, which she had at the beginning. For six years she has lived almost entirely on a vegetable diet, and it is chiefly to this diet that we must refer the favorable change in her condition.

Eight years ago I commenced to prescribe the vegetable regimen for phthisis. I borrowed this practice, which may be found, for that matter, at different epochs in medical tradition, from an old physician, Dr. Brunner, who had made a great study of urology. This regimen consists in withholding all meats and wines from consumptives. The aliment, which appears to us the most appropriate in phthisis, consists of farinaceous articles and milk, soups of all kinds, broths, *purées*, all vegetables, including salads, all fruits, and eggs. Certain fish, and shell-fish also, afford a sufficient variety for a diet, which must, in some cases, be taken for years. The difficulty of getting good milk in some of the large cities, and the distaste that many adults have for it, caused me, almost from the first of my prescribing this diet, to replace it by meat-broth, from which the grease must be carefully removed. With this addition, the patient bears this diet much better than without it.

I have found no bad effect from permitting such patients as cannot content themselves with water at their meals, to drink beer instead. In this I except, of course, the English beer, which contains entirely too much alcohol. I also permit the use of coffee and tea where they have no bad effect on the cough, and the patient is accustomed to their use, and where they constitute, as we call it now-a-days, an economical remedy.

I return to the contra-indications of the vegetable diet in the treatment of phthisis, so that such of you as may prescribe it on my recommendation may not be disappointed. In the cachectic stage, which is characterized by hectic fever, colliquative discharges and increasing inability to quit the bed, the *vegetable diet* is positively contra-indicated, and its use will only precipitate the death of the patient.

In the early period this regimen is well borne, and, pro-

viding the patient can easily digest the materials that compose this diet, is of great service; but a bad digestion, acidity, and, above all, a diarrhœa, constitute a decided contra-indication for its use. In these latter cases this diet should not, however, be entirely abandoned, for often by giving the patient meat three times a week, and a little wine at each meal, we may arrange a diet that will be easily borne, and from which excellent results may be obtained. This is the line of conduct that we followed in Case No. IV.

A certain proportion of patients *will not* conform to the vegetable diet, either because it is distasteful to them, or, more frequently, on account of their prejudice against it. In the former case, we should tax our ingenuity to find such food as will suit the taste of the patient; in the latter, it is best to say very decidedly that we will not, under such circumstances, take the responsibility of the result. But it is above all in the very commencement of phthisis that the vegetable regimen is of the greatest benefit. We have collected a large number of cases in proof of this view,—cases, for example, in which the patient has coughed only a few months, and where there is already an observable emaciation, a slight difficulty of breathing, and sometimes hemoptysis and dullness, with dry rattling at the apex of the lung. These symptoms often disappear after a few weeks of this particular regimen. You have seen a marked illustration of this in Case No. V.

When the patients are getting better, they should not return at once to an ordinary diet. If the disease is in its early stage, I do not permit either wine or meat until the cough has entirely ceased. I then allow meat three times a week, once each day, and if the improvement is not delayed by this, I allow the patient to return to his usual bill

of fare, charging him not to abuse the use of meat or of wine, and to drop them both if the cough reappears.

In the more fully developed stage, where the diet must continue for years, I am less severe; and when the cough is very much better, the nights are good, and the patient gains flesh, I allow meat three times a week, but once on each day; to be replaced by the stricter regimen whenever it produces an aggravation of the symptoms. Patients bear this diet very well, even while they are at work.

I will detail some of the symptoms that I have observed in patients with phthisis when they have been placed upon this meagre diet. During the first two weeks they complain of loss of strength, and this complaint, although it is partially due to imagination, has been too often made not to have some truth in it. At the same time, it is exceptional, if the patient does not find an improvement in his sleep, and that the cough is less frequent, with a general sense of relief, which comes from the subsidence of the febrile movement. This relief will encourage him to continue the diet, and at the end of three weeks there is a very evident improvement in the patient's condition. Shortly after, if the regimen be continued, the emaciation is arrested, and then the patient begins to gain flesh. This last phenomenon is the certain sign of the successful resort to the vegetable diet in the treatment of phthisis.

But how does this diet act? The farinaceous substances and the milk, which form its basis, are recognized by all hygienists as the elements that increase the flesh. The vegetable diet is, therefore, essentially a fattening diet; now a tuberculous patient, who gains flesh, is certainly one who is improving, and it is, therefore, not surprising that the vegetable diet should be useful in such cases. But, we repeat, it is impera-

tive that the diet should agree with, and be grateful to, the organism. This rigid diet would not be proper in case of inanition, for in such a case it is necessary, in order to produce the desired effect, that the patient should absorb a considerable amount of substantial food.

The prejudices that generally exist in medicine, upon the etiology of phthisis, contribute very greatly toward preventing physicians from using the diet that we have advised in the treatment of this disease. That tuberculosis is the result of an enfeeblement of the organism, is a proposition which is generally accepted as an axiom, and which has its corollary in the affirmation that a strong animal, and a no less strong alcoholic diet, is the best prophylactic of pulmonary phthisis.

This etiology, which we dispute, rests not only upon theoretical ideas, which are badly elaborated, but also upon certain well-known facts, from which certain inferences have been drawn that do not belong to them. Thus the disease is often caused by a too prolonged lactation, by venereal excesses, by living in dark and badly ventilated rooms, or by great grief; and in such cases it is impossible to say that tuberculosis is the result of an enfeeblement of the organism. If the predisposition to pulmonary phthisis did not already exist, all of the occasional causes just enumerated could not produce it; while, on the contrary, we know that it appears in persons who are predisposed to it in spite of the most fortifying aliment.

We cannot forget that phthisis, like other tuberculous affections, numbers among its victims, in the wealthy classes, those young subjects who are well nourished, and in whom there is no cause for enfeeblement. Indeed it is especially during youth, the age in which the vitality is strongest, that phthisis is the most frequent. Recent researches have demonstrated that the blood of a sufferer from phthisis is, at the

beginning of the disease, very rich in globules, while, on the other hand, chlorosis is an affection with which phthisis has no necessary connection.

The tendency to classify all diseases into sthenic and asthenic is a systematic idea which only results in misleading the physician, and in causing him to lose sight of a more exact etiology. My own observations, which, it is true, are imperfect, have shown me that phthisis is extremely rare among the religious sects, where, according to the rules of the order, they abstain almost entirely from meat; and this is the case, notwithstanding the fatigues of teaching or of preaching, and the living of this class in the large cities. Phthisis is, on the contrary, to be found, but too frequently, in seminaries and among those religious teachers who are not restricted to the vegetable diet.

The working class in cities who eat meat twice a day, and who abuse the use of alcoholic drinks, furnish a large proportion of the deaths from pulmonary phthisis.

Facts, therefore, lead us to conclude that the use of meats and wines, far from preventing this form of phthisis, seem rather to incline the patient to it, since the greater number of its victims are persons who use such food most freely, while such as abstain from it are almost exempt from that disease.

On the Choice of Remedies.

Before closing this lecture I have something more to say to you of the rules which should guide us in the choice of a remedy.

The formula *similia similibus* expresses, as we have often said, the law of positive indications in the treatment of disease; but it must be interpreted in its largest sense, and it must also be confirmed by clinical experience. The formula employed by Hahnemann and the first homœopaths, is this:

"*Give the medicine which is indicated by the totality of the symptoms.*" This formula is incomplete, for you can readily understand that the ulceration of Peyer's patches, pulmonary hepatization and pleuritic effusion are morbid phenomena, which are at least as important as febrile heat, thirst, cough and diarrhœa. However, the early homœopathic physicians did not include these morbid processes in their picture of *similia*, because these are *lesions*, and the formula expressly says the totality of the *symptoms*. These *lesions*, for that matter, are not *apparent*, and cannot be *known* except by diagnosis, and diagnosis was a secondary affair with the first practitioners of the homœopathic school.

We should, therefore, complete the formula cited above, and say that the remedy is indicated by *the totality of the symptoms and of the lesions.*

But this is not all, for there are diseases in which indications may be drawn, not only from the totality of the symptoms and of the lesions, but also from the course of the disease. For example, intermittent fevers, and all the diseases which accidentally assume an intermittent type, require those remedies which respond to this type, the most prominent of which is quinine, then arsenic, nux vomica and many others.

We suggest, therefore, that the law of similars should be formulated thus: Administer the remedy which corresponds to the totality of the symptoms, the lesions, and to the course of the disease, or, in other words, to the disease in its totality. Thus, without believing in specifics, and without teaching that for each morbid affection there is a corresponding treatment, or an especial remedy, which would be false, we insist upon it that there is no reliable and satisfactory therapeutics apart from the diagnosis of the mor-

bid condition. It is in fact this diagnosis which shows us not only the symptoms, but the lesions and the progress of the disease, but which gives the physician a true view of the totality of the morbid phenomena. Without this diagnostic ability the doctor is like a nurse who sees only the most conspicuous of the symptoms in a given case; he can have no idea of their connection or of their rank or order. You have had in our clinic two examples in which serious trouble had resulted from the lack of a proper diagnosis. The first of these, you recollect, was the case of the old woman who entered the hospital on the ninth day, of an unrecognized pneumonia, and who died a few days after coming to us. In the case of this patient no diagnosis had been made, and the *aconite*, which was indicated by the violence of the fever and the agitation of the patient, was continued for eight days without modifying the disease.

The importance of the diagnosis in this case was very great, for it would have added to the totality of the external symptoms, the emphatic development of the pulmonary lesions, which call for *bryonia* and *phosphorus*.

More recently still, you have seen us hesitate with regard to an obscure case of croup, and seen us prescribe *phosphorus* and *aconite* on purely symptomatic indications, and without effect; whereas the *bromine*, *bryonia* and especially the *cyanide of mercury* which were indicated by the diphtheritic lesions might have been, if given in season, alone sufficient to cure the patient.

In a case that came to us from Baltimore, the patient had been ill for four years, or since the birth of her last child. Her condition was really deplorable. The menses were regular, but scanty; there was much intra-pelvic pain and distress; spinal irritation, and sleeplessness, with a complete loss of appetite. Mentally she was on the verge of insanity; nothing on earth interested her; her lovely child, her sister, her friends, society, the church, were very distasteful; she could not read or think with any diversion or satisfaction, and she became emaciated and wretched. She had had treatment from both and all schools of practice, had worn pessaries, and passed through the purgatory of leeching and

blistering, starvation and hydropathy, without being benefited in the least. Locally there was an extensive abrasion of the cervix uteri, to which I applied the oleaginous collodion. She was of a rheumatic diathesis, which, with the character of the suffering and of the mental symptoms, indicated *macrotin*. She was given this remedy in the third decimal trituration. In a short time she began to improve, and in a few weeks was quite well again. She took no other remedy. Two years have now passed and there has been no return of the old troubles. She has gained in flesh, is rosy and hearty, and the centre of attraction for a large circle of friends.—L.

On "Individualization."

Our brother physicians have reproached us for not "individualizing" in the choice of our remedies. Let us see what is to be understood by the term individualization in therapeutics, and to what extent on this point we fall under the lash of our critics.

The extreme homœopaths mean by "individualization," to attach no value to diagnostics (people generally attach little value to that of which they are ignorant), and they seek the proper remedy only through the guidance of certain symptoms proper to each individual case that they have to treat. Thus, they prescribe *carbo vegetabilis* for a patient who is affected with a cerebral tumor, simply because he expressed the need of fanning himself; or they give *nitric acid* to another who has angina pectoris, because he is relieved by riding in a carriage; or *chamomilla* for the croup, because the child is easier when it is carried about in the arms. There are those who consider this the highest order of therapeutics.

For ourselves, we declare that we will have nothing to do with this kind of individualization; and that we will not consent so to degrade the system of therapeutics that was raised so high by Hahnemann himself. I know that by this method some chance successes have been obtained, but it has been at the cost of disasters that we never can fully realize.

As we view it, individualization is the searching out of all the peculiarities which the case of the patient whom we have

to treat presents. We say the *patient*, and not the *disease;* and herein we are to be distinguished from those who use specifics, and who pretend to have a ready-made treatment for each disease, and who literally cure diseases by their names. We do not treat pleurisy, pneumonia, cholera, etc., but we treat patients who are ill with pleurisy, pneumonia, cholera, etc.

Thus understood, individualization takes note not only of the diagnosis of the various diseases, but also of their form and variety; of epidemic influences; of the stage of the disease, its complications, and the idiosyncrasies of the patient,—idiosyncrasies which sometimes are strangely revealed by those special symptoms to which the most rigid homœopaths attach so great an importance.

These particular symptoms belong to the individual more than to the disease, and they form no part of the nosographic description. They are of real importance, however, in deciding upon the choice of a remedy, where several remedies are equally indicated by the totality of the morbid phenomena. For example, here is a patient with pleurodynia, characterized by pain under the breast; this pain is intense, increased by respiration, and by coughing. Several remedies are appropriate, among others *nux vomica* and *bryonia*. If the patient is relieved by lying on the sound side, *nux vomica* is indicated; on the contrary, if he is easier when resting upon the affected side, *bryonia* is the proper remedy. Thus the position of the patient, by aggravating or relieving the pain, is, in this case, the symptom which *individualizes* the case, and decides the choice of the remedy.

We differ in another respect from the early homœopathists in the great importance that we attach to *clinical experience*. Hahnemann and his first disciples expressly advised against the drawing of any indications whatever from the use of remedies in disease, *ab usu in morbis*. A precept so opposed to a

sound medical judgment could not be enforced for any considerable time, and we believe that there are few physicians to-day who uphold this extreme doctrine in therapeutics of taking no note whatever of clinical experience.

Beyond a doubt, the law of similars was the guide for homœopathic physicians in finding the remedies which they prescribed for their first patients; but it is clinical experience that has definitely settled their practice. When the first homœopaths found themselves face to face with the cholera, and with dysentery, the law of similars offered them a certain number of remedies; but it was clinical experience that fixed the value of *veratrum*, of *arsenicum*, of *cuprum*, of *carbo-vegetabilis*, and of *camphor*, in the cholera; and of *ipecac.*, of *mercurius*, of *arsenicum*, and of *phosphorus*, in dysentery.

The proof of the insufficiency of the law of similars to determine the treatment of a disease is in the changes that have been made by clinical experience in the practice of most physicians. Who treats the croup to-day with *aconite* and *spongia*, or typhoid fever with the *rhus toxicodendron?* To what do we owe the precise indications for *cantharis* in pleurisy, and for *apis mellifica* in ulcerative keratitis, if not to clinical experience?

Clinical experience confirms or weakens the appropriateness of the choice made by the law of similars; it *proves* that the cure has been well or badly made. Clinical experience decides upon the value of the indications, and eliminates the remedies that are unreliable. It declares the worth of remedies in a given case authoritatively. Thus *veratrum*, *tartar emetic*, *aconite* and *colchicum* are indicated for the symptoms of confirmed cholera, but experience has long ago proved the superiority of *veratrum*. The spasmodic cough in phthisis, with the vomiting of food, demands *drosera*, *hepar sulphur*, *silicea*, etc.; but clinical experience has placed *drosera* at the head of the remedies indicated in such cases.

Lastly, clinical experience eliminates those remedies whose action is uncertain, and their number is very great. How many of these remedies appear with a pathogeny that is more or less complete, and with promises, according to the law of similars, of brilliant success, and how many return to the obscurity in which they should have been permitted to rest! Who of us has forgotten the marvelous effects promised from *glonöine* in headaches, or from *gelsemium*, which was to cure meningitis, or from *thalium*, a specific for the affections of the spinal marrow, and of many others which cumber the pages of our periodicals and the shelves of our pharmacies?

The laborious researches of our brethren produce new provings without end; the clinic takes possession of these new agents, and, rejecting such as are worthless, it retains with gratitude such as *sanguinaria*, *apis mellifica*, *actea racemosa*, and numerous others that are of the greatest service to us every day. It is, finally, the law of similars which indicates to the physician the proper remedies in the treatment of disease, but it is clinical experience which stamps the real value of those remedies.

LECTURE XIV.

SUMMARY. — Remedies. The Materia Medica Pura; indications; examples. *Case* of abscess of the liver; indications for the opening of these abscesses. *Case* of chronic pleurisy; indications for thoracentesis; suppuration following the operation made with Dieulafoy's aspirator; the abuse of thoracentesis; indications for it in empyema. The law of contraries and the law of similars.

Remedies — Indications — The Experimental Materia Medica.

GENTLEMEN: We may, without further preamble, enter upon that part of the clinic which treats of symptoms and of lesions, because semiotics and pathological anatomy rest on a basis accepted by all, and which needs no discussion. But it is not so with therapeutics, for this part of medicine has, even in our day, undergone many changes, and we cannot enter upon this territory without some preliminary considerations.

The ancient hypotheses, which served as the basis of therapeutics, have been overthrown by modern physiological discoveries; and since Harvey's work on the circulation of the blood, we may say that the therapeutics of Galen, which controlled the schools for so long a period, have no scientific foundation. And therefore the treatises of Materia Medica and therapeutics that were inspired by the superannuated hypotheses of ancient and modern humoralism constitute, in our day, a real anachronism of which, let us hope, the work of Trousseau and Pidoux may be the last example. The science of therapeutics is now undergoing a transformation, and it belongs to us, who have been, if not the first, at least the most ardent, promoters of this reform, to enter at once upon the

solution of such problems in experimental therapeutics as shall present themselves to us.

We shall not repeat this year what we said to you last year concerning the place of homœopathy in therapeutics, but we shall, with your permission, recall to your minds some of the general principles of therapeutics. You know that the science of therapeutics includes two subjects: (*a*) the *remedy*, and (*b*) the rules which serve for the application of the remedy, or, in other words, what is called the *law of indications*.

The *remedy* is a substance which appertains either to the animal, the vegetable, or the mineral kingdom, and which, administered to the living organism, has the property of determining in that organism a totality of symptoms and of lesions, presenting a special character, and subject to a certain evolution.

You observe that the definition of the remedy resembles the definition of the disease. The positive effects of a drug on a healthy organism are, in fact, very analogous to disease, and you are aware that the history of cases of poisoning constitute a complete department in nosography. The knowledge of a remedy, therefore, does not end with understanding its physical and chemical properties merely, but, above all, it must include the study of the symptoms and lesions which it produces when given to a healthy person. It was upon this immovable basis that Hahnemann built the monument of the *Materia Medica Pura*. It was a materia medica that was pure in a theoretical sense, but a still better name for it would be to call it the *Experimental Materia Medica*.

The rules which serve for the application of a remedy in the treatment of disease have received the name of *indications*. These rules are numerous, and sometimes contradictory; but first let us see what is meant by the word *indication*.

Traditional science explains through the mouth of Galen: "*The indication is the evident necessity for a fixed course of action.*" If we examine the terms of this definition, gentlemen, we shall find in this axiom the surest and wisest rule by which the physician and surgeon can be guided in the practice of his art.

"*The indication is the evident necessity for a fixed course of action.*" Thus, in order that the physician or surgeon may act as he should, the necessity for such action must be evident. Without this necessity they have no right to proceed, for what man has the right to interfere in the great drama of suffering which constitutes disease, if the necessity for doing so is not obvious? It is this necessity alone which permits the physician to carry the heavy responsibility of the treatment of the sick. The patient, it has often been said, is a child that is entirely at the discretion of the doctor, of whose science he is no judge, and whose authority he may not dispute. He is entirely in the hands of his adviser, and for this reason the physician is not justified in interfering to modify the course of the disease unless there is an evident necessity for it. Mere routine, trifling and fancy in the combat with disease at the bed-side are out of place, and are a serious abuse of the patient's confidence.

Galen very properly adds that the physician should not only act, but he should act in a *decided manner*. This complement to the definition is absolutely necessary, and the doctor, when in the presence of a case where the necessity for action demands his interference, knows this very well, although he may hesitate about the particular means to be employed. An example, which is not theoretical merely, but which is practical and genuine, will best serve to illustrate this definition of the word *indication*.

Case XLI.—*Abscess of the Liver.*— A child of eight years had a fluctuating tumor of the liver. This tumor was located on the anterior face of the organ, and had the effect to raise the ribs in a very noticeable manner. It was accompanied by transient pains; the child was thin and pale, but he ate well, and was up and out-of-doors every day.

The diagnosis was doubtful, and, although taking the age of the patient, and the absence of pathological antecedents into account, we inclined to the idea of a hydatid cyst of the liver, we were not absolutely certain of the nature of this tumor. One of my old comrades while an interne, and who to-day is a surgeon at the Hôtel Dieu, called in consultation, hesitated about interfering by an operation, and we waited because there was no *evident necessity* for action.

A month later the affection had developed itself. The pain had become permanent; there was fever and considerable emaciation; the size of the tumor had increased, and another important symptom developed itself, viz: an œdema of the integument about the tumor.

The diagnosis settled the fact that, whether an hydatid cyst existed or not, the fever, the pain and the puffed appearance of the skin showed, at least, that there was a purulent collection, and a purulent formation, that was designed to eliminate something, which condition also showed the *evident necessity* for a *determined action* on our part.

It was imperative that the abscess should be opened at once, or nature itself would, perhaps, do so, and discharge its contents into the peritoneal or the pleural cavities. The location of the abscess also decided the mode of operation. An incision by a bistoury would, in this case, have been very inconvenient; the use of the Vienna paste would have been too tedious. It was necessary that the method should be prompt, and one in which there would be no danger of an overflow of the liquid into the neighboring cavities. The

indication was not founded upon a whim, nor upon an hypothesis, but it was positive. The trocar No. 2 of Dieulafoy's aspirator was passed into the center of the tumor, from which we drew sixty grammes of a thick, reddish pus. The child was relieved at once, the pain ceased, and the cure is now complete.

The microscopic examination of the liquid taken from this abscess, made by M. Davaine, showed that it was composed of pus, with a little blood, and some débris of hepatic cells.

The indications are not, I know, always as clear and as positive as in this case; but from its very clearness the definition of Galen may be better understood.

Another example, which of itself is of great interest, is that of

Case XLII.—*Chronic Pleurisy—Thoracentesis—Empyema.* A man, whom you may have noticed during the summer in a private room of the hospital, came first to the clinic in May, 1874.

At that time a large effusion occupied two-thirds of the left pleural cavity. The clinical history, which was gathered carefully, made it impossible to doubt that this pleurisy was a chronic one. The patient, of good constitution formerly, and very robust, aged thirty-five years, was able to resist the disease up to this time, and to continue the mode of life, or nearly so, of those about him. For some months past this has been changed; the dyspnœa increased very much; the emaciation and loss of strength had made such progress that when he came to us he looked like one in the last stage of phthisis. He still was able to be up a little and out occasionally; but the appetite and sleep had left him, and the constant increase of the symptoms gave warning of a sad issue in the course of a few months. An attentive auscultation, and the absence of fever, gave us reason, however, for

pronouncing that there was neither pulmonary phthisis nor a purulent transformation of the effusion. The organism was fast failing, and giving signs of yielding in a short time to the influence of an imperfect respiration and obstructed circulation that was due to a displacement of the heart.

Here again there was the *evident necessity for action*, and I will add that the action itself was *decided.*

In this case, in fact, no account needed to be taken of therapeutical resources. Since the beginning of the pleurisy the patient had vainly exhausted the whole series of revulsives and of derivatives employed in similar conditions, and the large cicatrices proved clearly that the use of these means had been pushed as far as possible. To acquit my own conscience, I had prescribed *cantharis* and *sulphur* for several weeks, during which time I took occasion to study the question of remedies more carefully in order to act with decision; but this treatment, which is usually so successful in my hands, failed entirely. Should we try other remedies? Certainly not; for pathological anatomy teaches us, in fact, that very old pleuritic effusions constitute veritable cysts that are almost as rebellious in the resorption of their liquids as the cysts of the ovary. If we add that the lung which had been compressed for ten years, and which was fixed and flattened along the vertebral column by organized bands that had been there for years, would only obstruct this resorption and make it the more difficult, you will understand that we only gave a few remedies as a sop to conscience, and to afford us time in which to decide upon a more energetic plan of treatment.

There was, then, in this case a necessity for action, and the only effective method of action was to evacuate the liquid by a surgical procedure. And not only was the necessity for giving vent to the liquid evident on account of the compression of the lung and the displacement of the heart, which interfered

with hematosis, but the method of this action was also indicated. In fact, the absence of fever, and the long duration of the effusion, led us to believe that the liquid was serous, and the simple operation of thoracentesis was called for, as offering the last chance of a cure.

By auscultation and percussion, we found that the lung was crowded upward and backward, and that the effused fluid occupied three-fourths of the pleural cavity. The heart was strongly pushed to the right, the apex beating beneath the sternum.

Percussion gave a flat sound in all the parts included by the effusion, and by auscultation we could hear the soft souffle of pleurisy.

In making the operation of thoracentesis, we chose Dieulafoy's instrument, and the first puncture was made in the posterior and outer part, between the sixth and the seventh ribs. From this we took more than a quart of a serous fluid, which looked like veal broth, and which contained a great deal of albumen. We did not draw off any more, because toward the end of the operation the patient complained very much of drawing sensations that were extremely painful.

After the operation, and during the next few days, he was very much relieved; the respiration became easy, and his strength and appetite returned.

In the space of fifteen days we tapped his thorax four times, drawing at each time about three pints of a liquid that was of the same character as that withdrawn at the first operation. The patient improved constantly, and by physical examination we found that the quantity of effused fluid was steadily reduced, and we, therefore, hoped for a successful termination of the case.

But the second day after the fourth operation the patient, who was always careless about the observance of proper hygienic rules, went out-of-doors. The weather was damp and

cold, and he returned in a chill. When we saw him again the next morning he was in a violent fever.

On the third and fourth days after this relapse the patient grew rapidly worse; he became emaciated, and felt his strength to be failing, while at the same time the dyspnœa increased every hour; the side became very painful, and this pain was increased by pressure, and his breath became very fœtid. In three days the effusion was as large as ever, and there were unmistakable signs of the purulent transformation of the fluid. The event proved the correctness of our diagnosis.

Before going any farther, let us note this fact with regard to the purulent transformation of a serous effusion from tapping, which is recommended as being absolutely safe. For several years physicians have been accustomed to consider thoracentesis as an operation that was unattended by danger; and the ease with which it may be made by the use of the ingenious instruments of Dieulafoy and of Potain has brought about such a real abuse of tapping the pleural cavity that, with many physicians, it constitutes the exclusive treatment for pleurisy, just as others make tracheotomy the specific for croup.

The publication of this fact, in addition to those already so numerous, in which death has occurred a few hours after the operation, from a too sudden relief of the compressed lung, and consequent and frightful œdema which has followed, are calculated to make the physician careful and prudent, and to cause him to remember that fashion and fancy are wretched counselors in the sick chamber.

But to return to our comments on Galen's definition of the word *indication*. What ought we to have done in the case of this unfortunate patient; and what indication should we have drawn from the risk of death by asphyxia, and by

the progress of a suppurative fever? Was there in this case an evident necessity for action, or should we have left the patient to the unaided efforts of nature?

First, let us examine this last method. Purulent pleurisy provoked by such conditions, and left to its natural course, must end, either in the rapid death of the patient from the violence of the fever, or it must terminate in the opening of the intra-pleural abscess. Now this abscess might discharge itself externally, into the bronchii, or even into the peritoneum. Without opening into the peritoneum, the inflammation, which accompanies and which initiates the opening of all abscesses, might spread to the peritoneum and produce death by inflammation of this very extensive serous membrane. These peritoneal complications are not imaginary, or merely theoretical, for they have already been seen in a number of cases.*

The only chance of cure, therefore, which remains to our patient, and which is the natural discharge of the empyema externally, is as seriously compromised by the duration of the disease as it is by the danger of which it is the source. However, if the opening can be obtained will our patient then be certain to recover?

Beyond a doubt, there have been a number of cases of empyema, with spontaneous opening through the thorax externally, and even into the bronchial tubes, that have terminated in the complete recovery of the patient; but the cases which end in the exhaustion of the patient from hectic fever and from the bad results that accompany the decomposition of pus are infinitely more numerous. Indeed these effusions almost always open in the mammary region, which is too high up for the pus to discharge itself freely.†

* See Andral's Clinic, Case 20, Vol. IV, page 480; and Case 36, page 542 of the same volume.

† Andral's Clinic, Case 17, Vol. IV, page 464; and especially Case 36, p. 542. This last case is of great interest from another point of view. It is in fact an undoubted illustration of the spontaneous development of the *purulent diathesis*.

The opening, which is too small to permit a free escape of the fluid, is large enough to establish an easy communication with the air, and the abscess is thus in the worst possible condition, being too high, and the opening so small that the pus stagnates and putrifies in the pleural cavity.

Therefore, if we had not "*acted*," we should have had but two alternatives,—either the death of the patient by suppurative fever, or the breaking through of the intra-pleural abscess. In this last alternative the natural opening of the abscess would have placed the patient in a far more dangerous condition than its artificial discharge. This state of things created an "*evident necessity for action*"; and a free opening of the chest was positively indicated. We did not even discuss the possibility of emptying the abscess by numerous tappings with the aspirator. The extreme difficulty of bringing the lung and the parietes of the thorax together did not prompt me to try a method which must be quick in order to be successful.

The operation of thoracentesis was made on the most sloping part of the chest, and by flattening the superior surface of the diaphragm. The skin and the muscular layers were successively incised, and after having penetrated the pleural cavity, the surgeon enlarged the opening with his bistoury, so as to make it about ten centimetres in length. A flow of pus, which was grayish in appearance, and fœtid, poured from this opening. There was at least three and one-half pints of this matter. A large compress of lint was introduced into the wound in the form of a tent; and abundant injections containing alcohol were given three times a day. The fever subsided, the appetite and the strength returned, and, in fact, the *operation* that was indicated produced just what was expected of it, which is always the case when we conform strictly to the law of indications.

Permit me, gentlemen, to give you, incidentally, the remaining history of this interesting case. He remained three

months longer in this hospital under local treatment, consisting of repeated injections, sometimes of water and alcohol, and sometimes of the tincture of iodine in water. His health returned gradually, and the capacity of the pleural cavity grew less each day, as much from retraction of the ribs as from expansion of the lungs. He had a return of fever every now and then, sometimes because of his own imprudence, and sometimes because the injection was not thoroughly given.

These accidents and accidental drawbacks were counteracted chiefly by *arsenicum* and *aconite*. At the beginning of the cold season he left for the south in order to complete his recovery. He returned to Paris in May. His general condition was good; he has gained a great deal in flesh, and has no fever, but he still has the pleural fistula. The ribs are badly retracted, the shoulder is very much depressed, and the patient leans toward the affected side. The pulmonary expansion is heard over almost the whole thorax; but there still remains a zone of three fingers' breadth about the fistula, where all the normal sounds are absent. The heart has returned to its place.

In the month of July, 1875, I saw this patient again. He still has the fistula, which has discharged blood once or twice in rather large quantities. He is more of a hypochondriac than ever, and complains of "*wind*," but he is stronger, more active, and has no cough nor oppression of breathing.

The author might also have found an illustration in those cases of puerperal poisoning in which the means that are called for are prophylactic and curative, although they are not strictly medical. The risk of septic and purulent infection, either through the laceration of the soft parts, that is an almost necessary consequence of labor, or through the uterine sinuses that have been left open by the separation of the placenta, or by both these avenues, is very great. And emergencies arise in which a very prompt and decided action, that looks to the removal of the cause of the trouble, is imperatively demanded. When the temperature of a lying-in woman is at or above 103°, with an arrest of the involution of the uterus, a diminution or disappearance of the lochial and of the lacteal flow, with a hot skin and a quick pulse, delirium, and more or less local pain in the abdominal and pelvic regions, the indication is to irrigate and disin-

fect the vagina and uterus as speedily as possible. We must wash away the post-organic matters, arrest the sepsis, and, by a direct and tangible remedy, make it possible that life should continue by bringing the temperature down to a living standard and keeping it there.—L.

These examples are quite sufficient to make you understand what I have quoted from Galen. Now the word *indication* has, therefore, a well-defined meaning, and the therapeutics of inspiration and of fancy will be certain of your scorn; for you have a rule to guide you in the treatment of such cases which is as clear as it is inflexible, *id est*, the *necessity for decided action*.

We now understand the *remedy* and the *indication*, as they are included in the general subject of therapeutics; but when we come to their application, that is to say, to fix the rule which must govern this "decided action," depending upon the evident necessity for interference, we find ourselves confronted by two laws, viz:

The Law of Contraries and the Law of Similars.

The law of contraries being that which is most generally accepted, we shall speak of it first in order. This law rests upon two formulæ, of which one is the complement of the other,— *contraria contrariis curantur*, and *sublata causa tollitur effectus*. This last formula has the style and character of an axiom. No one, in fact, has ever contested that when the cause was destroyed the effect would not continue to exist, and that whenever the cause can be directly attacked by its opposite, a rapid and certain cure will follow. But this *cause*, which must be removed or destroyed, cannot be determined, defined or understood, except in the large class of diseases that arise from *external causes*,— such, for example, as traumatism, parasitical affections, and cases of poisoning in their earliest stages. Kill the parasite; expel or antidote the poison; reduce a fracture or dislocation, and you have destroyed

the *cause* of the suffering, and by an opposite remedy:—*sublata causa tollitur effectus.*

In this domain the simplicity of the method is only equaled by its efficiency. Surgery triumphs in this case in the certainty of its therapeutics; to open an abscess, to tie up an artery, to remove a tumor or a foreign body, is often to heal the wounded or to cure the sick, and it is always a direct means for remedying an important *lesion.*

But if we enter on the domain of the veritable diseases which arise from internal causes, the law of contraries is no longer applicable.

General pathology teaches us that the external circumstances, which have received the name of the *external causes*, of disease, are merely conditional or contingent, and that they furnish an *occasion* for the development of disease, whilst the real cause itself is to be found in a *special predisposition* that belongs to the organism. Thus, for example, cold and fatigue may favor the development of pneumonia, but only in those persons who are predisposed to it. In certain cases, and in the absence of cold or fatigue, the predisposition alone will suffice to develop this disease.

How could we hope to find in a remedy the contrary to an organic disposition or tendency if we were ignorant of its essential nature?

This is the way in which the old leaders in therapeutics have wandered from one hypothesis to another in search for the opposite, or the *contrary*, of the direct causes of disease.

The Galenists believed that the proximate cause of disease predominated over the four humors of the body. From this came the resort to evacuating remedies, that are designed to expel the hypothetical cause of the disease. The *iatro-chemists* have tried to neutralize the acids and alkalies, from which, they tell us, all diseases proceed. The *solidists* have fought

irritation, whether excessive or deficient, through indications that called for leeches and tonics; and those who hold that diseases are due to a poisoned state of the blood are still hunting for the antidotes with which to cure them.

These are the hypotheses, more or less absurd and more or less ingenious, which have reigned for a long time, and which continue to reign, in therapeutics. If we add that, up to the close of the last century physicians entirely ignored the positive action of medicines upon a healthy man; and that on this point, which is so important in materia medica, they were possessed of hypothetical notions exclusively, we may gain a pretty correct idea of what they would do in the treatment of disease, depending as they did upon the imaginary virtues of their remedies. And you may form some idea of the bad repute into which therapeutics and the Materia Medica had fallen before Hahnemann instituted his reform. The old-school therapeutics have been well characterized by Scarron:

> "I saw the shadow of a valet,
> Who, with the shadow of a broom,
> Brushed away the shadow of a coach."

The shadow of the broom is the imaginary virtue of the remedy, and the shadow of the coach is the hypothetical cause of the disease.

It is useless to argue this point. The law of contraries, the *sublata causa*, is not applicable to the treatment of diseases that arise from internal causes.

The law of similars is formulated in this manner: "Apply to the treatment of a certain morbid condition the medicine which, given to a healthy man, would produce a totality of lesions and of symptoms which are like those of the disease."

You observe this law presupposes a knowledge of the action of the drug upon a healthy man; and it rests, therefore, upon an experimental basis. And as its application is founded

entirely upon this positive knowledge, and the clinical recognition of the symptoms and lesions of the disease that is to be treated, as it has need of no hypotheses whatever in its application, we are authorized to conclude that the *law of similars* is *the law of positive indications.*

In the application of the law of similars, the necessity of a knowledge of the action of the drug upon a healthy person explains why this law remained without application for Hahnemann to put it into use. Until the experimental study of the Materia Medica had reached a certain degree of perfection, no physician could apply the law of *similars.* This is why Hahnemann, who inaugurated on a large scale this very important study, is really the founder of Homœopathy, and why Paracelsus, Van Helmont and Hunter should be considered only his precursors, because, being ignorant of this materia medica, they could not apply the law of similars.

But, as we have already indicated, we believe that the law of similars is not always and altogether sufficient for the choice of the remedy. In our first lecture we spoke of the legitimate rôle of empiricism, and of palliative medication in therapeutics. And in Lecture XIII we have tried to detail and to establish the value of clinical experience as another aid in the selection of the remedy.

LECTURE XV.

SUMMARY.— Hemoptysis, *case*. What is hemoptysis? Differential diagnosis of hemoptysis from hematemesis and epistaxis. Varieties of hemoptysis and their semiotic value. Therapeutic indications for the relief of hemoptysis; ligation of the extremities; ice and cold; *aconitum*, *arnica*, *millefolium*, *ledum palustre*, *ferrum perchloricum*, *ipecac.*, *phosphorus*, *hamamelis* and *nux vomica*. The old-school treatment of hemoptysis. Hemoptysis is never the cause of phthisis. Niemeyer's error. A rare *case*.

Hemoptysis.

GENTLEMEN: We have just seen in No. 4, of the men's ward, an extremely serious case of hemoptysis. The patient is a young man, who has all the signs of incipient phthisis. The following is a detailed account of the case:

CASE XLIII.— M. L——, an artist, twenty-one years of age, entered the hospital on the 9th of December, and left it on the 11th of January. This young man is of a frail and delicate constitution; the skin is fine and transparent, with a bright color, and he is without hereditary antecedents. His parents are still living, and well.

Although the disease for which he comes to us is of only three months' duration, he says he has suffered from difficult respiration for nine years past. When this began he had an attack of pneumonia or pleurisy in the left side, which lasted, he says, for two or three months; but notwithstanding this difficulty of breathing, his general health has been good until within the last three months.

Three months ago he began to cough. The cough was dry, and came in paroxysms which returned principally at night; but in spite of this he retained his strength and appetite, and showed no signs of fever.

On the 24th of November, after a more than usually severe fit of coughing, he commenced to vomit blood by the mouth-

ful. He continued to raise blood almost every day after this during the fortnight which preceded his entrance into the hospital; he lost in this way more than three pints of blood.

He is now extremely feeble, and the pulse is small and frequent. There is slight heat of the skin, and no appetite.

By auscultation, which is necessarily imperfect, we find there are humid râles on the left side when he breathes deeply. The heart is perfectly healthy; the patient scarcely coughs at all; the sputa are very slight, and consist of mucus tinged with blood. We prescribed *millefolium*, 3d dil., three drops in 200 grammes of water, one spoonful to be taken every three hours. The diet to consist of milk.

December 14. The patient has not expectorated any pure blood since he entered the hospital; the fever has disappeared. *Ipecac.*, 3d dil., for the cough with a bloody expectoration. He is allowed some soup.

December 16. The strength and the appetite have partially returned. The slight matters raised are rounded in form, white, and more opaque. *Phosphorus*, 12th dil., four globules in 200 grammes of water, and three spoonfuls during the day.

December 18. The general health of the patient improves each day; the cough is much better. *Phosphorus*, 12th dil.; the vegetable diet, with beer for a drink.

December 21. The patient is doing well, and all medication was suspended.

December 23. There is a slight bloody expectoration this morning. *Phosphorus*, 12th dil.

December 26. The patient complains of pain in the left third intercostal space when coughing. *Bryonia*, 3d dil., three drops.

December 30. The pain in the side is gone; the cough is considerably diminished; the digestion is bad; the appetite is less than for some days. We prescribed *nux vomica*, 12th dil., one hour before eating, and *graphites*, 12th dil., one hour after meals.

January 3. Under the influence of these last remedies the digestive troubles have disappeared. The appetite is excellent.

We suspended the *nux vomica* and the *graphites*, and gave *bryonia*, 3d dil., for the pain in the side, which has returned, but is less violent than at first. The patient left the hospital on the 11th of January, in a very good condition.

The examination of this patient at the time of his quitting the hospital showed that on percussion there was a comparatively dull sound in both apices, especially in that of the left lung; the respiration is obscure, and is scarcely perceptible on the left side and behind. But the patient has gained considerable flesh; his strength has returned, and he scarcely ever coughs any more. I allowed him to eat meat three times a week, but not more than one meal per day, and he continues to drink beer.

I saw this young man on the 15th of March, when he seemed very well.

This patient had been treated at home by *millefolium*, and came to us just at the end of an attack of hemoptysis. For this reason I will read you a case from my private records, in which *ipecac.* and *millefolium* have been of very great service. This second case will also be useful in completing the clinical history of hemoptysis, and it will show you that the very grave prognosis that is usually given in this difficulty ought to be qualified.

Case XLIV.—M. L., an employé in a large establishment, is twenty-four years of age. He has, heretofore, suffered from scrofulous affections, and recently from scrofulides on the face, which have left their indelible traces. He is of a very nervous temperament, and has some symptoms of hysteria. His skin is pale, and he is of a slender figure, and he has a cough which has no very decided peculiarities. He was subject to epistaxis during childhood.

In the month of March, 1870, he was taken, during the night, with paroxysms of coughing, accompanied by an abun-

dant expectoration, of a bloody, frothy, foamy nature. This hemoptysis returned several times during the week, but was not so copious as it was in the first attack. At the end of a week nothing of it remained, save a loose cough with frequent expectoration, at first of blackish blood, then of a chocolate-colored fluid, and finally of mucus tinged for several days with a varying proportion of blood.

We were very reserved in resorting to auscultation during the hemoptysis; thus we only recognized some moist râles in the chest, and a perfectly physiological condition of the heart and of the larger vessels.

In the onset, my colleague, Doctor Frédault, who was called in my absence, prescribed *ipecac.*, 3d dil., and *millefolium*, 3d dil., two potions with three drops of each remedy to 150 grammes of water for alternation, one teaspoonful to be given each hour, and afterward every two hours.

We continued this prescription. The next morning we added to it the cold and milk diet, with rest and absolute silence.

Ipecac. and millefolium were continued as long as the sputa contained portions of bright blood; and later, when they were of a chocolate and rusty color, we prescribed of *phosphorus*, 12th dil., six globules to be put in 200 grammes of water, and from three to six spoonfuls to be taken during the day.

The patient was for a long time kept in quiet and silence. We added to the milk the vegetable diet, and gave him beer to drink, and toward the latter part of June we had the satisfaction of seeing our patient completely restored to health.

At that time, on auscultation by another physician and myself, no positive sign of tuberculosis was to be found. The patient took the hydropathic treatment at Bellevue; and although six years have now passed since the former attacks, he has had no symptom of a pulmonary affection. On the other hand, he

has developed several scrofulous affections, as a sore throat with ulceration of the anterior folds of the veil of the palate; the incipient symptoms of osteitis of the nasal bones, and a cold abscess of the perineum. These different affections have yielded with singular promptness to the *kali jodatus* in doses of 1.50 grammes each day; and this result, joined to the character of the affection of the throat, and those of the nasal bones, has strongly inclined me to believe that there was a syphilitic complication, although the patient has positively denied the possibility of any such condition whatever.

These two cases clearly demonstrate that the prognosis, even in case of an abundant hemoptysis, and even in young persons, is not always so bad as has been supposed. We may draw from these cases some clinical and curative conclusions which ought to be settled definitely.

I apply the term hemoptysis to a syndrome which is characterized by the pouring out of pure blood from the inferior respiratory passages, and which is discharged either by vomiting or by expectoration.

In the two cases cited we made the diagnosis without hesitation, and thus declared that the blood which escaped came neither from the nasal fossæ (*epistaxis*) nor from the stomach (*hematemesis*), because we found in both these patients the positive signs of hemoptysis before, during and after the hemorrhage. *Before* it, the cough; *during* it, the expectoration of frothy, red blood; and *after* it, the expectoration of brownish blood that had remained for some time in the bronchii. The cough indicated that the lung was the diseased organ; the frothy, red mucus showed that the blood had been mixed with air, and, consequently, that it came from the bronchial tubes; and finally, the brownish expectoration, which, for some days succeeding the spitting of blood, afforded a stronger and more decided proof of the primitive seat of the difficulty.

But all cases of the kind are not so simple. For example, a very abundant epistaxis, *if it occurs during sleep*, may be accompanied by the unconscious introduction of a certain quantity of blood into the respiratory passages, and may, therefore, be followed by the expectoration of this blood; but the blood which takes this course is always in a very small quantity, and a nose-bleed is always free and easily detected. In such a case it is sufficient to have the patient blow his nose to prove that the blood comes from the nasal fossæ, and moreover it is mixed with nasal mucus. Let me add that some writers have attached a great importance to the differential diagnosis of such a case, because, when the blood flows too freely from the nasal fossæ of a patient who is lying down, or in whom the nostrils have been plugged, the blood will flow into the stomach. Then, afterward, he may vomit it, or pass it from the bowels, and a careless observer might mistake the attack for one of hematemesis, or of hemorrhage from the bowels.

The differential diagnosis of hemoptysis from *hematemesis* has also been indicated. It is true that in some cases of hemoptysis the blood is a little dark, and that, in a fit of convulsive coughing, hemoptysis may be accompanied by the vomiting of the food; that the blood which flows too abundantly in hemoptysis may reach the stomach, and either be expelled by vomiting, or altered by the gastric juices, and afterward its surplus may be passed the next day by the bowels. Here are evident sources of error in diagnosis, but these conditions are brought together in this way upon theoretical grounds, for they never exist conjointly in actual practice. At all events, we may, in a few words, sum up the differential characters of hemoptysis and hematemesis.

In hemoptysis the blood is usually without clots, mixed with bubbles of air, and frothy. When it is darker, and contains small clots, the hemoptysis is associated either with an

affection of the mitral valves, or with a tuberculous cavity, and these are lesions that are unmistakable. The practicing physician need not hesitate regarding the source of the hemorrhage, even if the color is a little dark, and there are clots which make him think of hematemesis.

In hematemesis, the vomiting of blood is preceded by nausea, and by a sense of weight in the stomach. These two symptoms are indeed of great value in the differential diagnosis of this affection. The blood is usually black and clotted, and mixed with food, and it is discharged by the effort of vomiting. If some particles of the matter ejected fall into the trachea, this accident is succeeded by a paroxysmal cough which is of longer or shorter duration. But the date of the appearance of this cough is very important; it is a symptom which comes during the vomiting, and the mechanism of which it is easy to explain, for it cannot mislead us in the diagnosis.

There is also a sign, which in doubtful cases should be carefully sought for, which is the alkalinity or the acidity of the blood. The blood ejected in hemoptysis preserves its proper alkaline reaction, while that which comes from the stomach in hematemesis is more or less changed and acidulated by the gastric juice.

Finally, if the physician looks for the symptoms of this affection as laid down in its symptomatology, he will find included with the hemoptysis some diseases that are easily recognized, *id est*, pulmonary phthisis, affections of the mitral valves, and aneurism of the aorta.

Hematemesis will often reveal to us the existence either of cancer of the stomach, or of a simple ulceration of that organ, in which case the diagnosis will have acquired a mathematical precision.

It is only in supplementary hemorrhage, and in those which are symptomatic of purpura, or of a very serious fever, that the diagnosis will be very difficult. It is so much the more difficult because several hemorrhages may occur at the same time. In such cases the signs of epistaxis, of hemoptysis, and of hematemesis are often more or less confounded, and more or less obscure, and error is therefore possible. We may add that this is not a serious thing, for in such cases the prognosis, like the treatment, is more subordinate to the disease itself than to any of its symptoms.

Now that we have with some degree of care settled the question of the significance of hemoptysis, and clearly distinguished it from the hemorrhages that are liable to be confounded with it, let us examine its semiotic value, and the therapeutic indications which it presents.

There are five principal varieties of hemoptysis:

A.—*The overwhelming variety of Hemoptysis.*—In this case the blood is foamy, and escapes in streams from the nose and from the mouth; filling the bronchial tubes, and falling into the stomach, the patient dies from syncope. It is the sign of the rupture of an aortic aneurism.

This kind of hemoptysis is sometimes met with at the onset of tuberculous phthisis, but oftener in the more advanced period of the disease.

There are two varieties of a copious hemoptysis:

(*a*) In the first the blood is foamy and frothy. It is ejected by the cough and by a sort of vomiting; in a few moments the patient may lose from 200 to 300 or 500 grammes of blood, and after an interval which varies from a quarter of an hour to several hours, the hemorrhage begins again. Death by syncope may occur after a few hours, but oftener the patient resists and the hemorrhage is arrested. This variety is al-

most always symptomatic of pulmonary phthisis, being in some cases an initial symptom, and at others a sign of the confirmed stage of the disease.

This same form of hemoptysis is also to be observed in cases of supplementary hemorrhage.

Finally, it may exist as an idiopathic affection, in which case it usually repeats itself several times during the life of the patient, and rarely stops with a single attack.

(*b*) In the second of these sub-varieties the blood lost is always abundant, but it is much darker than in the preceding variety. It is a very little frothy, and it is the usual sign of an affection of the mitral valves, and also, according to Niemeyer, of a rupture of an artery in a tuberculous cavity. This form of hemoptysis also occurs in bad cases of hemorrhagic fever, in variola, scarlet fever, and in purpura.

B.—*Slight Hemoptysis.*—This variety also has its subdivisions:

(*a*) In the first of these the blood is foamy and frothy, but it is ejected in detached portions. This is the hemorrhage of confirmed pulmonary tuberculosis.

(*b*) In the second of these forms the blood is also thrown out in a detached way, but it is dark and not frothy. This is the sign of an affection of the heart, and we have even seen it in chronic catarrh, with dilatation of the bronchial tubes.

(*c*) In the third variety there are bloody sputa, but the blood is not mixed with mucus as it is in pneumonia. When the expectoration is viscous, it is the certain sign of a pulmonary congestion that is symptomatic of an affection of the heart, or of the aorta, but when it is diffluent, it is indicative either of phthisis or of chronic catarrh.

(*d*) In the fourth we may have habitual or periodical hemoptysis. Independently of the varieties of hemoptysis,

which depend upon the abundance and color of the blood that is expectorated, we recognize still other varieties in which the type and duration of the hemorrhage are peculiar.

Thus the vicarious hemoptysis, that is symptomatic of amenorrhœa, comes, like the menses, at a fixed period each month; and in the form of pulmonary phthisis that we call hemoptoic, the spitting of blood becomes habitual, and patients sometimes have it almost daily for two or three months. A correct idea should be had of these two varieties, the *periodical* and the *habitual*, for they are important, both from a diagnostic and from a therapeutical point of view.

In our clinic at the Hahnemann Hospital we have lately shown the class three sisters, each and all of whom have had hemoptysis in connection with the establishment of puberty. For three years, in the eldest of them, this hemorrhage had continued to alternate pretty regularly with amenorrhœa. She would miss her period for one month, or perhaps for two, and then have an attack of spitting of blood instead. The youngest of the three sisters sometimes had hemoptysis, and again epistaxis, with irregular menstruation. All these girls were anæmic, and manifestly of the hemorrhagic diathesis. The mother, who came with them to the clinic, was a healthy-looking, robust woman, who complained of symptoms incident to the climacteric, and also of hemorrhoids.—L.

Therapeutic Indications Drawn from the Different Varieties of Hemoptysis.—When hemoptysis is overwhelming, we should not think of internal remedies, but the patient should be taken to an open window, his body should be straightened, and the extremities ligated by a wide band as in practicing venesection.

If this method is successful the bands should be loosened one after another, and carefully, for the great quantity of blood that is retained in the extremities by the ligature may, by reëntering the circulation suddenly, reproduce the hemorrhage. At the same time ice should be applied to the chest, or, if it cannot be had, a cloth, wet in very cold water and constantly changed, may be substituted for it. *Arnica* will be the principal remedy if there is time in which to give it.

In the moderate form of hemoptysis, where the discharge is composed of red, frothy blood, *ipecac.*, *millefolium*, *ledum palustre* and *aconitum* are the principal remedies.

When the blood is black, the *hamamelis* is a precious remedy, as are also *arnica* and *digitalis*. To the use of these medicines we should add the hygienic methods already indicated in the preceding paragraphs, and of which we shall have more to say directly.

In the less violent forms of hemoptysis, *millefolium* and *aconite* are the principal remedies, especially when the blood is foamy; when it is black, we give *nux vomica*.

Phosphorus is the principal remedy for the hemoptysis that is associated with dangerous cases of fever.

Phosphorus is not a valuable remedy for the active stage of hemoptysis; but when the flow of blood has ceased, if there are signs of inflammation and induration of the pulmonary tissue, or of tuberculosis, with a rough, hoarse voice and cough; or, if there is a frequent hacking, dry cough, with great oppression of the chest and tickling in the throat, with a short, rapid, panting respiration, it is invaluable. The chief indication for *phosphorus* in this, as in all other hemorrhages, is found in the hemorrhagic diathesis, against which, all things considered, *it is undoubtedly the best remedy that we have.*—L.

Ferrum perchloricum has been given empirically for copious and rebellious hemoptysis, but it is almost always given in strong doses, say of from fifteen to twenty drops of the perchloride in a potion of 200 grammes of water. We have sometimes used it successfully in habitual hemoptysis.

Let us now consider each one of these remedies, and endeavor, with the aid of the Materia Medica, and of clinical experience, to fix the indications for each of them.

Aconitum is the remedy for those congestions and hemorrhages that are called active. The blood is red, frothy and abundant, with an incessant cough. The chest is the seat

of heat and of a characteristic sound like boiling. The face is red, the pulse is quick and hard, and the patient anxious.

Hartmann recommends it, also, in an opposite condition of the circulation, viz: where the pulse is feeble and filiform, and can scarcely be recognized, and the face is pale and expressive of anguish.

Aconite has often been successfully given in tuberculous hemoptysis, in that which accompanies cardiac affections, and also in that which is incident to pregnancy. The symptoms upon which we rely are those of active congestion in the lungs, anxiety, agitation, and the two states of the pulse just now indicated. We prescribe the lower dilutions, which, in copious hemoptysis, are to be repeated very often, the intervals between the doses to be lengthened as the risk diminishes.

Arnica is a popular remedy that is principally indicated by an abundant hemoptysis, where the flow is composed of blackish blood with clots. Great sadness or despondency only confirms the indication for its use. It is particularly useful in cases of hemoptysis that are connected with heart affections or with traumatism. The sixth dilution is the one which is most generally employed. I have prescribed the mother tincture with good results.

Millefolium is perhaps the remedy that is most frequently prescribed in the treatment of hemoptysis. It is, above all others, a faithful remedy, *id est*, it almost always justifies the indications furnished by the Materia Medica for its use. The "thousand leaves" is a very old remedy. Cazin says it contains many resinous principles.* It has the power to bring on the menses again, and the lochia also, and to increase the former when they have already begun to flow. For all this,

* *Traité des plantes médicinales indigènes.*

Cazin, a homœopathist without knowing it, prescribes the millefolium as a remedy for the control of hemorrhage.

The foregoing indication for this remedy is invaluable. It *is* especially called for in case the hemoptysis is complicated with amenorrhœa, and in the puerperal state also, where it follows a suppression of the lochia. Under these circumstances it is quite as prompt and useful as it is in bleeding piles, where the flow of blood is vicarious of menstruation, or where it is connected with chronic uterine disease.—L.

Millefolium is especially indicated in the slighter forms of hemoptysis occurring in tuberculous subjects, when the blood is red, frothy, and ejected without the violent effort of coughing. It is often alternated with ipecac. Millefolium has also been successfully used in cardiac and supplementary hemoptysis.

Hamamelis is one of our best remedies in hemoptysis occurring in persons, and especially in women, of an hemorrhagic diathesis. It is adapted to the venous constitution, and is indicated when the blood that is expectorated is of a dark, venous hue. It is most useful when, with a tickling cough, there is a taste of blood, or of sulphur; when there is a tightness and constriction of the chest, and when, because of difficult breathing from congestion, the patient cannot lie down. In this country it is more frequently given than any other remedy in the onset of hemoptysis, and, if we are not mistaken, the general preference is for the first or the second attenuation.—L.

Ledum palustre, or the wild rosemary, is a plant that also contains many resinous qualities. Outside of homœopathy it is employed in the tanning of leather; indeed, it is this which gives to the Russian leather the peculiar odor which has brought it into such demand. This plant is capable of causing hemorrhages, and ought therefore to be useful in their treatment.

Ledum is indicated by an abundant hemoptysis, with a loss of red and frothy blood, accompanied by a strong pulse and a violent spasmodic cough, and especially when it is provoked by tickling in the larynx and the trachea.

Ipecac., whose curative virtues in hemoptysis had already been tested in the treatment of dysentery, is indicated in an

abundant hemoptysis, when it is preceded by a sensation like that of bubbling in the chest.

Experience has taught us that it is well to alternate this remedy with the millefolium. We prescribe it in the lower dilutions. But beside the use of remedies, there are certain hygienic indications that should not be forgotten: A well-aired room, and not too warm; the elevation of the head and chest; the feet to be kept warm; the food and drinks cold; the milk diet, if the patient can bear it, and in all cases the vegetable diet, constitute very necessary aids to treatment.

One word now of the treatment of hemoptysis by the old school, and my lecture will close. First of all, and without any partisan spirit, one is struck by the extreme poverty of the officinal therapeutics, and the absence of special indications. Excepting ergot and the perchloride of iron, which are prescribed empirically, what are their resources against hemoptysis? Only one single remedy, and that is ipecac., which was praised by Trousseau, who in this case, as in a good many others, did not hesitate to borrow a remedy from the homœopathists. Let us add that he gave it in emetic doses, thus uselessly exhausting his patient's strength; for if it was not the action of *ipecac.*, but that of a mere emetic, that he sought, why did he not give the tartar emetic, or the sulphate of copper?

In terminating this lecture on hemoptysis, we should examine one question of pathology which has recently been raised by Niemeyer.

The frequency of hemoptysis as the initiatory sign of phthisis caused the ancients to believe that that disease often resulted from pulmonary hemorrhage. In this view of the matter the hemoptysis was always accompanied by a lesion, or a wound in the lung, and this wound was thought to be the origin of the characteristic ulceration of phthisis. Hoffmann

and Morton described phthisis *ab hemoptoë*. This doctrine was upset by Bayle and Laënnec, and the question appeared to have been definitely settled until Niemeyer adopted the old notion, and tried to give it a new life. He professes that, in hemoptysis, a certain quantity of blood remains in the ultimate bronchial branches and in the pulmonary air-cells. He says that this blood becomes a powerful cause of irritation to these organs; that this irritation gives rise to caseous pneumonia, and that, consequently, hemoptysis is certainly, in such cases, the origin and cause of the pulmonary phthisis.

Jaccoud, who has but too often accepted an opinion because it was offered him with a German stamp on it, affirms, in his Medical Clinic,* that from the point of view of the pathology of phthisis we must distinguish in the broncho-pulmonary hemorrhages those which terminate brusquely, and in which the last expectorations are still composed of foamy blood, and those which have for several days discharged a brownish matter composed of blood that has been altered by its arrest in the bronchial tubes. According to Jaccoud, it is this last form of hemoptysis that should be followed by pulmonary tuberculosis, because it has left a certain quantity of decomposed blood in the capillary tubes of the bronchii.

Niemeyer's opinion consists of as many hypotheses and errors as there are affirmations. "Some blood remains in the bronchial tubes and the pulmonary vesicles." This purely hypothetical statement is contrary to all that we know of the physiology of the bronchial passages. The blood of this pulmonary pneumorrhagia, which Laënnec denominated *pulmonary apoplexy*, alone remains infiltrated in the vesicles and pulmonary tissues. But when the blood has not filtered into the lungs, when it is poured into the bronchial tubes it is expelled and discharged by the expectoration at the end of a few

Tome II, page 29, et seq.

days, in the same manner as the mucus and other foreign substances contained in the bronchial tubes.

"This blood becomes a cause of irritation, or of caseous pneumonia." Here is another hypothesis, for it has not been demonstrated that the blood is a cause of irritation to the bronchii, and if the *infarctus* of apoplexy becomes *occasionally* the point of departure for an inflammation of the lung, we must be able to observe a wound, or a tearing of the tissue. There is a gap between these two propositions, that the blood, which is said to be contained in the bronchial tube, is a cause of irritation, and this irritation gives rise to caseous pneumonia. However, Niemeyer decided arbitrarily between them, and without giving us even the beginning of a necessary proof for observation, teaches us that when the nucleus of pulmonary apoplexy becomes the point of departure for an inflammation, this inflammation can terminate only in three ways, viz: either by resolution, suppuration, or gangrene. The termination by caseous pneumonia is, therefore, purely theoretical.

Finally, the distinction, proposed by Jaccoud, between the hemoptysis that terminates abruptly, and that which is followed for several days by the expectoration of a brownish and disorganized blood, is evidently theoretical and not clinical. We have sought in vain, for years, for a case of this kind, in which the hemoptysis ended so abruptly; and for that matter we are at a loss to understand how the bronchial tubes can relieve themselves completely and instantly of all the blood which, under the circumstances, they have contained. It is, moreover, perfectly useless to search for this pathological rarity, for in the two cases of hemoptysis, which serve as the text of this lecture, we have two very opposite examples, in which, for several days, there was an expectoration of blood that was altered in character and brownish in color; and yet we are able to state that, in neither of our patients, were there

any symptoms of *irritation* or of caseous pneumonia; neither was there the rapid progress of phthisis, of which these hemorrhages were an undoubted symptom, at least in the first of the two cases.

We may, therefore, conclude that Niemeyer's attempt to reinstate the phthisis *ab hemoptoë* has as little foundation in fact as his famous theory of caseous or tuberculous pneumonia. They are two errors with which it is a pity to have encumbered a subject that was so clearly set forth by Laënnec.

Ten days ago we were called to a case of hemoptysis which was, in some respects, peculiar. The patient, a beautiful, intelligent miss of eighteen, and a recent graduate of our high school, had been ill for some time with what her physician decided was an inflammation of the upper lobe of the left lung. During a fit of coughing she was seized with hemoptysis, of which she had had several slight attacks before. The blood raised was bright and copious, and I found her very pale, weak, and almost pulseless. *Hamamelis*, 1st dil., soon stopped the flow; but a harassing cough followed for which she took *aconite*, 3d dil. This was at six o'clock in the evening. Two hours later she expectorated a mouthful of bloody mucus which evidently contained a foreign body, for it rattled when it fell into the cup. This foreign body was fished up and found to be the brass tip of the crochet-needle *which she had swallowed ten years before*. She remembers having swallowed it, and has, indeed, always insisted that it never had been discharged.

A little while after the accident — which happened when she was eight years old — she was seized with what appeared to be whooping-cough. The cough was very intractable, and did not respond to remedies, but finally wore itself out. As she grew older she became more and more delicate, and although there is no hereditary tendency to phthisis in her family, her friends have been positive that she was going into a decline. Indeed, they had lately come to the determination, through the advice of her physician, who is well informed and responsible, that as soon as she should recover from the present attack of pneumonia she must try the effect of a change of climate.—L.

LECTURE XVI.

SUMMARY.— Hemorrhoids, *case*. Are hemorrhoids only varices of the hemorrhoidal veins, or do they constitute a disease ? The connection between gout and hemorrhoids. Hemorrhoids with profuse hemorrhages. Indications for *sulphur*, *nux vomica*, *æsculus hippocastanum*, *hamamelis*, *millefolium*, *ferrum perchloricum*, *aloes*, the *phosphoric* and *muriatic acids*, *arsenicum*, *carbo-vegetabilis*, *capsicum*, *collinsonia* and *sedum acre*.

Hemorrhoids.

GENTLEMEN: Among our patients is a man who came to the hospital for a hemorrhoidal flux, which was of such frequent occurrence, and so abundant, as to give him great uneasiness. In this case you can judge of the efficacy of the homœopathic treatment, from the rapid cure of this man by the *hamamelis virginica*.

CASE XLV.— M. F——, fifty years of age, a coachman, entered the hospital on the 17th of December, 1874, bed No. 5, and left on the 18th of January, 1875.

This man has been troubled with hemorrhoids since the age of fifteen. From time to time he lost blood at stool, which did not, however, weaken him, nor affect his general health, which latter has remained good until six months ago. At that time, and from no known cause, a hemorrhoidal flux occurred, which has continued almost constantly ever since. The blood flows quite freely on the slightest movement. Even during repose he has had a constant oozing away of this blood.

When he came to us he presented all the symptoms of anæmia. He complained of having lost almost all his strength. The appetite, however, is good. At the margin of the anus there was a large hemorrhoidal swelling.

He was given *hamamelis virg.*, in the 3d dil.

December 19. The patient is already a little better, but he always loses a little blood at stool. The same remedy.

December 24. The blood no longer flows when the patient is quiet. *Hamamelis*, 3 dil.

December 27. He is much better. He has lost but a small quantity of blood since he came to us. He was ordered the *perchloride of iron*, in the 6th dil.

December 30. The patient lost a small quantity of blood during the night. Continued the same medicine.

January 2. Since taking the perchloride, he is not so well. Yesterday, during the day, he had several stools, and with each one some blood was passed. Resumed the *hamamelis*, in the 6th dil.

January 6. He is better again under the influence of the old remedy. He can rise and walk about a little without any loss of blood. *Hamamelis*, 30th dil.

January 8. The improvement continues. The remedy was suspended.

January 10. The patient has lost some blood during the past two days, but in much smaller quantities than heretofore. The same remedy.

January 12. He continues to do well. There is a very slight oozing of blood at stool. He took hamamelis, 3d dil., again, which he continued to take until the time of his discharge from the hospital. When he left he was entirely cured.

This patient promised to write us if the hemorrhages returned, but we have heard nothing from him.*

Are Hemorrhoids a Local or a General Disease, or both?— In this connection I have something to say on the subject of hemorrhoids. It is a very difficult subject, and one that is full of contradiction. We find in medical tradition two totally different views, both of which have been perpetuated from the time of Galen to our own day. By some of them, and I find in this list the names of most of the masters of our art—the Stahls and Sydenhams, etc. (I do not mention the most illustrious)—the hemorrhoidal affection was considered as a disease, *totius substantiæ*, of which the rectal varices

*The hemorrhages did not return for six months. He placed himself in the care of a surgeon, was operated upon, and died a few weeks after.

were but a symptom. Others, from Boerhaave to Virchow, including your professor, M. Gosselin, believe hemorrhoids to be a simple affection of the veins of the rectum and of the anus,— they are varices which are due to the compression of the hemorrhoidal veins, or an affection arising from purely mechanical and local causes.

With which of these opinions shall we agree; and how are we to know the truth in looking at the matter from two points of view that are so radically opposed to each other, and each of which is supported by the eminent men whose names I have given?

The first thing to do is to study the question from a purely clinical standpoint. Let us begin with the local affection, and see whether a mere compression of the hemorrhoidal veins will explain the development of this affection. The local hemorrhoidal difficulty consists, essentially, of three things,— the tumor, the pain, and the bloody discharge. M. Gosselin, who is the modern representative of one of these views, speaks as follows of the pathology of this affection:

"Constipation induces straining at stool; the fœcal mass forces down the mucous membrane so as to make a hernia at the anus; the hemorrhoidal veins, which are very much swollen because of the contraction of the circular fibres of the rectum, are strangulated by the spasm of the sphincter, and the hemorrhoidal tumors are the consequence." (*Nouveau Dictionnaire de médecine et de chirurgie pratiques, t. XVII, page 412.*)

This mechanical explanation of the cause of hemorrhoidal tumors is not supported by clinical proof, and may be upset by merely observing, on the one hand, that all constipated people do not have hemorrhoids, and on the other, that there are numerous cases of hemorrhoids without constipation, as, for example, those which are complicated with chronic diarrhœa in warm climates.

It is a fact that has been very much insisted upon by authors, that the hemorrhoids are very prevalent in warm countries. Boerhaave reports that in Greece and throughout Asia, they are as common as menstruation is in colder latitudes, it being the exception for a person, whether male or female, not to have them. He, however, attributes it to the existence of constipation, with which, he says, nearly all the people are afflicted.—L.

Those physicians who consider a local hemorrhoidal affection as a symptom, the effect of a disease, *totius substantiæ*, assume that all this trouble with the anus is due, not to the influence of a mechanical pressure, but to that of a congestion which comes and goes under the influence of the disease.

The great variation in the size of the hemorrhoidal tumors confirms this idea, and entirely disproves the mechanical doctrine concerning their origin and special pathology. These congestions, in fact, are often periodical, and come as regularly as the menses in a woman. In some women the hemorrhoids accompany the menstrual flow, and are manifestly the result of the sanguinary afflux to the pelvic organs, *id est*, of the *molimen*, which precedes and accompanies that function. The morbid process that results in the hemorrhoidal discharge is of itself a real congestion, and all the symptoms of this hemorrhagic *molimen*, as, for example, heat, weight, throbbing at the anus, and in the loins, are symptoms of a general plethora, the existence of which has often been confirmed by careful clinical observation. Besides the physical and moral relief that follows, the sanguinary discharge in hemorrhoids has all the characteristics of a salutary crisis, and of the termination of a pathological process, and not those of a flow which was due to a compression of the veins.

It seems to me useless to speak further of the untenable theory of the mechanical and organic cause of hemorrhoids. Virchow tried, but in vain, to help the matter by giving it the weight of his endorsement; but, since this explanation of

the source of the affection was insufficient, he added that a catarrh of the rectum was also a prominent factor in causing it. But this catarrh is another demonstration of a morbid determination of blood, and consequently of a disease of which the suffering that is located at the extremity of the rectum and at the anus is only a *symptom*.

Let us now enlarge the scope of our observation. If we examine a hemorrhoidal patient let us note whether, outside of this local affection, he does not present an array of symptoms and lesions having a definite and special character, and which constitute the disease. Take, for example, a patient of from forty to fifty years, he will tell you that in his youth he was subject to attacks of bleeding at the nose, that were more or less frequent, and that they originated and returned without any known traumatic cause. The women will tell you of early and profuse menstruation, and other patients will also have suffered from hemoptysis or hematemesis. Thus hemorrhoidal sufferers are those persons who, from their youth, and sometimes from infancy, have shown a marked predisposition to hemorrhages. If we continue this analysis of the hemorrhoidal constitution, we find the nervous system so affected as to cause vertigo, neuralgia, headache, hypochondria, and, above all, the sclerosis of the nervous tissue, which is so carefully studied in our day. It is the hemorrhoidal subjects who furnish nearly all the cases *of general paralysis of the insane*, and of *locomotor ataxia*.

In the respiratory system you will find special affections, as asthma and catarrh; in the vascular system, chronic endocarditis, aortitis and angina pectoris, which is merely a sequel of the last-named lesion, but all of which are hemorrhoidal affections.

Lastly, in the digestive system, you will find flatulent dyspepsia and gastralgia. You should study each and all of

these affections, and make note of their character and of their order of succession in hemorrhoidal patients, and you will finally conclude that they constitute a veritable disease, like the gout, the scrofula, etc.

Hemorrhoids may be related, either as a cause or a complication, with conjunctivitis, blepharitis, coryza, acnè, eczema, herpes, lichen, prurigo, furuncles, vesical catarrh, urethritis, phlebitis, chronic hepatic, renal and cardiac disorders, bronchitis, laryngitis, spasmodic asthma, headache, melancholy, epilepsy, angina pectoris, and intractable forms of neuralgia. This fact has an important bearing in the selection of remedies, for here, as elsewhere, it may happen that the most appropriate remedy will be indicated by symptoms belonging to a remote or a symptomatic affection.—L.

Do not hesitate, therefore, to regard this disease from a higher point of view than that which is generally taken by our surgeons, who see only the local affection in hemorrhoids. Fortunately, this old surgical notion is changing somewhat, and I have read with pleasure an article contained in the "*Nouveau Dictionnare de médecine et de chirurgie pratiques*," entitled, "Hemorrhoids treated in a Medical Way," by a young professor, Doctor Lannelongue.

This question of hemorrhoids, however, seems destined to remain obscure, and to be endlessly discussed. If the careful study of its symptoms causes us to recognize it as a general disease, that should no longer be confounded with varices of the rectum, still the numerous connections between hemorrhoids and gout serve to complicate the matter, and to embarrass the whole subject. This leads me to say that most hemorrhoidal affections, as headache, neuralgia, asthma, flatulent dyspepsia, endocarditis, etc., are equally common in gouty patients; that nearly all gouty subjects at a certain stage of the disease show signs of very severe rectal and hemorrhoidal difficulties, as a bloody discharge, pain, tumors, etc., and that those physicians who have recognized a hemorrhoidal affection as distinct from gout, profess that the patient is subject to pains

in the joints and to arthritis. You will see how extremely difficult it is to clearly separate these affections from each other.

The Connection between Gout and Hemorrhoids.—Are hemorrhoids simply a gouty affection, characterizing a particular form of this disease, which should receive the name of hemorrhoidal gout, or do the hemorrhoids themselves constitute a disease which differs essentially and radically from the gout? This is a plain question, and clinical experience must answer it.

Let us look at the positive results that have been gleaned from observation. First of all, these results show that the local hemorrhoidal symptoms are frequently met with in gouty subjects; of this fact there can be no doubt. It is also true that, in a certain proportion of cases, the general symptoms of the hemorrhoidal affection are so pronounced that it cannot be mistaken. The case which serves as the illustration for this lecture is a very clear example of this. Here is a man fifty years of age who has never had asthma, headache, or any gastric troubles. This is a simple case of hemorrhoids, which is known by the hemorrhage, the hemorrhoidal tumor, and by the symptoms which directly belong to the congestion, and to the anal hemorrhages. We may add that, in cases like this one, the rectal affection is excessive, and that these are the patients in whom the hemorrhages, because of their abundance and of their frequent repetition also, compromise the life of the patient. It seems that in such cases the disease exhausts itself through a single symptom. This illustrates what, in scrofula, is called a *fixed form*, as in cases where the disease spends its whole force upon one serious lesion, such as tuberculous meningitis, Pott's disease, white swelling, etc. etc.

Shall we, therefore, conclude that hemorrhoids do not exist separately, but that they are only a gouty affection? But what shall we do with those cases in which there is no symptom of gout?

Let us rather say that since the morbid species are not distinct; since they are only species by analogy, not being as distinct and separate as the animal species, we need not be surprised to find a mixture of them on pathological domain. This state of things may vex the nosologist, but it should not be neglected by the clinical teacher. In all cases let us remember that the local affection is common both to gout and to hemorrhoids.

But to return to our patient, whose case is the subject of this lecture. His attack was one of the serious kind which often necessitate surgical interference, and which may terminate fatally. He was rapidly cured by homœopathic remedies. Before knowing the resources which the new method of treatment offered, I treated cases like this one by external applications of the perchloride of iron, and, in desperation, by the actual cautery. You will find cases in which these powerful measures have not prevented the death of the patient. The article by Lannelongue, to which I have already referred, quotes an example of this kind. It is therefore very important to arrange a definite plan of treatment for hemorrhoids. I will profit by this occasion to speak to you of the treatment of hemorrhoids and of their contingent disorders.

The Treatment of Hemorrhoids.—In the treatment of this affection there are two remedies which dominate the rest, and they are *nux vomica* and *sulphur*. These two remedies not only correspond to the local affection, but also to the congestion, the neuralgia, the dyspepsia, the hemorrhages, and, in brief, to the greater part of the general symptoms of this constitutional complaint.

Nux vomica is especially indicated in cases where the following symptoms are observed: An ineffectual desire to go to stool; tenesmus; anal constriction; diarrhœa or constipa-

tion, with clear blood or mucus in the stools. The general symptoms that call for this remedy are congestion and hemorrhage, epistaxis or metrorrhagia, neuralgia, dyspepsia and hypochondria. I ought, in this connection, to speak to you of its remarkable efficacy in *epistaxis*, which, as a rule, is almost always one of the symptoms of the hemorrhoidal diathesis. When the nose-bleed is preceded by slight headache or redness of the cheeks, or when it comes on during sleep, it may almost always be cured by *nux vomica*. I generally use the 6th or the 12th dilution in globules.

Sulphur does not correspond very well to the local affection; but clinical experience has long ago confirmed its efficacy when given in alternation with nux vomica. This remedy has the following pathogenetic symptoms: Itching with or without smarting pain; tenesmus; mucus or blood with the stools, and constipation. We have also among its general symptoms a rush of blood to the head, with vertigo and sense of fullness and pain.

A third remedy, and one that is not so well known or carefully studied, is the *æsculus hippocastanum*. According to a legend, which everyone who has practiced medicine knows, this remedy has been used for a long time. You know that a goodly number of hemorrhoidal patients are in the habit of carrying horse-chestnuts in their pockets, supposing that they bring them relief. I do not know whether they are useful in this way or not. I have no faith in this traditional prescription; but it is certain that, from an empirical use of this kind, this remedy has passed into the general medical practice.

In America it is often prescribed for hemorrhoids. Dr. Richard Hughes recommends it where there is obstinate constipation, with sharp pains and slight hemorrhages. He also advises it for the pains which follow the stools, pains which

resemble those proper to a fissure. We shall see that the *sedum acris* is particularly indicated in this latter case.

The *æsculus* was experimentally tested upon the healthy man some years ago. It produced different symptoms on different subjects, but notably there were pains in the rectum and anus. It also caused suffering in the throat; and you are aware that a majority of those who have chronic pharyngo-laryngitis are also subject to hemorrhoids. Among those experimented on, one man, who had never had the hemorrhoids, experienced, according to Richard Hughes, the development of real hemorrhoidal tumors, which was due to the influence of this drug.

Some months ago, my friend Dr. C. S. Fahnestock told me that he had met with a case of dysmenorrhœa which was associated with an intractable sore-throat, and that he had cured the former affection by addressing his remedies specifically to the latter. There are some cases of this kind; and there are others also in which both the painful menstruation and the pharyngo-laryngitis are associated with hemorrhoids. Cases of dysmenorrhœa occurring in those who have had children are very apt to be associated with the piles, and when they are, the *collinsonia can.* is a valuable remedy.—L.

How are those cases to be treated in which the hemorrhage is excessive? The remedy which appears to have been most useful against this form of the complaint is the *hamamelis virginica*. It is indicated in an abundant, sanguinary flow, and above all, with those persons who have varices of the anus. Clinical experience has confirmed this indication very extensively, so that the *hamamelis* may be looked upon as a certain remedy. It is much employed in England, and the old-school pharmaceutists have prepared an anti-hemorrhoidal mixture, of which hamamelis is the principal ingredient.

Millefolium comes next, and may be used for profuse hemorrhages. Cazin cites examples in which he has used it successfully for hemorrhoidal losses of blood.

When the hemorrhages are slight, but frequent, producing, by their repetition, a tendency to anæmia, the *perchloride of iron* is preferable. I have given it in the sixth dilution with excellent results.

Another symptom, and one that is very much dreaded by patients, is the painful inflammation of the hemorrhoidal tumors. Where this is present we have recourse to a remedy that is well known to the Old School, where they use it with good results to produce a slight congestion of the anus. This remedy is *aloes*, a pinch of which is used as a powder; and it is a popular remedy for this difficulty as well as a source of income to the druggists. This remedy, which is perfectly homœopathic, is applicable to cases in which there is a congestive determination of blood to the head, and deafness accompanied by hemorrhoidal tumors that are excoriated with smarting and burning pains.

The *phosphoric* and *muriatic* acids are indicated in case of hemorrhages with painful swelling of the hemorrhoidal tumors.

Arsenicum is suited for burning, itching pains, with nightly exacerbations, and where the tumors burn like fire.

Carbo vegetabilis presents, in its symptomatology, oozing of a serous liquid and the excoriation of the anus. This is the remedy for the *white hemorrhoids*, or for the mucous or the muco-purulent discharge, which, in some patients, characterize the hemorrhoidal affection.

Next to *carbo vegetabilis* we may mention *borax* and *mercurius*. These remedies are less frequently used. I will say but little about them, as I do not wish to burden your memory, and because I intend to call your attention to a remedy which has been very successful, and which has a great reputation

among a goodly number of our brethren. This remedy is *capsicum*, which was presented to the Academy of Medicine, of Paris, about fifteen years ago, as a good remedy in cases of hemorrhoids. It was accepted by that illustrious body, in ignorance of the fact that this homœopathic medicine was recommended by a homœopathic physician, which circumstance called from Prof. Imbert Gourbeyre the remark that this presentation of pepper smacked a little of salt! *Capsicum* is indicated in peculiar cases, where the hemorrhoidal affection is accompanied by diarrhœa and tenesmus, and by the presence of mucus and of blood in the stools.

There is a tradition among the people in some parts of the country, which is as old as the hills, to the effect that "if a man will eat Cayenne pepper freely and habitually with his food, he will never have the piles." An old physician, of fifty years' practice, assures us that where this rule has been faithfully applied he has never known it to fail. So much, therefore, for capsicum as a prophylactic.—L.

The American physicians praise the *collinsonia can.*, and judging from its pathogeny, this remedy affects the rectum principally. It produces the following symptoms: flatulency and colic, constipation, with straining and a dull pain in the anus after the stool. It is, therefore, principally indicated in hemorrhoids with constipation. Dr. Richard Hughes, from whom I have borrowed these details, adds that the collinsonia is also an excellent cardiac remedy, which affords a good reason for trying it in the cases of endocarditis and aortitis that are so frequent in hemorrhoidal subjects. Pruritus of the vulva, which is so often an incidental symptom of hemorrhoids, has been cured by this remedy.

We have often used this remedy both in hospital and private practice. It seems especially adapted to women, and to those women who have hemorrhoids either during, or as a sequel to, pregnancy and parturition, or in complication with obstinate constipation or chronic inflammation with slight displacements of the womb. For the first of these cases, where the trouble dates from gestation or from labor, or from both, and the condition has become chronic, there is no remedy to compare with it for efficiency. We have cured a dozen cases of this kind that have been sent to us by physicians from as many states, with the

collinsonia in the third dilution. And the college class can bear witness to its remarkable efficacy in many such cases in our clinic at the Hahnemann Hospital. When the hemorrhoids are associated with constipation, and with a mild form of retro-flexion or retro-version, and especially with prolapse of the uterus, it will often relieve the whole difficulty.

There can be no doubt of its efficacy when the above-named symptoms are associated with functional disturbance of the heart's action; and, for aught that appears, it may be equally useful in some forms of organic disease of the heart.—L.

I have read, in an article on hemorrhoids, that the use of the *sedum telephum* for hemorrhoids is common in Italy. I knew that this plant, of the same family as the *sedum majus* (*Joubarbe des toits*), was recommended for painful hemorrhoids, and especially for fissures of the anus. I inquired of Catellan, our pharmacist, if he had the sedum telephum, and on his replying that just at that time he had only the *sedum acre*, I took the latter, and prescribed it in the third dilution for a man who was suffering from an extremely painful fissure of the anus. The relief was very rapid, and it was followed by his cure after a few weeks' employment of this remedy. Since then I have continued to prescribe it; and although it is not always successful, yet it has often produced a happy effect in relieving the pains that are incident to fissures of the anus and to hemorrhoids. The indication for the *sedum acre* is: excessive pain, which is greater after the stool, and which may persist for some hours.

The first of these varieties of the *sedum* is the *sempervivum tectorum*, the vulgar name for which is the *house leek*. In his excellent monograph on HEMORRHOIDS, page 256, Dr. Frédault says: "The *sedum telephum*, or *orpin*, has been very much extolled in former times. At Naples it was a popular remedy in all kinds of hemorrhoids. Ettmuller and other authors have recommended it, especially in the dry and painful form of the disease. I have used it in the third trituration, and also in the sixth dilution. In one case of large hemorrhoidal tumors, where the discharge was copious, and the case had resisted other remedies, it caused the tumors to disappear and the discharge to cease promptly. In other instances, where there was only an acute pain, the relief to the suffering was quite as prompt and decided; but where there were fissures, and I had hoped that this remedy would render me the best service, it did not come up to my expectation. For although it cured two rebellious cases of this kind, I prefer the *podophyllum*." The reader will find a suggestive memoir upon the *sedum acre*, contributed by Dr. Ladelci, in the Transactions of the International Homœopathic Congress, held in Paris, 1878, page 121.—L.

LECTURE XVII.

SUMMARY.—Chronic gastritis, *case;* the potencies vary with the disease. *Broussais* and gastritis. Typhoid fever. J. Davasse and reform in the doctrine of fevers. Confusion in the German school. Distinction between chronic gastritis, dyspepsia and gastralgia. Treatment of these three affections. Remedies correspond to the suffering organ more than to the disease itself. General and special indications for remedies in gastritis, dyspepsia and gastralgia. *Nux vomica*, *ignatia*, *carbo-vegetabilis*, *cocculus*, *arsenicum*, *lycopodium*, *sulphur*, *pulsatilla*, *plumbum*, *chamomilla*, *belladonna*, *veratrum* and *graphites;* the alternation of *nux vomica* and *graphites*. *Case* of chlorotic dyspepsia.

Chronic Gastritis.

GENTLEMEN: Here are the notes of a case of chronic gastritis.

CASE XLVI.—M. Tardy, aged fifty-three years, entered the hospital on the 2d of December, and left it on the 17th of December.

Tardy is a man of strong and vigorous constitution, and has never shown any signs of the gout, herpes or hemorrhoids. Being a poor man, he has usually been badly nourished. While he was a soldier in Africa, fifteen years ago, he used alcohol to excess, but he assures us that, since his return to France, he has always kept sober.

The disease for which this man entered the hospital began three years ago with great difficulty of digestion and cramps in the stomach (?). In two or three months he commenced to vomit. At first the vomiting was not frequent, but by degrees the attacks grew nearer together, and for the past two years they have been of almost daily occurrence.

The vomiting sometimes occurs before meals, and sometimes after them, the matter ejected after the meals being composed of the ingesta; before eating, of a slimy liquid that is partly colored. The patient has grown very thin, but, strange to say, has always retained his appetite.

He has never vomited blood nor any black matters. The pain, from which the patient suffers in the pit of the stomach, is increased by pressure, while, on the contrary, firm pressure upon the abdominal wall gives a slight feeling of relief.

December 3. The patient is allowed to eat meat and vegetables. We prescribe *nux vomica*, 12th dil., to be taken an hour before eating; and *graphites*, 12th dil., an hour after eating. These medicines are in the form of globules.

December 4. He vomited considerably, throwing up a slimy liquid and water in the morning. The vomiting was preceded by a slight increase of pain in the epigastric region. The same treatment.

December 5th. There was no vomiting during the day. The sensibility at the pit of the stomach has considerably diminished. *Nux vomica*, 30th dil., in globules dissolved in water, three spoonfuls during the day.

December 7. Yesterday the patient had a painful attack, accompanied by cramps in the stomach, but without vomiting. The appetite is excellent. Suspend the remedy.

December 9. The pain, of which he complained so continually, has entirely left.

December 11. Yesterday he had a very slight attack, but without vomiting. *Nux vomica*, 30th dil., as before.

December 13. Patient is not so well; he suffers in the epigastrium and in the abdomen, and the appetite has failed. No remedies.

December 17. He improves continually. He vomits no longer, and suffers no pain. He eats well, begins to gain flesh, and insists upon returning to his work.

The following case is one that is taken from my private records, and is the more conclusive from the duration and severity of the disease. Two distinguished physicians had diagnosticated it to be a cancer of the pylorus, and the patient, in fact, presented the usual signs of that disease. Notwithstanding this, a cure was effected in a few months, and there has been no relapse; so that it is impossible that this diagnosis could have been correct. *Nux vomica*, in globules, in the 12th and 30th dilutions, was the only remedy used in this case.

Case XLVII.—M. C——, forty-three years of age, has been ill for four years. His trouble began with attacks of vomiting of his food, which at first were infrequent, with a failure of the appetite and obstinate constipation. Although Mr. C—— sometimes eats to excess, yet he does not abuse the habit of taking alcohol. He is of sedentary habits; is employed in a large business house, and passes his Sundays in fishing. During the previous six months the disease had made great progress, and I found him in the following condition:

Great emaciation, with so little strength that he is obliged to lie down almost the entire day, and he can scarcely walk a short distance in his room. The face is anæmic, but not of that yellow straw color that is peculiar to the cancerous subject; the feet are very œdematous.

Percussion reveals an enormous dilatation of the stomach. The patient vomits every week, and oftener if he is careless of his diet, which usually consists only of broth and milk. The vomiting is copious, and the matters thrown up seem to be composed of the undigested food which has accumulated for several days. There are, therefore, symptoms of contraction of the pylorus with consecutive dilatation of the stomach. I am assured that M. Gueneau de Mussy diagnosticated the case as one of scirrhus of the pylorus. I made a most careful examination, and found a smooth and lengthened induration, which followed the movements of the diaphragm, and which left me without a doubt concerning the nature of the tumor.

The patient's diet consists of milk and broth. He takes a purgative enema every alternate night and an opiate every night; the march of the disease is slow but continuous.

November 2. I prescribed a continuation of the same diet, but a suppression of the opium and of the purgative injections, and ordered *nux vomica*, 30th dil., four globules in 125 grammes of water, two teaspoonfuls each day. The patient is expecting to have a fit of vomiting any day.

December 7. He has not yet vomited; he finished his medicine two days ago. *Nux vomica*, 30th dil., in 200 grammes of water, to be taken in the same manner.

December 12. There is no vomiting yet. *Nux vomica*, 12th dil., in the same way.

December 15. There is great improvement, for the patient has not vomited for three weeks. He feels a little better; thinks he could eat; the constipation is less obstinate, although he is sometimes obliged to use an injection of honey. He has continued taking *nux vomica* in the 30th dil.

December 28. The improvement is decided; the swelling of the feet has disappeared. The patient is stronger; walks about his room; insists upon taking food; he has not vomited for seven weeks, and the constipation has disappeared. His diet has been improved by the addition of rice-cream, cream to drink, soups, and finally roast chicken, all of which is well digested. His strength returns, and we allow him wine. Continue *nux vomica*, 30th dil.

At the beginning of January his convalescence was complete; he ate two good meals with some meat each day, and commenced to go out again. This good result has continued for a year, notwithstanding occasional excesses at the table, the attractions of which he has not had the courage to resist. A few months after the cure he suffered from sub-orbital neuralgia, and later from an eczema of the extremities.

These two are very remarkable cases. They once more illustrate the heroic virtues of nux vomica in affections of the stomach; the efficacy of the smallest doses, as the 12th and 30th dilutions, in globules; the propriety of suspending a remedy, and the aggravations easily induced by their continuance. In fact, in Case XLVII we have seen that nux vomica in the 30th dilution could not be continued for more than two days without increasing the suffering, and that the improvement continued and a cure was effected in the absence of any other remedy.

The following case, which in many respects is similar to Case XLVII, was recently reported to the Clinical Society of the Hahnemann Hospital by my colleague, Prof. A. E. Small. It will serve to illustrate that nux vomica is sometimes very useful, when given in the lower potencies in gastric affections of a serious character. This case has never before been published.—L.

Case.—"A gentleman, aged fifty, of large physical frame, and of a sanguine temperament, who resided in a malarious

district, was seized early in May, 1877, with a gastric fever, from which he suffered intensely for five weeks, from continuous vomiting. His stomach was so irritable and inflamed that, during this entire period, he could retain nothing either in the shape of food or drink. He was first treated by physicians of the regular school, who finally decided that he was the victim of some organic and probably fatal difficulty which resisted all their efforts to obviate. At the conclusion of this period of suffering a change of practice was determined upon, and the writer was called in to take charge of the case.

"June 8. A careful examination revealed the following symptoms: Great distress in the epigastric region, accompanied by the vomiting, every ten or fifteen minutes, of a dark-colored mucus, mingled with the delicately prepared food which he had taken into the stomach. The stomach was greatly distended, and the entire gastric region was exceedingly sensitive to the touch. *Nux vomica*, in the third decimal trituration, was prescribed in the evening, the dose to be repeated every three hours until there was some relief or change. After the third dose was administered the vomiting ceased, and the patient was able to retain some gruel.

"June 10. He was very uncomfortable from the distension and pain, and on further examination it was ascertained that the parietes of the stomach were completely indurated, from the pyloric to the cardiac orifice. The external appearance was that of an indurated tumor, which involved the whole epigastric region. The third decimal of *nux vomica* was repeated at intervals of three hours for the succeeding two days.

"June 12. The patient is still able to retain some food without vomiting. He complains much of the weight and pressure of the tumor. To him it seems like the weight of a brick or a stone pressing upon the stomach. He also complains of a burning sensation and thirst, which the nux vomica had not relieved. The third decimal trituration of *arsenicum* was sub-

stituted for the nux vomica, but without affording any relief. His vomiting partially returned.

"June 16. Resumed the *nux vomica*, and applied cooling emollients externally. This treatment was continued for the next week with some benefit.

"June 24. Finding no improvement in the induration, and fearing some serious if not fatal organic derangement, Prof. Ludlam was called in consultation. The case appeared to indicate some formidable growth the nature of which was not easily determined, but that of a scirrhous tumor was feared.

"July 1. Another consultation was had with Dr. L., and it was mutually agreed that nux vomica was having a favorable effect, and this remedy, in connection with the external emollients, having stayed the progress of the disease, it was thought best to rely upon it in the future treatment of the case. Two weeks later the patient exhibited a decided improvement, and from this time onward the induration gradually disappeared and the normal function of the stomach became restored. The weight of the patient when taken sick was 215 pounds, and when convalescence began his weight was only 140 pounds.

"Since nutrition became established he has regained his flesh, and after many months the tumor was completely dissipated, or absorbed. His suffering from first to last was modified, restrained and ultimately cured by *nux vomica* in the third decimal trituration."

We shall see that in other chronic diseases, as, for example, in eczema and in scrofulous ophthalmia, and contrary to what we have said of gastritis and nux vomica, it is sometimes necessary to give the low dilutions, sometimes the mother tincture; and that these stronger preparations must be continued for some weeks without interruption. There are complications that are full of obscurities, to which we do not possess the key, and which make the treatment of chronic

affections so difficult. I know very well that there are those who say that when a medicine is *well chosen*, the smallest doses are not only sufficient, but that they are the best. If this be the case, I am surprised that during so many years the proper remedies for eczema and ophthalmia have not been discovered, and that in these serious affections we are still obliged to employ such strong doses, and to continue them for a long time, if we desire to effect a cure; and for myself, I prefer to confess frankly that, outside of clinical experience, we have no certain rule to govern us in the choice of the attenuation.

The Clinical History of Gastritis and Dyspepsia.—I presume that you will be surprised at my employment of the term *chronic gastritis*, for I do not know if in sixty years we have ever heard of acute or chronic gastritis. The expression, by a reaction which belongs to human nature, fell out of our medical literature, as though the maladies appeared and disappeared at the command of those who make and fashion the different theories. It is, therefore, useful that we should dwell a moment on this question of *gastritis*, and give it its positive value by showing that it serves to designate a disease that is very clearly defined.

When Cullen created the class which he styled the *dyspepsias*, and reunited, under this name, all the organic affections of the stomach excepting cancer, there was no longer a question of gastritis or of gastralgia.

During the reign of Broussais, the dyspepsias disappeared as tainted with speculation; gastralgia was considered as an effect of inflammation, and everything was gastritis.

At this time nosology became marvelously simple. All chronic diseases belonged to the class of *chronic gastritis*, and all the acute diseases either to *acute gastritis* or *acute gastro-enteritis*.

Through the *sympathy* of the organs with the stomach, Broussais explained the symptoms of each and every disease. We know that, concerning acute gastritis, he reunited the four continued fevers of the ancients in one, thus contributing to the unity of typhoid fever, never supposing that, in this, he was striving to establish the essential nature of fevers, a doctrine which he had so violently opposed under the name of *ontology*.

Broussais still reigned, but a threatening reaction had already begun against his system when, in 1826, Barras published his treatise on *gastralgia*. This affection next took the place of gastritis; as for dyspepsias, they had fallen into oblivion. However, Chomel, and several physicians of his time, commenced to write about dyspepsia. The teachings of Cullen were again accorded their deserved honor, and we entered upon true nosology, in recognizing, as distinct affections, chronic gastritis, dyspepsia and gastralgia.

About the same time, Jules Davasse, one of M. J.-P. Tessier's most distinguished pupils, completed Broussais' work by writing on *ephemeral fever* and *synochal* fever, which, with the *typhoid*, includes all the continuous fevers.

In this way (and the work was done almost entirely by the French physicians) modern pyretology was developed, so that we now have the eruptive, the intermittent and the continuous fevers, including the ephemeral, the synochal and the typhoid fevers.

Niemeyer, who resumes and adopts the theory of gastritis under the title of gastro-intestinal catarrh,—has sought to reconstruct the old system under the names of *gastric*, *bilious* and *mucous* fevers; and Jaccoud has followed this author in his treatise on special pathology. This tendency, which is greatly to be deplored and regretted, and the consequences of which we begin to feel in the imperfect diagnoses of *mucous* and *bil-*

ious fevers, rests upon a faulty study of semiotics and of pathological anatomy. It is only a system that will pass away like all others, and to which we need pay but very little attention.

The Differential Diagnosis of Chronic Gastritis from Dyspepsia and Gastralgia.—Let us, then, return to the distinctions between gastritis, dyspepsia and gastralgia.

Dyspepsia is an affection (it is not a disease) that may be symptomatic of gout, of hemorrhoids, of herpes, of chlorosis, or of hysteria. It is generally found to be present in the greater number of chronic diseases, such as phthisis, scrofula, cancer, diseases of the heart, etc. etc. The lesions of the liver are always a more or less marked cause of dyspepsia; and chronic poisoning, alcoholism in particular, may be a cause of dyspepsia and of chronic gastritis.

Dyspepsia, as its name indicates, is characterized by a difficulty of digestion. Sometimes the trouble is slight, a mere sluggishness of this function that causes the food to remain a long time in the stomach. This is the variety that is known by the unmusical name of *bradyspepsia.*

Again, this difficulty of digestion is accompanied by the development of gas in the stomach and in the intestines, with borborygmus and a burning regurgitation of gas that is almost always inodorous. This is the *flatulent dyspepsia.*

When there are regurgitations of liquid and of acid food, and veritable eructations of what has been swallowed, it is the *acid* form of *dyspepsia.*

Finally, dyspepsia is sometimes characterized especially by cardiac or cephalic suffering, dizziness, cephalalgia, palpitation of the heart, breathlessness, spurious pleurisy, arrest and irregular beating of the heart. This is the *masked* form, because the symptoms of indigestion are not very pronounced,

but are, so to speak, obscured by the cerebral and cardiac symptoms.

Each of these forms presents sub-varieties, which differ with the diseases of which the dyspepsia is a symptom. In dyspepsia the tongue is clean, the appetite is usually retained, a fact that distinguishes it in a characteristic way from gastritis and from other organic affections of the stomach.

Gastralgia is an affection that is more clearly defined. It is a cramp of the stomach, and, like all other neuralgias, is habitually symptomatic, and it often alternates with other forms of neuralgia.

Gastralgia is characterized by an extremely acute pain, that may be accompanied or not by a feeling of constriction, located in the epigastrium, but which radiates along the intercostal nerves and their anastomosing branches. The pain returns in paroxysms, is accompanied by a feeling of anguish, crying aloud, by hot and cold sweats, sometimes by lipothymia, and more rarely by efforts to vomit.

Moral causes and variations of the temperature, storms, and thawing and melting snow, have all a remarkable influence over the repetition of the attacks.

As for *chronic gastritis*, it may be recognized by a dull pain, accompanied by the vomiting of food, or of an acid mucus. The tongue is usually furred, and the urine contains a large proportion of the phosphates. The emaciation and loss of strength are much more rapid, and much greater in this disease than in dyspepsia.

When this form of gastritis has lasted a long time, the membranes of the stomach are hypertrophied at its pyloric portion, which occasions a real contraction of this orifice. Then follows a considerable dilatation of the stomach, and the sensation of a hardening or induration in the region of

the pylorus, while at the same time the patient is seized with copious vomiting of the aliment that had been taken into the stomach several days before, while, perhaps, the food swallowed the same day is retained.

At this period it may be very difficult to make the diagnosis between cancer of the stomach and chronic gastritis. But in this last affection the appetite is always more constant and reliable than in cancer of the stomach, and this is a sign that is worthy of your attention. The emaciation is also less rapid, the straw-colored complexion and the vomiting of blood, which characterize the cancer of the stomach, are lacking.

Case XLVII is an excellent example of chronic gatritis, which simulated cancer of the stomach. You recollect that one of the most skillful practitioners in Paris made a mistake in this case, and that the cure of the patient alone enabled us to settle the diagnosis satisfactorily.

You have seen that *nux vomica* was the principal remedy for chronic gastritis. We will now mark out its exact indications, and also speak of other medicines that may be given in this disease.

The Treatment of Chronic Gastritis.

With your permission, we will examine the treatment of chronic gastritis, dyspepsia and gastralgia. You will observe that the same remedies are frequently indicated in the treatment of all three of these affections. This is not strange to us as homœopathists. For we very well know that medicines are not specifics for any one disease in particular; but that they correspond to a totality of symptoms and of lesions; that, consequently, their action is rather upon the organ and its perturbed functions than upon the disease itself. There are, therefore, medicines for the *stomach*, just as there are medicines for the brain, the heart, the kidneys, etc. etc.

We will not forget these principles, and whenever we study a remedy that may be indicated in the treatment of gastritis, of dyspepsia, or of gastralgia, we shall commence by recognizing the general properties of that medicine, because these very properties may serve to determine the choice of a remedy in the treatment of any disorder of the stomach in which it is indicated.

Nux vomica is the principal gastric remedy. It is suited to hemorrhoidal cases, and, as Hahnemann said, to vigorous, sanguine and irascible constitutions. A sedentary life, the abuse of good living, and the effects of too assiduous intellectual labor, are all indications for the employment of this remedy.

The sufferings of the digestive organs which principally indicate this medicine are: constipation with tenesmus, difficult digestion with disposition to sleep after dinner, and insomnia after midnight, and pains in the stomach in the morning.

Nux vomica is an excellent remedy in dyspepsia. The feeling of weight on the stomach after eating, flatulence and pyrosis especially call for nux vomica. The tongue is covered only on the posterior part (Dr. Boyer); bitter or acid taste, with eructations of the same nature (Hughes); weight in the head, sometimes the canine appetite with quick satiety, and the predisposition to nausea after eating, all confirm this indication. But, above all, we recommend the alternation of *graphites* with *nux vomica* in the treatment of dyspepsia. We will return to this treatment farther on.

In *gastralgia*, *nux vomica* is indicated when there is great flatulency, the pains have the character of cramps, radiating either into the hypochondria or beneath the sternum and toward the neck, following the course of the phrenic nerve.

The disease must also present the general characters that are found in the provings of this remedy. I have remarked that, as in this case, it was necessary to give it in the medium and higher potencies, viz: the 18th, 30th and 200th dilutions, in order to avoid bringing on the very painful paroxysms. Let us observe here that nux vomica is not a remedy for the *paroxysms*, but its effect is better if given between the fits, say two doses a day for four days, then suspend its use for four days, and afterward resume it again. Ignatia, chamomilla, veratrum and belladonna are medicines that are suited for the paroxysms, as we shall see directly.

In *chronic gastritis* we have found that *nux vomica* was a very reliable medicine (Cases XLVII and XLVIII). Independently of the dyspeptic symptoms already given, we find as an indication for nux vomica in chronic gastritis: an habitual pain in the pit of the stomach, regurgitations of bitter and acid liquids, vomiting of the same nature, and the vomiting of food. Clinical experience also teaches us, that nux vomica is indicated by a contraction of the pylorus with dilatation of the stomach, when this lesion follows chronic gastritis. Abundant vomiting of food occurring long after eating, and containing the aliment that was taken some days ago, to the exclusion of that which was taken more recently, being the usual symptom of contraction of the pylorus, also indicates the employment of nux vomica.

Ignatia, which is so analogous to nux vomica, is distinguished from it by the preponderance of the hysterical symptoms. Clinical experience long ago proved to us that the St. Ignatius bean can rarely be successfully used in chronic gastritis and dyspepsia, but that it is the principal remedy that is required in *gastralgia*.

The symptoms that particularly indicate *ignatia* in gas-

tralgia are periodical attacks of cramps of the stomach, coming on usually at night or after eating, which are aggravated by the slightest contact and relieved or mitigated by a change of position.

Carbo-vegetabilis.—This is a remedy for hemorrhoidal subjects and for those patients who are disposed to diarrhœa with a great deal of flatus, the stools slight and flatulent, with the evacuation of which the desire to go to stool ceases. Hahnemann expressly noted that this flatus was almost always inodorous, although Dr. Richard Hughes, and most other homœopathic physicians, have considered the fetidity of the excretions as a positive indication for *carbo-vegetabilis.* This discrepancy probably arises from the fact that the symptom of inodorous gas spoken of by Hahnemann was one of the curative effects produced by the medicine in making the proving.

To the great flatulency developed in the stomach and intestines, and the putridity of the stools, must also be added a sensation of burning in the stomach, bordering often on pyrosis; eructations that are acid, bitter or sweet; epigastric distress and absence of vomiting, as specifying the range of use for the carbo-vegetabilis in *dyspepsia.*

Cocculus.—The Materia Medica Pura of Hahnemann contains symptoms which make it impossible to neglect the Indian berry in the treatment of *gastralgia*: "Violent cardialgia, a constrictive pain in the stomach; cardialgia, a stricture in the epigastrium; constrictive pain in the stomach, as though it were *tightened by a band; compression as though from pinching in the epigastrium*, which interrupts the respiration." Dr. Richard Hughes very properly says that *cocculus* affects the muscular system especially. It is, therefore, the remedy for a genuine *cramp* of the stomach. Hartmann speaks positively

of having cured the most obstinate cases of gastralgia with cocculus, but under the following circumstances: where the patients were constipated, where they had no pyrosis, and, above all, where the treatment had been commenced by *nux vomica*. I will add, as symptoms proper for fixing the choice of cocculus, great flatulency and considerable flow of the saliva.

China.—The allopathic school furnishes us every day, by its abuse of quinine, and by the suffering which results from this abuse, the proof that it is a remedy for gastric difficulties. China agrees principally with those patients who have been exhausted by privation, by losses of fluids, by hemorrhages, or by some previous disease. Hahnemann says that china is not efficacious unless the patient's sleep at night is troubled, as it is when the drug is taken by healthy persons. The peculiarity of this sleep is that it is agitated with anxious and frightful dreams, the terror continuing even after awaking.

China is an important remedy in *dyspepsia*. The slowness of the digestion is accompanied by a sense of weight and difficulty of breathing. Great flatulency, and stools of a liquid nature passed *immediately after eating*, is a characteristic symptom. Observe, again, that it is a special indication for china in dyspepsia when the tongue is thickly covered with a yellow coating; there is a predominating bitter taste in the mouth, the appetite continues, and there is a temporary relief from gastric suffering by eating.

China corresponds in its symptoms, in a healthy man, to cardialgia with suffocation, and may also be given in the masked form of dyspepsia, with cardiac symptoms.

I am not in possession of such clinical experience as will permit me to decide upon the indications for china in *gastritis* and *gastralgia*.

Arsenicum.—This remedy acts with great power on the organs of digestion, and provokes, when given to a healthy man, acute and chronic inflammations, examples of which abound in the history of cases of poisoning by arsenic. A sensation of faintness during the suffering, palor, emaciation, loss of strength, thirst, nocturnal aggravations, eczema and psoriasis, which may be either primary or secondary, form the characteristics of this remedy.

In chronic gastritis, arsenicum has been successfully employed. The special symptoms which indicate it are: a white tongue, loss of appetite, acid and bitter eructations, *very frequent* bilious and alimentary vomiting, constant pain in the stomach, and habitual burning, which is worse some time after eating.

In *dyspepsia*, arsenicum has done me good service, especially where this affection has developed from herpetic disorders. The general symptoms of this medicine, as well as those enumerated under the head of gastritis, will guide the physician in the choice of arsenicum for the treatment of dyspepsia. The following symptoms may be added: yawning, a desire to sleep and great prostration after eating; thirst, with relief from warm drinks, and often a diarrhœa, or loose stools. Great anxiety, with very painful cardiac pressure, indicate arsenic in the masked form of dyspepsia.

Arsenicum has sometimes cured those cases of *gastralgia* which are symptomatic of dartrous affections. Here there is relief from hot drinks and warm applications, and a burning cardialgia, with anxiety, and lipothymia are especial indications for arsenic in gastralgia.

Lycopodium.—Lycopodium seems to us to be principally useful in the hysterical, chlorotic and dartrous subjects. Here are some general signs by which we may regulate the employ-

ment of lycopodium, and which we borrow from Dr. Guerin-Menneville's translation of Dr. Richard Hughes' work: "Instead of the acute disorders, we find gradually advancing chronic disease; instead of excitement, we have depression and decay. Mental, nervous and bodily weakness; sallow complexion and cold extremities; anorexia, *slow and irregular digestion, flatulence and constipation;* a passive catarrh of the air passages, and an unhealthy state of the skin, are the morbid conditions presented to us."

We have emphasized several of these symptoms, which indicate the evident action of lycopodium upon the stomach.

Lycopodium has rendered its greatest service in *dyspepsia* and *flatulent dyspepsia*, and Richard Hughes does not hesitate to recommend it as a very important remedy in the treatment of this disease. The following are its principal indications: pyrosis, flatulency and constipation. As accessory symptoms, bitter or acid eructations, bulimia, with repugnance and disgust of food, and *intestinal* meteorism. Dr. Hughes also says that an irresistible desire to sleep after dinner, followed by great weariness, are indications, and that lycopodium may be successfully used for dyspepsia engendered by the abuse of farinaceous food.

Some of the symptoms of lycopodium indicate its employment in *gastralgia* and in *chronic gastritis;* some very serious cases of the last-named disease, with black vomiting, have been cured by it. It should, therefore, always be remembered in grave cases of gastritis of a chronic nature.

Sulphur.—Sulphur is rarely advised in affections of the stomach. However, its pathogenesis affords a complete picture of dyspepsia, and I am indebted to it for the cure of several very chronic cases. The habitual failure of this remedy in gastric disorders is probably owing to the fact that its indica-

tions have not been as carefully sought for as they should have been.

Sulphur is better than *arsenicum* in the treatment of internal affections which alternate with, or which follow, certain cutaneous disorders. Like nux vomica, it may be used in hemorrhoidal subjects. Everyone knows that the skin affections of sulphur are characterized by itching of the whole surface of the body. This pruritus is aggravated by friction, and is increased at night by the warmth of the bed.

The gastric symptoms of sulphur are much like those of *chronic gastritis* and *dyspepsia*, the principal of which are: great weight in the stomach, slow and difficult digestion, with rumination, and sometimes vomiting of food *a long time after eating;* the digestion of meat is particularly difficult; there are sour or sweetish eructations; a feeling of cold or of heat in the stomach, and various pains in the epigastrium. The dyspepsia of sulphur is accompanied by acidity, flatulency and dyspnœa.

Pulsatilla is a medicine that is not to be forgotten in dyspepsia. We know that this remedy is especially suited to blonde, fleshy persons of a mild and indolent disposition. The importance of these symptoms, as given by Hahnemann, have been so exaggerated that our physicians are too much inclined to prescribe it only for women or for effeminate men. I attach more importance to a frequent chilliness, and to the absence of thirst, as generally characteristic of this medicine. Dr. Hughes has given the special and precise indications for pulsatilla in the treatment of dyspepsia. The tongue is covered with a thick coating of a dirty white color; there is constant nausea, with slight vomiting and *little pain;* the diarrhœa is almost passive, and occurs principally at night, and a feeling of distension after meals, forcing the patient to loosen his clothes. To these symptoms we may add the *rising of water* into the

mouth in considerable quantity, and the predominance of a *bitter* or a *putrid* taste.

Plumbum.—Plumbum is a remedy that is seldom given in gastric affections. However, I cannot forget that by using it I effected a cure in one serious case of chronic gastritis, which had caused and been accompanied by great emaciation and loss of strength.

The symptoms which, according to my experience, indicate plumbum, either in chronic gastritis or dyspepsia, are quite characteristic. They are: abundant vomiting of a thick, white fluid, which falls in a trembling mass, like the white of an uncooked egg; stubborn constipation, and violent pain in the epigastrium.

I sometimes alternate *opium* with plumbum in obstinate cases. I have always used the thirtieth dilution of plumbum, but Dr. Richard Hughes advises the low dilutions, as the third and sixth of the carbonate of lead.

Chamomilla, *belladonna* and *veratrum* are very important remedies in the treatment of *gastralgia*, especially during the paroxysms. *Veratrum* is indicated where the pains are very violent and accompanied by palor and cold sweats. *Chamomilla* is the remedy for the same pains with unrest, anxiety, frightful cardiac oppression, as if the heart would be crushed, redness of the face and a warm perspiration. In cases where, despite these indications, it does not act, I have found it useful to alternate chamomilla with *belladonna*, both remedies to be given in the third dilution. In these cases veratrum is also given in the third and the sixth dilutions, and the doses may sometimes be repeated as often as every fifteen minutes. As the pain diminishes, however, the medicine should be given less frequently.

Bryonia.— Dr. Marston, in the *Monthly Homœopathic Review*, London, 1867–8, speaks very highly of this remedy, and suggests that it is especially adapted to those cases of dyspepsia in which the muscular coat of the stomach is chiefly at fault. The symptoms indicating bryonia in this affection are: "a sense of *pressure* after taking food, as if a stone was lying on the stomach, bitter taste and vomiting, and tenderness of the epigastrium to the touch and on movement, especially when making a false step." In our experience, bryonia is often adapted to the dyspepsia of bilious and aguish subjects, especially if they have much headache, and are inclined to constipation.—L.

Graphites.— I must speak, before closing, of the good effects obtained in the treatment of *dyspepsia* by the alternation of *nux vomica* and *graphites.* For this reason I have reserved the history of this medicine for the termination of my lecture. Graphites produces, in its provings, many of the symptoms of dyspepsia, the most characteristic of which are the following: Bitter or acid regurgitation of food, a kind of rumination, obstinate vomiting of food, salivation, the raising of phlegm, and the indigestion of liquids.

Clinical experience has taught us that the alternation of nux vomica and of graphites constitutes an excellent plan of treatment for dyspepsia. We are indebted to Dr. Emery, of Lyons, for having suggested it. His custom was to give nux vomica, 12th dil., six globules in 200 grammes of water, one teaspoonful to be taken an hour before eating the two principal meals, and graphites, 12th dil., prepared in the same way, to be taken an hour after eating. This mode of alternating these two remedies almost always succeeds in relieving the dyspeptic symptoms, at least temporarily, and very often we have obtained a complete cure by it. It is one of the very best prescriptions for illustrating the efficacy of infinitesimal doses, as well because of the frequency of dyspepsia as because of the certainty of a cure. When the twelfth dilution fails, I am in the habit of using the sixth, or even the third, trituration.

To cite an example of a case, which has passed under your notice, I will read you the clinical history of the patient

who occupied bed No. 2 of ward No. 1, and who had the chlorotic form of dyspepsia.

Case XLVIII.— Miss Guillot, a servant, twenty years of age, entered on the 11th, and left the hospital on the 21st of December.

This young girl, of delicate health, came to Paris in 1871. At the end of two years the disease, which finally brought her to our wards for treatment, forced her to return to the country. While there, her health was partially restored, and in about two months she returned to Paris.

She fell ill again immediately upon her arrival in town, and her condition, when she came to us, was as follows:

She presents the facial expression which is typical of chlorosis; her skin is transparent and of a yellowish cast, and her lips are quite colorless.

The slightest movement provokes vertigo and palpitation; the appetite is almost gone; the digestion is excessively slow and painful; the occular and palpebral mucous membranes are pale and colorless.

Her menstruation was regular until the month of October. Since that time, however, she has not menstruated but once, which was in the early part of December, the flow continuing only a few hours.

Auscultation in the region of the heart is negative in its results, but in the vessels of the neck, on the contrary, a continuous *bruit de souffle* may be heard.

Ferrum metallicum, 6th dil., was prescribed.

December 14. No improvement from the *ferrum metallicum*.

The patient complains of oppression after each meal, and of difficulty of digestion. The appetite being very moderate, we began a systematic treatment, and gave her *nux vomica*, 12th dil., before her meals, and *graphites*, 12th dil., after them.

December 16. The digestion is easier. The palpitation, which was very frequent a few days ago, even when the patient was lying down, seldom returns. The same treatment.

December 18. She is improving. The appetite has considerably increased. Continue the *nux vomica* and the *graphites*, and give, at the same time, the *protoxalate of iron*, in the first decimal trituration, ten centigrammes daily.

December 21. The patient has partly recovered her strength. Her general condition is very satisfactory. Having secured employment in which she would have but little work, she asked permission to leave the hospital. She was given *nux vomica* and *graphites*, each in the 12th dil., and the *protoxalate of iron*, also, to be taken as before.

We have seen this patient since she left the hospital, and her health is entirely re-established and continues good.

In very exceptional cases of mere functional dyspepsia, where the patient was anæmic and the vitality very low, we have had good results from practicing Brown-Séquard's method of giving only a small quantity of liquid or of solid food at one time and at regular intervals, varying from ten to twenty minutes, or perhaps half an hour. This plan may need to be persevered in for from two to three weeks, after which the patient may gradually resume the three meals daily.—L.

LECTURE XVIII.

SUMMARY.—Chronic Congestion of the Liver, *case*. What is a chronic congestion of the liver? The diseases in which it occurs. Its symptoms. A study of the symptoms of hepatic dullness. Gravity of this congestion. Indications for the animal poisons and for *nux vomica*. Hypochondria, *case*. Indications for *nux vomica* and *aurum*.

Chronic Congestion of the Liver.

GENTLEMEN: Here is another fact which affords indubitable evidence of the efficacy of the homœopathic remedies. It does not relate to one of those nervous affections that sometimes astonish us by their sudden and unexpected cure; nor yet to one of those lesions which disappear by the unaided efforts of nature. A chronic congestion which had gone so far as to develop a decided and tangible lesion of the liver; a congestion which had resulted from the dysentery of warm climates; which had had its alternations of being better and worse, but which had not disappeared in eight years; which had resisted all the resources of the Old School, and the benefit to be derived from a change of climate seven years ago, improved for some days, and then disappeared entirely, under the influence of *lachesis* and of *nux vomica*. This cure was confirmed ten months after the patient had left our hospital. This clinical fact includes, I think, all those conditions which should carry conviction to the minds of such as are not blind to the merits of any system of treatment excepting their own. Here is the detailed clinical history of this patient:

CASE XLIX.—M. Rochelin, aged thirty-six, was admitted on the 26th of December, 1874, and discharged on the 8th of January, 1875.

This man, who was of a robust constitution, had enjoyed very good health until the year 1866.

He then went to Egypt, where, after a residence of some months, he contracted a dysentery, with an affection of the liver. He says he was treated in that country for an hepatic congestion.

For a month, while he was ill in Egypt, he had a diarrhœa. The stools were brownish, but more frequently bloody.

The right hypochondrium became the seat of a pretty violent pain, accompanied by fever and loss of appetite. At the same time he became jaundiced, but the discoloration was limited to the conjunctiva and to the face.

He returned to France in 1867. His health was very imperfectly restored, and he continued subject to gastro-intestinal troubles that were almost constant. In 1872 he had a slight indisposition, with some fever, which was soon followed by a diarrhœa that was almost identical with that which he had had in Egypt; by a slight jaundice, and also by pains in the region of the liver. This attack continued for about six weeks. He was seized again in January, 1874; but in the interval which separated these two last attacks he continued to have pains over the liver, and during all of the last summer he has had diarrhœa, with bloody stools.

Now he complains of a continuous pain in the right shoulder, and, at the same time, of a decided uneasiness in the right hypochondrium. By percussion, we find that the volume of the liver is considerably increased. It extends very high, and, at its inferior margin, projects more than three finger-breadths below the border of the false ribs.

The appetite is very poor, the digestion slow and difficult, and there is some constipation. *Lachesis*, in the 3d trit., was prescribed, 20 centigrammes in four doses during the day.

December 30. There is a slight improvement. The region of the liver is less sensitive. The same medicine.

January 3. The good effects that have been produced have disappeared. The patient suffers a great deal with his right shoulder. We hesitate to change the remedy, but considering that there is already a very slight but positive diminution of the hepatic dullness, we continue the *lachesis*, but order it in the 2d trit.

January 5. The general condition is better; the patient is recovering his strength, and the appetite is returning a little. More than all, by percussion, we are positive that the size of the liver is very much diminished; it scarcely projects beyond the borders of the false ribs. *Lachesis*, in the 2d trit.

January 8. The case goes from good to better. The pain in the right shoulder has entirely disappeared, and the liver has returned very nearly to its normal size.

We saw the patient ten days later, and he continued to get along very well. We saw him again at the end of October. Until the month of April he had spells of being better and worse. Now there is an absolute improvement which is very remarkable. The strength and plumpness have returned, and, although the liver is still liable to occasional attacks of congestion with enlargement, these attacks are far from being as severe as they were at first. We have found excellent effects, whenever the gastric troubles predominated, from *nux vomica*, 30th dil., given twice a day for four days. The *lachesis*, in the 2d trit., was given whenever the liver became enlarged.

October 31. The patient is constantly improving; he has grown fleshy, and has not had a relapse for several months.

We may find it useful, gentlemen, to discuss, for a moment, the subject of *chronic congestions of the liver*. Indeed, it belongs to the clinic to explain the particular facts which are met with, and the problems of pathology, which nosography, with its didactic method, sometimes leaves without explanation. Now, this is the case with chronic congestion of the liver, for physicians in general have a very confused idea of the pathology of this lesion, and of its symptoms.

Chronic congestion of the liver is essentially due to an afflux of blood to the organ, which determination is much more marked than in the physiological state. It differs from *hypertrophy*, because it is not accompanied by an increase in the number of the hepatic cells; from *chronic hepatitis*, because it does not induce a proliferation of the interstitial

cellular tissue, nor a fatty degeneration of the organ; from *organic lesions*, because, in chronic congestions of the liver, we do not meet either with amyloid productions or with heterologous degeneration of any kind.

What are the diseases in which we find the lesion that is known as a chronic congestion of the liver?

1. In all those cases in which there is a mechanical obstruction to the return of the blood from the liver to the right side of the heart. Affections of the heart, and especially those of the mitral valves, are the most frequent; then follows the compression exercised upon the vena cava by glandular and other tumors, and finally, the embarrassment of respiration that is caused by acute or chronic affections of the respiratory organs; but these latter causes are much less powerful than the former.

Chronic congestions of the liver, of a mechanical kind, vary with the cause upon which they are dependent. These are the congestions that are styled *passive*.

2. Besides the mechanical causes, chronic congestions of the liver are most frequently met with in the cachexia of intermittent fevers; in the dysentery of warm climates, and in leucocythemia. These are the three diseases which cause eight-tenths of the cases of chronic congestion of the liver; almost all others are related to alcoholism. To include everything, some cases are due to scurvy, others to gout or to syphilis (apart from syphilis of the liver), and some to scrofula.

Now that we know positively what this chronic congestion of the liver is, and in what diseases we are liable to meet with it, let us inquire for the symptoms that accompany it, and by which it may be diagnosticated.

The first and most important symptom, which by itself is sufficient for the diagnosis, and which, being absent, totally

excludes the possibility of this congestion, is the increase in the volume of the diseased organ. This enlargement of the liver is recognized by percussion and by palpation.

Palpation will tell us when the liver projects beyond the false ribs. On causing the patient to lie upon the back, with the muscles of the abdomen relaxed, we find the border of the liver below the false ribs, in the right hypochondrium. It gives the sensation of a smooth, resisting tumor, and it exactly follows the movements of the diaphragm during respiration.

But the liver may be prolapsed without being increased in size, and percussion must be used to verify the signs that are furnished by palpation.

In order to utilize the percussion of the liver, it is necessary to know the height of the dullness in the healthy state; we must also know that this dullness has a character of its own, and that it is *relative* at its upper portion, passing from above downward, and *absolute* at its inferior part. With these two lessons, as we shall see directly, we shall come to recognize very accurately the size of the liver, so as not to confound this hepatic dullness with a dullness that is due to pleuritic effusion.

According to Monneret, the measurements given by percussion of the liver are as follows: upon the median line, the dullness is five and a-half centimetres; upon the line of the nipple, twelve and a-half centimetres; upon the axillary line, ten and a-half centimetres, and upon the scapular line, nine and a-half centimetres.

We said that, in proceeding from above downward, the percussion of the liver, within certain limits, yields a *relative* dullness. This phenomenon corresponds with the anatomy of the liver and of the lungs. The right lobe of the liver has a convex surface, which fits exactly into the concavity of the inferior surface of the diaphragm. At its base the

lung presents a corresponding concavity, making a cap, so to speak, for the right lobe of the liver. Now, this natural arrangement finds itself exaggerated when the liver is increased in its volume. The thin borders of the base of the right lung rest in the groove of the diaphragm, whilst the centre is depressed and hollowed out, in order to receive the hypertrophied liver.

This topographical arrangement explains perfectly how the upper part of an enlarged liver gives a comparative dullness on percussion, whilst the organ which furnishes the type of absolute dullness is separated from the ribs by a portion of the lung, which is an extremely sonorous organ. It also explains how the pulmonary layer, interposed between the liver and the ribs, becomes thinner as we approach the base of the thorax; from which it results that the dullness increases in proportion as we descend with the percussion, becoming absolute when it reaches the point at which the liver is no longer protected, or, rather, covered by the lung.

There is, therefore, a particular form of dullness, and if we have insisted upon its peculiarities it is because of their extreme importance in diagnosis. Do not forget that the liver may project beyond the false ribs without being really hypertrophied; that it may, for example, be forced out of its place by a pleuritic effusion. Very well; but how in this case are you to distinguish by percussion alone a liver that is forced down in consequence of a pleuritic effusion from one that is hypertrophied? By the outline and the characters of this dullness.

Suppose that we have an effusion which reaches to the nipple in front, and that the liver is forced down three finger-breadths below the false ribs. The dullness will be absolute from the superior limit of the effusion to the inferior margin of the liver. If, on the contrary, it is the liver that reaches to the nipple, the dullness will be imperfect, com-

parative at least for three finger-breadths, and this character will be sufficiently diagnostic of the lesion.

The second symptom due to congestion of the liver is the *pain*. This pain is sometimes dull and disagreeable; it is located in the right hypochondrium and often extends to the shoulder of the same side. Such was the case with our patient. This peculiar pain is increased by palpation and by motion.

A certain degree of dyspnœa, of dyspepsia, of constipation, and more frequently of diarrhœa with icterus, are the usual consequences of chronic congestion of the liver. Our patient had these symptoms also.

The *prognosis*, in congestion of the liver, is generally serious. If we are to believe the authorities, a case of the kind which has existed for more than eight years must long ago have reached the stage of hypertrophy and of cirrhosis, *id est*, of almost certain incurability. The detailed history of the case, which serves as the basis for this lecture, demonstrates the error of such teaching; for this man has had, with alternations of tolerable good health it is true, for eight long years this lesion, and in all that time it has neither resulted in destruction of the gland nor become incurable. The cure of such a chronic case is not more remarkable than the categorical proof which it gives of the efficacy of the homœopathic treatment.

Why did we give the poison of the serpent to this patient?

The history of cases of poisoning from the bite of the viper, and of all venomous serpents, shows an evident action of the poison upon the liver. The swelling, the pain and the jaundice are symptoms that have been noted by observers, and which it would be ridiculous to attribute to the fright of the victim. It has been observed in the autopsy of those who

have died from the bite of the trigonocephalus, and of the crotalus, that there was a marked congestion, and sometimes a softening of the parenchyma of the liver.

Therefore, the poison of the serpent is a remedy that is adapted to certain diseases of the liver. I have chosen that of the viper because my clinical experience has often shown its efficacy in similar cases.

I should remark, that on the eighth day of the administration of this remedy, and after a decided improvement had been observed, there was a characteristic aggravation of the symptoms, as shown by a very severe pain in the right shoulder. Should we have continued the use of the same medicine, or should we have tried another? I confess that I hesitated somewhat; but, when there was a diminution in the size of the liver, which, although slight, was nevertheless certain, I continued the remedy, but increased the strength of it by passing from the third to the second trituration. In two days more there was a new and a very decided improvement. In this case I gave it in a lower form, in order that the doubt concerning the good effect of the remedy should not prolong itself indefinitely, and because I attributed the return of the pain, not to a badly-chosen remedy, but to the insufficiency of the dose.

What would have happened if, on account of the aggravation of the pain in the shoulder, I had changed the medicine? It is very probable that the patient would not have been cured, and that, in lieu of success, we should have been forced to report a failure?

Let me recall a precept which I have already given you, and which is that, without a very good reason, it is not well to change the remedy in our treatment of disease. It is a hundred times better to lose some hours in an acute disease, and some days in a chronic one, by the continuation of a

useless remedy, than it would be to change a remedy at the very moment in which it begins to take effect.

By acting very favorably upon the digestive functions, the *nux vomica* has contributed to the cure of our patient, and has been a powerful auxiliary of the *lachesis*.

The *ammonium mur.* (which Dr. Dunham extols in sciatica, see *Allen's Mat. Med.*, Vol. I, page 298) is of the greatest service in the milder forms of this disease as met with in the Western and Southern States. Attention was first drawn to it by Dr. William Stewart, in the *British Medical Journal* for 1870. This notice was followed by other papers explaining its use and mode of action in diseases of the liver, more especially in congestion and inflammation of this organ, as it occurs within the tropics. In his work upon the *Diseases of the Liver*, Murchison speaks of it as "holding a preëminent place" as a remedy. —L.

Intermittent Hypochondria.

If, in closing these remarks upon congestion of the liver, we direct your attention to the patient in No. 2, of the same ward, and who is affected with hypochondria, it is not because we accept the ancient theory concerning the rôle that the liver and *atrabile* play in the production of hypochondria. We reject both the humoral hypothesis and the more modern *psychical* theory also; for we insist upon it, that the mania for a physiological explanation of disease is the plague of a sound nosology. While physiology affords very valuable instruction for the explanation of *symptoms*, which are only functional, it nevertheless is powerless to explain that condition of the living being which constitutes *disease*. If I speak to you, therefore, of our hypochondriac to-day, it is because he is going away very soon, and at a later period you may, perhaps, have forgotten him. This is his clinical history :

Case L.—M. Dupin, aged forty-five, entered the hospital on the 2d of December, and left on the 29th of December, 1874.

This man's disease began fifteen months ago. He is thin, pale, and of late appears to have suffered many privations.

The affection for which he came into our wards is remarkable for the crises which recur every two days, and which are characterized by a loss of appetite, a general malaise, an extreme weakness and sadness, and a violent headache, and also by an apathy which renders him quite indifferent to all that is passing around him.

On the days in which he has no paroxysm he is pretty well. He has a good appetite, and, more than that, his recollections are correct, which is never true on the days in which he has the fit. He is habitually constipated. At first he was treated on the expectant plan.

December 5. He was given, by hypodermic injection, a solution of the sulphate of soda, 1-10, which was repeated the next day, for the purpose of overcoming the obstinate constipation; but the remedy was not successful.

December 10. He took *diadema*, 3d trit., which was continued until the 16th of December.

December 16. The paroxysms persist and return regularly every two days. *Nux vomica*, 30th dil.

December 18. Under the influence of nux vomica there was a slight diminution of the headache at the time of the fit. Continue the same medicine.

December 23. All medication was suspended, because the improvement is so very marked and the paroxysms have ceased.

December 27. The improvement continues. *Aurum*, 30th dil., was given because indicated by the great sadness of the patient. This remedy was continued until the 29th of December, when the patient left us, feeling very well.

This case is a very rare specimen of hypochondria, and one which has not been included in the classical arrangement of this disease (see our *Médicine pratique*, Vol. I, page 407). We have divided hypochondria into two forms: a *common form*, which is continuous, and of an indefinite duration; and a *periodical* form, which is characterized by paroxysms of long duration, and that return at prolonged intervals. But here we have an example of the hypochondriacal

paroxysm with a duration of twenty-four hours, and which is of the tertian type. The word *periodical*, which is applicable only to the return of the paroxysm by the week, by the month, or even by the year, is not appropriate to this case. The term *intermittent* should alone be proper, because it serves to designate the return of the paroxysms at short intervals, which are counted by days, like those of intermittent fever, for example. This is, therefore, as I have just said, an exceptional case; but the exceptional cases constitute the peculiar difficulties in the way of the practice of medicine, and it is for this reason that I desire to say something to you concerning this patient.

In the first days which followed the entrance of this man into my ward, I believed he was trying to deceive us; and I thought that this poor fellow was very willing to enjoy the rest and quiet of the hospital. But a careful observation, in which we have been seconded by our assistant, has caused us to change our opinion. Every two days the patient fell into a kind of stupor, ceased to eat (which in the present case was an unanswerable argument for the fact of his suffering), and the next day he would appear almost entirely natural.

For eight days he remained under notice and without active treatment. On the eighth day I prescribed *diadema*, 2d trit. This remedy, as well as the *tarentula*, has given me good results in the treatment of nervous affections, which recur in the form of an intermittent paroxysm. The diadema was continued for six days, but without effect. I then ordered *nux vomica*, 30th dil., which was indicated for the hypochondria. On the third day of its use there was a decided diminution of the headache during the fit; the eighth day all treatment was suspended, because the improvement was manifest and the paroxysms had almost ceased. Four days later we prescribed *aurum*, 30th dil., which finished the cure.

It is very useful to remember that *nux vomica* is, as Hart-

mann taught, the principal remedy for hypochondria, although more recent authors, and Dr. Richard Hughes in particular, have omitted to give it under this indication. Here are the principal symptoms that indicate nux vomica in the treatment of hypochondria: gastric troubles, dyspepsia, loss of appetite, obstinate constipation, great irritability and profound sadness, more especially if this sadness is accompanied by a fear of death and by an impulse to suicide. Nux vomica is decidedly indicated in hemorrhoidal hypochondria.

The gastric troubles, the loss of appetite, the constipation, and the return of the paroxysm of the tertian type, were the three symptoms which, in this case, led us to decide upon nux vomica. We should not forget, indeed, that nux vomica corresponds, like *china* and *arsenic*, to intermittent affections, and that, for this reason, it is the best remedy for intermittent neuralgia in case the paroxysms return every morning or every alternate morning. *Aurum* was indicated in this case by the profound sadness of the patient.

During the first eight days that he was under our care we experimented with a remedy prescribed by an M. Luton (of Rheims) against constipation, which consists of hypodermic injections of the sulphate of soda in very small quantities. It was continued in this case for many days, but without result.

LECTURE XIX.

SUMMARY. — Scrofulous ophthalmia is an *affection* which has three forms. Blepharitis; indications for *merc. precipitatum rubrum*, *euphrasia*, *senega*, *calcarea carbonica*, *hepar sulphuris*, *digitalis*. Hordeolum; indications for *pulsatilla*, *staphysagria*, *silicea*. Inflammation of the lachrymal ducts; indications for *silicea* and *calcarea carbonica*. Scrofulous conjunctivitis; indications for *ipecac.* and *apis; cases*. Scrofulous lupus of the pharynx; indications for *hepar sulphur*, *arsenicum* and *opium*. Phthisis pulmonalis, two cases.

Scrofulous Ophthalmia.

GENTLEMEN: During this year we have had in our wards, and for consultation also, a variety of cases of scrofulous ophthalmia that have given us an opportunity to study this affection very thoroughly.

Scrofulous ophthalmia is, in fact, an *affection*, that is to say, a collection of symptoms and of lesions which are located upon an organ and developed under the influence of a disease, viz: the scrofula, which impresses upon it all of its peculiar characteristics. The tendency to ulceration, to softening, to suppuration, and to become chronic, is characteristic of scrofula. The lesions of the lids, of the conjunctiva, of the cornea and of the iris, that we encounter in the different forms of scrofulous ophthalmia, all present these peculiarities, and, therefore, this disease is properly denominated scrofulous.

The tendency to become chronic, and to be worse and better at long periods, is very marked in scrofulous affections of the eye especially. And this explains the fact that, without the most efficacious means of combating the acute attacks, which so often occur in the course of these affections, the case ends by the eye losing its functions either wholly or in part. Thus we find few affections in the treatment of which it will

be so necessary to cultivate patience and perseverance in the use of means in order to bring about a favorable result. If you will remember, at the same time, that scrofulous ophthalmia is a very common affection in Paris, you will appreciate the importance of this lecture, and will understand why we venture upon the field of the specialist.

Scrofulous ophthalmia presents three stages for study; *superficial ophthalmia*, which is limited to the lids, and to the lachrymal apparatus, this is *blepharitis; conjunctivitis*, which is limited to the ocular and the palpebral mucous membrane; and, finally, *ulcerative* and *interstitial keratitis*, which constitutes the really dangerous form of this affection. These three conditions may either succeed or coëxist in the same individual. Let me add that keratitis may extend to the deeper structures of the eye, and so complicate with iritis, with perforation of the cornea, and dissolution of the eye itself.

Tubercles springing from the sclerotica and attributed to scrofula have been described. They appear as if they would suppurate, of a yellow or white color, but remain firm; increasing to the size of a pea, they burst without suppuration. They may be extirpated. Atrophy of the eye-ball is frequently the result where no treatment is undertaken.—V.

1. *Scrofulous blepharitis* sometimes begins spontaneously at the age of eight to ten years, and sometimes in complication with other diseases, more especially with measles. Its first seat is upon the free border of the lids, whence it may extend to the Meibomian glands, the conjunctiva, and the lachrymal passages. Sometimes it occupies all of these points at once, but it is usually limited to one of them, or, at least, it predominates in one of these locations.

In its mildest form this affection is limited to the free border of the eyelids. Here it develops an habitual redness, with a blearing of the eye. In a more advanced stage, it produces granulations of the conjunctiva, little ulcerations on the free borders of the lids, the fall of the eye-lashes, and frequently there are styes.

We have said that superficial scrofulous ophthalmia may extend to the lachrymal ducts; let us add that it is a frequent source of chronic epiphora, of tumors, and of fistula lachrymalis.

We think that a lachrymal fistula should never be made, and under appropriate treatment will seldom occur. If such an accident happens, every inducement to its speedy healing should be made. To this end the canaliculus should be properly opened, and an exit for the sac accumulations thus made.

Pulsatilla will often prevent a fistula. *Hepar sul.*, *pulsatilla* and *silicea* greatly aid in curing it.—V.

This affection is extremely frequent, and having seen a great number of these cases, you have remarked its tenacity, and the comparatively slight effect of our therapeutic means. We have not habitually used external applications, such as ointments and eye-washes, because we have frequently observed that this kind of treatment has only a palliative effect. However, in very rebellious cases we should not deprive the patient of the relief which he may derive from external applications, from an unguent of the red precipitate especially.

We think the red precipitate ointment is unnecessary, and have a somewhat large experience at the Eye Department of the Hahnemann Medical College and Hospital, Chicago, corroborative of this opinion. Since it has been under our charge, such cases have been treated wholly without external medicaments, and with the most satisfactory results.—V.

I have no particular cases to report to you of this variety of scrofulous ophthalmia, but will confine myself to some remarks upon the principal remedies that are indicated, and which you have known me to prescribe against this affection for the out-patients of our hospital.

You have often heard me prescribe *mercurius*;—it is the *red precipitate* which I order in these cases. It is called for in a certain acuteness of the inflammation. The lids are red, inflamed, swollen and covered with crusts; they are agglutinated in the morning, and the borders are often ulcerated.

Hempel relates that a prover who took the red oxide of mercury was cured of a chronic inflammation of the Meibomian glands.

Euphrasia corresponds to a stage of the disease which is already advanced, and in which there is ulceration of the free borders of the lids.

Senega is principally indicated by a symptom which is very frequent in this disease: the existence of dry crusts at the base of the eye-lashes, and with the fall of the latter. *Calcarea carbonica* is also called for under these conditions.

Hepar sulphur is very important in the treatment of blepharitis. Dr. Richard Hughes recommends it, especially when the Meibomian glands are very much involved.

Digitalis is highly recommended by Hartmann in chronic cases. The patients are worse in the evening, from exposure to light, and they have a burning and dry sensation upon the tarsal borders, with swelling of the inferior lid. We must add to these symptoms agglutination of the lids and a free secretion of mucus. Inflammation of the Meibomian glands affords a special indication for digitalis.

Pulsatilla and *staphysagria*, but especially *silicea*, are indicated in the case of styes. Finally, *silicea* and *calcarea carbonica* have done me good service in the treatment of chronic inflammation of the lachrymal ducts.

Hepar sulphur is of the greatest service in the treatment of this latter trouble when pus has formed.—V.

2. *Scrofulous Conjunctivitis.*—Placed between blepharitis and keratitis, scrofulous conjunctivitis often precedes, accompanies or follows these two affections. However, it may exist alone; its march is more rapid than that of blepharitis, and its cure is much easier; it never has the gravity of keratitis.

Scrofulous conjunctivitis begins with redness and swelling of the conjunctiva, of the lid, as well of the palpebral as of the sclerotic covering. It affects especially the external surface of the eye; it is characterized by the development of the vascular branches which converge toward the cornea, and terminates by a pustule that is soon followed by ulceration. Sometimes, instead of an ulceration, there are pseudo-membraneous exudations, and the formation of little prominences as large as a millet seed. This lesion seated upon the sclerotica, is accompanied by suffusion of the eyes, a certain degree of photophobia and a slight pain. It has not the daily evening exacerbations of arthritic conjunctivitis, but its march is subject to irregular aggravations and remissions, like all other scrofulous affections.

You have observed that I very often prescribe *ipecac.* in the first decimal trituration for scrofulous conjunctivitis, and you have seen the success that has followed its use, which success was decided in proportion as the case was acute.

This is a real conquest in current therapeutics; for, although it is just to recognize that Hartmann had already spoken of ipecacuanha in the treatment of catarrhal ophthalmia, we must add that he had not properly given the indications for it, in that he did not recognize its real importance. It was only in 1869, when Imbert Gourbeyre first published his essay upon ipecacuanha, in *L'Art Médicale* that it was introduced into practice under this indication. And Dr. Hermel at first, and ourselves afterward, have often given it in the dispensary of the rue de Verneuil. We shall return to this subject in speaking of the treatment of keratitis.

It would seem that in this trouble *ipecacuanha* has not been tried to any extent in this country, as we find no mention of it in any of our standard works. Our experience has been limited, but strongly corroborative of the author's estimate.—V.

Belladonna is indicated in two different conditions, viz: when there is a very acute inflammation accompanied by violent congestions of the face, redness of the conjunctiva, of the lids and of the sclerotic, photophobia with a slight secretion and *dryness of the inflamed parts.*

Belladonna is also indicated in the more advanced stage of the disease, when there are vascular fasiculi which extend to the cornea, with pustules or vegetations on the sclerotica; photophobia, or pains in the eyes, which are increased by opening the lids.

Euphrasia is adapted to similar conditions, *but with an abundant secretion of tears and fluent coryza.*

There are certainly many other remedies that may be indicated in this variety of scrofulous ophthalmia, but we shall not insist upon them farther. This is why we confine ourselves to the cases that you have seen, and in which I have prescribed only one remedy, *ipecacuanha*, for the excellent reason that it is generally sufficient for the cure.

Pulsatilla is an excellent remedy when the pustules are situated on the conjunctiva, the lids are swollen and subject to styes, and the symptoms are relieved by cold applications, and by going into the open air.

Sulphur is also often called for by smarting, burning and itching in the eyes, and where the secretions are acrid, causing a biting sensation in the lids, and a great desire to rub them. There is usually much redness at the angles of the eyes, and the lids are glued together in the morning. Concomitant sulphur symptoms are present in other parts of the system.

We do not think any one remedy sufficient for the cure of most cases of this trouble.—V.

3. *Scrofulous Keratitis.*—This affection is commonly preceded or accompanied by scrofulous conjunctivitis, and some patients have blepharitis, conjunctivitis and keratitis simultaneously. The latter affection, however, may exist alone.

Scrofulous keratitis begins by the formation, on the transparent cornea, of phlyctenæ, which ulcerate and spread more or

less. At the same time, the red vessels develop in this membrane, and if one examines it with a glass, with the aid of the oblique light of a lamp, he observes a vascular congestion which is more or less extensive. This examination discloses, at the same time, little islands of plastic lymph between the layers of the cornea. In certain cases this infiltration becomes more considerable, the islands increase in size, and the whole cornea becomes cloudy, grayish, and more or less opaque. This has been styled *interstitial keratitis.* When the ulceration, or the ulcerations, for this lesion is often multiple, exist without decided infiltration, the keratitis has received the name of ulcerative. Sometimes the ulcerations of the cornea seem as if they had been made with a punch, and have no cloud upon their borders. The cornea then presents multiple facets, like the eye of certain insects.

The symptoms of scrofulous keratitis are an excessive pain, with much photophobia and suffusion of the eye. The photophobia corresponds with the intensity of the inflammation, and, in the acute stage, it is so severe that it is impossible for the patient to open his eyes, and I have seen children remain several weeks with the eyes obstinately closed.

Like all scrofulous affections, keratitis has a course which is irregularly periodical; it returns by fits or paroxysms, which are more or less severe, and it is extremely subject to relapses. The return of the catamenial epoch is often, as you have seen in Case LIII, a cause of its aggravation. Working with the eyes, cold, and a cold in the head, are also liable to renew the inflammation which increases the disease. Whilst we observe, from time to time, those inflammations of which the duration is quite brief, scrofulous keratitis is an affection of which the total duration is extremely long, for when it has not been treated properly, it may continue for years. At the beginning, when the remedy is well chosen, a cure may be obtained in a few weeks, as in Case LI.

I have cured some cases of this disease in a fortnight. But when the keratitis has not been treated, or when it has been badly treated, and especially when there are persistent lesions of the cornea, we must not expect a cure before several months have elapsed. The fibrinous exudation upon the cornea, the pustules which have been imperfectly healed, and the vessels of the new formation which has developed in the cornea, are conditions which always threaten a return of the inflammation.

Scrofulous keratitis may be complicated with serious accidents which you should bear in mind. These accidents are: the effusion of pus and the formation of abscesses between the layers of the cornea; the perforation of this membrane, the escape of the iris through the opening, and the formation of a staphyloma; iritis, and the inflammation of the deeper structures, and the dissolution of the eye. The young man in Case LII has furnished you with an example of the formation of an abscess between the layers of the transparent cornea.

When these abscesses develop a tendency to slough, we know of no remedy so valuable as *silicea;* we prefer the 6th decimal trit. When hypopion, or pus in the anterior chamber, is present, it quickly yields to *hepar sulphur.*—V.

Ipecacuanha and *apis mellifica* are the two principal remedies in scrofulous keratitis. Ipecac. is indicated in preference when the keratitis is accompanied by a violent inflammation of the sclerotic conjunctiva; and *apis* when the inflammation, limited to the cornea, has caused either infiltration or ulceration in that organ. We must not, however, conclude that ipecac. acts only upon the conjunctiva, or apis exclusively upon the cornea; for these two remedies modify this affection in all respects. And yet one of them seems preferable to the other under the conditions that we have named. Here is a case of scrofulous ophthalmia in which the keratitis has yielded quite promptly to these two medicines:

Case LI.—Juliette Ollivier, aged eight years, was admitted on the 18th of January, and discharged on the 14th of February.

This child, which is quite robust, has the appearance of general good health, but is subject to scrofulous ophthalmia. Two years ago, and last year also, she had a disease of the eye, which continued for a long time. The kerato-conjunctivitis, from which she is now suffering, began ten days ago. It seized the left eye only. The cornea is opaque to a limited extent, which interferes with the vision of that side. Both lids are slightly swollen, and very much congested; there is no fever or loss of appetite.

She has taken *apis*, 2d trit., three times daily.

January 23. The little patient is somewhat improved. The lachrymation has ceased, and the photophobia is less severe. The same remedy.

January 28. The conjunctiva of the right eye is congested, and very sensitive to the light. The cornea, however, is transparent, and vision on this side is intact. *Ipecac.*, 1st decimal trit., three times daily.

February 3. The speck on the cornea of the left eye has lessened, and the congestion of the right conjunctiva has considerably diminished. The same treatment.

February 5. There is constant photophobia of the right side, and ciliary blepharitis of this side also. The cornea of the left eye continues to be diseased. *Apis*, 1st trit., three times daily.

February 9. Both eyes are better. The child can bear the light without suffering. *Apis*, 1st trit, as before.

February 10. *Zincum oxidatum*, 3d trit., was taken for the affection of the lids until she left the hospital.

When this child was discharged she was completely cured of the keratitis, although she still had a certain degree of ciliary blepharitis.

Here is an example of scrofulous ophthalmia in which we find a coëxisting blepharitis, conjunctivitis and keratitis, with a predominance, on certain days, of the keratitis, or of the conjunctivitis. You have observed in this case the indi-

cations for ipecac. and apis, and my method of alternating these two remedies in the treatment of scrofulous ophthalmia. The success attained has been rapid, because the lesions of the cornea were comparatively recent, and the child was discharged cured, at least for some time, after twenty-five days of treatment. The blepharitis has persisted after the cure of the other affections. It was for this trouble with the lids that I prescribed the *zincum oxidatum*, but it is too soon to judge of the effects of this remedy.

Abscess of the Cornea with Scrofulous Ophthalmia. Here we have a case of scrofulous ophthalmia that is much more severe, and in which you could follow the development of the abscess between the layers of the cornea. This case is that of a young man who was already suffering with ulceration of the posterior fauces, and consequently predisposed to serious scrofulous affections.

Case LII.— M. Frenette, aged seventeen years, was admitted on the 8th of January.

This young man, who was born of a family in which all the children are scrofulous, entered the hospital to be treated for several affections of a strumous character. The following is his clinical history:

Of delicate health, he reached the age of sixteen without presenting the characteristic affections that belong to the scrofulous diathesis. Having been treated for nearly a year by an oculist for a conjunctivitis of the right side, he consulted us in November, when he complained of violent pains in the throat interfering with deglutition, and of pains in the left eye.

On examination, we found some specks upon the cornea and two patches of ulceration in the posterior fauces, which latter had perforated the arch of the palate and also the anterior pillar of the veil of the palate. These ulcerations and perforations were seated upon an induration and tumefaction of the whole posterior fauces. The submaxillary glands were extremely swollen and painful.

The patient had been considerably soothed by the treatment which had been used, when, at the beginning of the month of January, he came for consultation. He was then suffering very much from the right eye, the sight of which, he said, was entirely gone. The conjunctiva was congested and formed a red circle about the cornea. Between the layers of the latter there was an abscess of from two to three millimetres in diameter, and occupying the internal part of the circumference of the cornea. *Apis mel.*, 3d trit., five grains to be taken during the day.

January 11. There is a slight improvement. The pains of which he complained are less violent. *Apis*, 2d trit., four grains in the same manner.

January 14. The abscess seems smaller. The injection of the conjunctiva is not so great. The same remedy.

January 18. The improvement is more and more decided. The abscess is already partially reabsorbed, and the patient begins to distinguish objects with the right eye. The same treatment.

January 22. The conjunctiva is much more inflamed. The pains have returned in the right eye. *Apis*, 2d trit., fifty centigrammes.

January 23. During the night the patient has had a diarrhœa. The apis was suspended and *ipecac.*, 1st decimal trit., was given, twenty-five centigrammes.

January 25. The diarrhœa has ceased entirely. *Apis*, 2d trit., fifty centigrammes.

January 27. The vision of the right side has become pretty good. The cornea appears less opaque on a line with the small purulent collection. *Apis* as before.

February 1. The condition of the diseased eye is pretty good. The young man begins to distinguish objects somewhat vaguely. *Apis*, 1st trit., twenty centigrammes.

February 3. The right eye is very painful to-day, and, what is more, there is a pretty decided injection about the cornea. *Ipecac.*, 1st decimal trit., twenty centigrammes.

February 5. There is a fresh accession of inflammation in the cornea. At the superior and internal part of the cornea there is a small purulent collection, being of a somewhat larger

extent than the first. There is some lachrymation and photophobia. *Apis*, 2d trit., twenty centigrammes.

February 10. The eye is a little better. The injection is less marked, and the pains are not so severe. The same treatment.

February 15. The abscess which came last has almost completely disappeared. A slight opacity takes the place of that which was seated at the inferior part of the cornea. *Apis*, 2d trit., twenty centigrammes.

February 17. The improvement continues. *Silicea*, 30th dil., and *apis*, 2d trit., twenty centigrammes were given in alternation.

February 20. The sight is returning feebly. The perikeratic vascular circle diminishes. *Silicea*, 30th dil., and *aurum muriaticum*, 6th dil., alternately.

February 22. The inflammation reappeared, and the *apis*, 3d trit., was resumed.

February 24. The conjunctivitis has almost entirely disappeared, but there remain two opaque points upon the cornea occupying the site of the two abscesses. *Apis*, 1st trit, twenty centigrammes.

On the 1st of March there had been a new abscess in the upper part of the cornea. Besides this, and somewhat later, there was an effusion into both of the knee-joints.

Although this case is not a brilliant success therapeutically, it, however, has its lesson. During the period that this man has remained in our ward, you have several times seen the marked effect of *apis* upon the inflammation of the cornea; but what shall we expect from a constitution that is so profoundly affected, and in which all the scrofulous disorders tend to assume a malignant form.

During the months of March and of April, when we were absent, new abscesses formed in the cornea, and the articulations of both knees became the seat of an effusion.

À propos of this young man, I should call your attention to the affection of the throat with which he was attacked,

and which you will not very often have the occasion to observe. These deep alterations of the veil of the palate, and of the pillars of the fauces, constitute a *scrofulous lupus of the pharynx*. This disease seems still to remain almost an incurable one. It sometimes causes death by hemorrhage, on account of an ulceration of the carotid artery.

Scrofulous Ophthalmia with Double Keratitis.—The third case presents an example of scrofulous ophthalmia which had existed for many years when the patient placed himself under our care. In this case *ipecac.* and *apis* caused only a slight and temporary improvement, but *arsenicum* produced an effect that was very marked, and which has now continued for several months. You will also remark, in this case, that the gravity of the keratitis corresponds with that of the other scrofulous affections to which this patient is subject. For example, during her infancy she has suffered from a scrofulous disease of the tibia. This is, therefore, a serious case of scrofula, and it is not surprising that the keratitis is correspondingly severe.

Case LVIII.—Miss Emma, aged twenty-two years. Being of a feeble constitution, this girl has been subject, from her infancy, to many symptoms of scrofula that have principally affected the eyes and the osseous system.

Her health was really not good, excepting from the tenth to the fifteenth year. At the age of fifteen she was taken with double keratitis, and was under treatment for it for two years. In 1873 she was apparently cured, but the disease soon returned.

She says that both eyes are never equally affected. As a rule, the left one suffers the least.

While under treatment for some months, she took a great many remedies, and was alternately better and worse.

She complains of intense pain in both the eyes, and of frontal headache. As in all similar cases, the lesions of the cornea constitute the points of departure for new attacks of

inflammation, and what is gained in some weeks is soon lost by relapses. The keratitis having existed for several years, these permanent lesions have resulted from it. The relapses are most frequent with the return of the menses.

The conjunctiva is red, thickened, and presents some phlyctenæ on the margin of the cornea. The cornea is the seat of an interstitial inflammation, with some congestion, and also some slight ulcerations.

About the 1st of December we began the treatment with *apis*, in the 2d trit., twenty-five centigrammes, three times daily.

December 5. There is a slight improvement, with less photophobia. The same remedy.

December 14. She can open her eyes much more easily. The injection of the conjunctiva is diminished. The same remedy, one gramme.

December 16. To-day we are certain of an aggravation, either because or in spite of the *apis*. She complains of severe pains in the globes of both eyes. There is also considerable lachrymation. *Apis*, 30th dil.

December 17. The treatment was suspended.

December 19. The patient is better. The pains are mitigated. We return to *apis*, 3d trit., twenty centigrammes during the day.

December 20. The improvement continues. *Apis*, 2d trit., twenty centigrammes.

December 25. The patient is menstruating, and all treatment is suspended.

December 28. *Apis*, 1st trit., twenty-five centigrammes.

December 30. The patient suffers very much to-day. *Ipecac.*, 1st decimal trit., twenty-five centigrammes.

January 3. The local condition of the eyes is better. There is almost no lachrymation. *Apis*, 1st decimal trit., ten centigrammes.

January 6. The right eye is much better than the left one. She opens it easily enough, and for a certain time can fix it upon a bright object. The same treatment.

January 15. The improvement continues. The same remedy.

She took this remedy until the 28th of January, when its use was again suspended during the menstrual epoch.

January 30. *Apis* was given again, beginning with the 1st trit., ten centigrammes.

February 1. *Apis*, as before.

February 2. Improvement continues from day to day. The cornea becomes more and more clear. There is almost no photophobia. The same remedy.

February 5. The medicine was stopped because of a decided aggravation.

February 9. Both eyes have remained in the same condition for some days. *Apis*, 6th dil., five drops.

February 13. The lachrymation, as well as the congestion of the conjunctiva, have diminished very decidedly. The treatment was suspended, but the inflammation reappeared, and the *apis* was given again.

February 18. For two or three days there has been an arrest in the progress of the disease toward resolution. *Apis*, the 1st decimal trit., twenty centigrammes, was given, and some drops of the following solution of *apis*, 1st trit., ten centigrammes in five grammes of distilled water, were thrown into the eye. There was considerable aggravation, and all treatment was discontinued.

February 22. There is a fresh accession of the inflammation in the mucous membrane. The lids are tumefied, and the eyes cannot bear the light. *Apis*, 1st decimal trit., ten centigrammes.

February 27. No improvement thus far. The patient complains of much pain in the orbital region, and not having been benefited during the preceding month, was again placed in the care of Dr. Frédault.

After we had left, this patient was submitted to various kinds of treatment, of which the resident student of the hospital has furnished the following history:

This patient, whose eyes, at the commencement of the month of March, were suffering from a relapse of the inflammation, took *cuprum sulph.*, 3d trit., until the 9th of March.

March 9, she had *silicea*, 200th dil., which had the effect to calm the violent pains in the orbital region, but without producing any improvement in the local condition of the eyes.

March 13. *Apis*, 3d trit., twenty centigrammes.

March 18. *Graphites*, 200th dil.

March 23. The acute stage persists. Complete photophobia. *Phosphorus*, 6th dil.

This last remedy was continued until the 7th of April.

The local inflammation being mitigated, and the cornea being much less thickened, the patient began to perceive objects a little way off, when she had a relapse on the 8th of April. *Pulsatilla*, 6th dil.

April 13. No improvement. *Phosphorus*, 12th dil.

April 22. She is a little better, but complains of very severe neuralgic pain. *Cadmium carbonicum*, 3d trit., twenty centigrammes.

April 26. *Oleum harlemsis*, 3d trit., twenty centigrammes.

May 3. The same condition. The cornea and the conjunctiva are decidedly congested. *Graphites*, 6th dil.

May 11. *Graphites*, 6th dil., and *nux vomica*, 6th dil.

May 17. No improvement. *Chininum sulph.*, 3d trit., twenty centigrammes.

May 22. *Natrum silicatum*, 3d trit., twenty centigrammes. Under the influence of this remedy she became a little better, and the lachrymation improved.

May 27. *Chininum sulph.*, 3d trit., twenty centigrammes.

June 3. *Opium tinc.*, two drops, and *arsenicum*, 6th dil.

June 6. The patient is decidedly improved. The *opium* was stopped and *arsenicum*, 3d dil., was given.

June 15. The *opium* was ordered again, two drops to be given daily, and every morning *arsenicum*, 6th dil., dry upon the tongue, both of which remedies were continued during the month of June.

Under their influence the improvement became more and more decided. The little pustules that were about the margin of the cornea disappeared. The patient could easily open the eyes, and could even read without very much fatigue.

July 1. The *arsenicum*, 6th dil., was continued, but concurrently with it she took sometimes *creosote*, 6th dil., some-

times *belladonna*, in the tincture, or *cannabis*, 3d dil., until the beginning of August.

During this month both eyes were seized again, but very lightly. She took *apis*, 3d trit., twenty centigrammes, until the 15th; she also took the *protoxalate of iron*.

August 15. She is better, the sight has come again. *Phosphorus*, 6th dil.

September 4. The eyes are very decidedly congested, and on the border of the right cornea there is a small pustule. The photophobia, however, is less marked than in the preceding attacks. *Ipecac.*, 1st decimal trit., twenty centigrammes.

September 13. Considerable improvement. *Arsenicum*, 3d trit.

September 18. Lachrymation and photophobia. *Apis*, 2d trit., and some days later in the 1st trit.

October 7. She is in a very satisfactory condition. The congestion of the lids is very slight. The opacity of both corneæ has diminished very considerably. *Euphrasia*, 6th dil.

October 13. Better. *Arsenicum*, 12th dil.

October 15. From this time forward, until the end of the month, she took no other remedy, excepting on the 25th of October, when she was given one dose of *arsenicum*, 6th dil. She was discharged on the 4th of November, still having some spots on the cornea of both eyes, but being able to see pretty well.

In this case you observe that *apis* and *ipecac.* have caused a decided, but transient, improvement, and finally that this affection, after three months of treatment, has returned to about the same condition that it was when we began our service. Opium, in the mother tincture, and arsenicum, 6th dil., given concurrently, then the arsenic, 6th dil., continued alone, had a much more decided effect upon the keratitis, and, we think, have produced as perfect a result as the deep-seated lesion of the cornea would permit. You should not forget the passing effect of *belladonna*, *phosphorus*, and especially of the *protoxalate of iron*, and of the fortunate return, under very proper indications, to *apis* and *ipecac.*

This is not the only failure that we have observed with apis and ipecac. In the present year we were called to treat a lady who, during her lying-in with her eighth child, was seized with acute scrofulous keratitis. She had had a first attack in the same eye at the age of twelve or thirteen years. The disease had been very obstinate, and had left its traces in the transparent cornea. During lactation with her fifth child, four or five years ago, she had had a second attack, but the cure was effected in a fortnight with *ipecac.* and *apis.* This year, after a decided improvement following eight days of treatment with the same remedies, these medicines lost their effect, and, in about a month, successive relapses brought on congestion and infiltration of the cornea. However, under the influence of the treatment the acute inflammation had entirely ceased. Being obliged to be absent at this time, the patient, or more properly her family, determined to place her in the care of a specialist. Atropine and other means did no better than the *apis* and the *ipecac.* The infiltration of the cornea increased, and she got well, but with a decided scar upon the cornea.

We should not, therefore, consider *apis* and *ipecac.* as infallible remedies in the treatment of scrofulous keratitis, but only as those which succeed the most often in this trying infirmity. It is possible that the fact of her being in the puerperal state may have been one of the causes of our failure in this woman's case.

We have not a doubt of it. For the time being, in acute diseases of almost all kinds, the puerperal dyscrasia is quite as pronounced, and as important therapeutically, as the scrofulous, the hemorrhoidal, the dartrous, or the gouty constitution. We do not profess to know very much about the diseases of the eye; but on this theory, as well as pathogenetically, the *kali carb.* seems to have been indicated.—L.

In the practice of medicine these questions should be studied from all sides. We should add that, in these two recent cases, where *apis mellifica*, 2d and 2d trit. (*id est*, a tritu-

ration of the whole bee), did no good; the *apium virus*, 6th dilution (*id est*, the separate poison only of the bee), produced a rapid cure. Was it a change in the preparation, or in the dilution of the remedy, that caused the difference in the result? This is a question which further observation will help us to answer, and of which we hope to give the solution in another lecture.

Before dismissing this subject, let us remember the fact that *ipecac.* is especially indicated in the case of a violent inflammation of the sclerotic conjunctiva, while *apis* is more appropriate to inflammations and lesions of the cornea; and also that these two remedies may be appropriate for the totality of the symptoms in scrofulous ophthalmia.

Let us inquire what are the other remedies that are likely to be called for in the treatment of scrofulous keratitis?

Hepar sulphur is a remedy that clinical experience has demonstrated to be very efficacious in scrofulous ophthalmia. Hartmann insists especially upon its value in keratitis, and, contrary to his usual habit, advises it in the lower triturations. Dr. Richard Hughes is equally certain of its good effects. He regards it as the first remedy in the treatment of scrofulous keratitis, and declares that he has obtained the best results from its use. He also prescribes it in the lower triturations.

It is very fortunate that clinical observation has generalized the employment of the *hepar sulphur* in the treatment of scrofulous ophthalmia, for the experimental Materia Medica gives only very vague indications on this point. Hahnemann, in his *Chronic Diseases*, speaks of redness and inflammation of the eye; but he says nothing of ulceration, of spots upon the cornea, nor of any other symptom of keratitis.

We have already expressed, on page 250, our opinion of *hepar sulphur*. We prefer the lower trituration.—V.

The attention of physicians was called to *arsenicum* by the frequency of inflammation of the eyes in cases of poisoning by this substance. Hahnemann's *Materia Medica* does not contain any symptom that especially calls for the use of arsenicum in the treatment of keratitis. Here, also, clinical observation furnishes the indication for the remedy; but let us add that these indications are very indefinite, and that, as a rule, we prescribe arsenicum when other medicines have failed. This was true in the case of the young girl whose history is recorded in Case LVIII.

Although by no means the only ones, we think good indications for the employment of *arsenicum* in keratitis are: an anæmic condition of the general system, with a shifting of the inflammation from one eye to the other; the dread of light is excessive, the opening of the lids causing great shrinking; and usually, but not always, these symptoms are accompanied by a flow of hot tears. We have seen it succeed well, also, when *calcarea carbonica* was seemingly indicated, but where it had been administered without effecting a cure.—V.

I should remind you, also, that *opium* has undoubtedly been of service in the cure of this difficult case. But since the Materia Medica of our school affords no precise indications for the employment of opium in keratitis, we must acknowledge that its use is purely clinical.

We have not been able to get the effect from *opium* that we have several times seen attributed to it.—V.

Phthisis Pulmonalis with Incidental Bronchitis.

We have had this year but a very small number of tuberculous patients; indeed, we can only report two cases of this disease. The first of these was an example of bronchitis in a tuberculous subject which was treated very successfully by *ipecac.* and *bryonia*. The second is an example of phthisis with pulmonary lesions and diarrhœa, which were considerably improved by homœopathic treatment. The vegetable diet has been resorted to with both these patients.

Case LIV.—Miss B——, aged twenty-nine, was admitted on the 4th of January, and discharged on the 20th of January.

Being the daughter of a scrofulous and tuberculous father and of a gouty mother, this patient had never enjoyed very good health. In her infancy she had had scrofulous attacks, and was liable to take cold very easily. Moreover, her father died of phthisis some years ago. She had coughed in a continuous manner for five or six years only. She has had repeated attacks of expectorating blood; her strength is always on the decline, and a physical examination of the chest reveals the following symptoms:

By percussion, we find a dullness, which is almost complete, at the apex and on the posterior surface of both the lungs.

Auscultation discloses, on both sides, coarse, humid râles, from the summit to the base of the chest.

The patient complains, also, of a pain in the left side, which is located about the fourth intercostal space.

Bryonia and *ipecac.*, 12th dil., were given alternately every two hours, and the aforesaid regimen was ordered.

January 9. The patient is a little better to-day. The cough is much less frequent. The same treatment.

January 12. The general condition is improved, but she complains of a continual pain in the left side. The appetite, which had almost disappeared, has returned. *Bryonia*, 3d dil., three drops four times in the day.

January 15. The pain in the side has diminished in its intensity, but the bronchitis continues. *Bryonia*, 6th dil., and *ipecac.*, 6th dil., were given alternately.

January 17. The local condition of the lungs is also improved. The râles are less numerous, and the respiration is more free. *Bryonia* and *ipecac.*

These remedies were continued until the discharge of the patient, when she seemed to be considerably improved.

The second case of phthisis is the following:

Case LV.—Alfred Gozon, eleven years of age, was admitted on the 30th of January, and discharged on the 24th of February.

This child, who is pale, with soft, flabby flesh, has coughed for some years, and has never had very good health.

His antecedents are bad enough. His mother died of phthisis a long time ago. Besides, according to our imperfect information, it appears that at the beginning of winter he had an attack of pleurisy on the left side. In evidence of this we find the scars that were made by the blisters that had been applied.

Of late this little fellow has become very much emaciated. Some days ago he had several attacks of hemoptysis.

We find, on examination of the chest, that percussion gives a slight dullness behind and at the apex of each lung.

Auscultation by the naked ear discloses a hard respiration; the expiration is prolonged and even a little blowing in character. In front and at the left we recognize, in the sub-clavicular region, all the signs of a small pulmonary cavity. We can hear, but not easily, some crackling in front and at the right.

The patient was put upon the vegetable diet, and was ordered to take of *drosera*, 3d dil., three drops during the day.

February 3. The fits of coughing are less frequent. Every evening he is seized with fever; the temperature is 101.4°; the pulse, 104. There is also a serious diarrhœa, which is quite frequent. *Veratrum alb.*, 3d dil., three drops during the day.

February 5. The diarrhœa continues, but the appetite, which was lost at the beginning, has returned. Fever in the evening; temperature, 101.2°; pulse, 108. *Ipecac.*, 1st decimal trit., twenty centigrammes during the day.

February 8. The cough has very much diminished; the expectoration has almost ceased, and the fever and the diarrhœa have stopped altogether. The same treatment.

February 11. He gains strength, and the cough is becoming less and less frequent. The same remedy.

February 17. Continued improvement. By auscultation we cannot hear the râles, but the cavernous signs persist. He took *ipecac.*, 1st decimal trit., until he was dismissed.

In this case, on account of the diarrhœa, the vegetable diet was not literally adhered to, but a little meat was allowed.

LECTURE XX.

SUMMARY.— Pelvi-peritonitis and peri-uterine hematocele. *Case* of suppurating pelvi-peritonitis. Description of pelvi-peritonitis. Differential diagnosis from inflammation of the broad ligament and in the iliac fossa. Treatment: *Aconite*.

Pelvi-Peritonitis.

GENTLEMEN: Here is a patient who has been seized with a very serious but common affection, and one that is still but imperfectly understood by most practitioners. It is a case of pelvi-peritonitis, with adhesions, which has ended with suppuration. You will permit me to dwell at some length upon its clinical history, the practical value of which is evident. And first, we will have the notes of the case:

CASE LVI.— Mrs. N ——, aged thirty-one years, of a delicate constitution, is feeble and decidedly emaciated. She was delivered, twelve years ago, for the first time, and was treated for eighteen months afterward for ulceration of the cervix uteri.

Her health has never been completely restored, for she suffers continually with pressing and lancinating pains in the lower abdomen. These pains are much more severe at the monthly period, and the flow is always very abundant and long-continued.

Eighteen months ago she observed that her abdomen began to bloat considerably. Six months later she had a sudden and copious flow, which did not diminish the size of the abdomen in the least. Following this metrorrhagia she had chills every day. Applications of the tincture of iodine, sitz baths and injections were resorted to, but they brought no improvement in her condition. She remained in a state which is characterized by an irregular febrile movement, with pains in the hypogastrium and in the left iliac region, these pains being increased by fatigue and by the return of the menses. There was emacia-

tion and loss of strength, with increased difficulty in walking. Occasionally she suffered so much that she was obliged to take to her bed. Finally, in September, 1874, a large quantity of pus was discharged by the rectum. This discharge still recurs, but the pains are not so severe as they were before.

We can easily recognize a tumor in the hypogastrium, which extends low down upon the left side, and which is also recognized by the vaginal touch. It occupies the left lateral cul-de-sac, and also the posterior cul-de-sac.

This woman has experienced great relief from homœopathic treatment, which has been prescribed for her by my friend and predecessor, Dr. Gonnard. The principal remedy given was *silicea*. Under its influence the discharge has greatly diminished, and the patient is gaining strength and flesh. Some months later, and after excessive labor and exposure on her part, the discharge by the rectum returned, and the frequent attacks of pain and of fever also.

Here, then, is a case of adhesive pelvi-peritonitis following an ulceration of the neck of the womb, and probably a coincident metritis. This disease, which has been aggravated by labor and by venereal excesses, and perhaps also by ill-timed cauterization, finally, after about eighteen months, terminated in suppuration.

The suppuration, characterized at the beginning by an irregular febrile movement, with constant pains, and especially by the marked development of the tumor, finally ended, after a year's duration, by the opening and discharge of the abscess into the rectum. From that time the rectal fistula has persisted, and the patient, after having obtained considerable relief, experienced a return of the suffering when she resumed her old habits. It is extremely probable that the suppuration will continue, that she will fall into the cachexia of chronic suppuration, and that she will finally die of it.

I believe it useful at this time to speak to you of pelvi-peritonitis, because it enters into the *rôle* of the clinic to give

the history of diseases which are but imperfectly known, whenever such cases fall under our observation.

Without desiring to spend much time with the bibliography of this affection, I will say that Lisfranc was the first to describe it under the name of *Engorgement of the Uterus;* and it was a credit to him to indicate a nosological group that is characterized by pelvic pains, and by the existence of a tumefaction, which concerns very intimately a particular portion of the uterus. The name of *peri-uterine inflammation*, which was suggested by M. Nonat, was unfortunate, because it confounded uterine engorgement with inflammation seated in the iliac fossa, these two sets of affections being in reality quite distinct. It did, however, signify that the inflammation and tumefaction were not confined to the womb, as it was thought to be prior to the researches of Récamier. The credit of recognizing and of describing the pathological unity of this affection is really due to Bernutz and Goupil.

It is generally known among gynecologists that the controversy between Drs. Bernutz, Nonat, and others, regarding the comparative frequency of perimetritis (*phlegmon péri-uterin*) and pelvi-peritonitis, has been very prolonged, and has given rise to a deal of partisanship among physicians not only in France but also in this country.

In this connection we cannot refrain from translating and copying the following case from *Guérin's Leçons cliniques sur les maladies des organes génitaux internes de la femme*, Paris, 1878, page 358:

"I formerly had, as an interne, M. Obedenare, who was a very zealous pupil, and who left me to enter the service of M. Nonat, in the Hôpital de la Charité. When he came to bid me adieu, I expressed a wish to be present at the autopsy of such women as might die of peri-uterine affections under his eye, in his new position, and urged him to notify me when such an occasion offered.

"One day I received a letter inviting me to come the next morning to the amphitheatre of la Charité, and you may be sure that I went there. Just as they were about to begin the post-mortem, I inquired of M. Nonat of what disease the woman whom we were about to examine had died? He told me, without hesitation, that she had had a peri-uterine phlegmon. I then asked permission to apply the "touch" to this subject. I found a hard tumor surrounding the uterine cervix, which was evident to the touch in front, behind, and at the sides of the os-uteri; and I said that, until that moment, I had always told my pupils that such a lesion as this belonged to pelvi-peritonitis. I

also said that this case would decide the question, for, if this is a uterine phlegmon, I shall no longer have a sign by which to recognize a case of pelvi-peritonitis.

"They proceeded with the autopsy, and it was proved, in the most conclusive manner, that the intestinal folds were so joined with the posterior wall of the uterus as to form a peritoneal pocket on all sides, which was filled with pus."—L.

The most frequent causes of pelvi-peritonitis are: first, the puerperal state (seventy-five per cent arising from this cause); the catamenial period, and blennorrhagia; and, finally, the traumatic causes, among which we must not forget excessive coitus, the employment of the uterine sound, and of cauterization by the hot iron.

The cause of the meteorism, the colicky pains, and of the disposition to vomit also, in this disease, is the adhesion of folds of the intestine to parts that are naturally free from such an attachment. Half the women who have tympanitis, menstrual colic, and vomiting at the "month," are really ill with pelvi-peritonitis, although perhaps in so mild a form that it has not been recognized.

When these adhesions are roughly broken up, whether by the introduction of the sound, the use of the speculum, or of the sponge-tent, by dilators, or the vaginal or the rectal touch, or by forcible or too frequent coitus, there is a renewal and extension of the inflammation. And the symptoms induced show, to our mind at least, that Nonat and Emmet are wrong in locating this inflammation in the peri-uterine cellular tissue exclusively.—L.

M. Bernutz still teaches that pelvi-peritonitis is always an affection which is symptomatic of disease in the uterus, the Fallopian tubes, or of the ovaries. It seems to me, however, that if we recall the causes of pelvi-peritonitis which we have already given, and that are enumerated in M. Bernutz' work, we shall be convinced that this inflammation may occur independently ot any definite disease, or, at least, of what is called a disease, viz: labor, abortion, menstruation, coitus, the use of the sound or of the hot iron. We must conclude that the eminent pathologist from whom we quote, and who has studied this subject so thoroughly, has reached a merely intellectual conclusion when he insists that pelvi-peritonitis is always a symptomatic disorder. We believe that an *ensemble* so complete, so characteristic of symptoms and of lesions, which has

undergone so regular a development, and occurred so often in the absence of any other disease, constitutes a veritable morbid species, at least where it cannot be associated with any evident disease of the womb.

Pelvi-peritonitis consists essentially in an inflammation of the serous membrane within the pelvic basin. In women this inflammation corresponds with inflammation of the tunica vaginalis in men, and blennorrhagic pelvi-peritonitis is only the epididymitis of women.

This disease presents itself in various forms, the principal of which are the *common*, or the *sero-adhesive* form, the *benign* form, the *purulent* form, and the *chronic* form. There is also a *tuberculous* and a *cancerous* form. We think that the *hemorrhagic* form, once admitted by Bernutz, should be classed as a variety of hematocele.

The *common form* is characterized by an inflammation of the peritoneum, with the formation of false membranes, and with serous effusion. It is the sero-adhesive variety. Its advent is sometimes sudden; sometimes it is preceded, for a greater or less length of time, by pains in the lower pelvis,—pains which are connected with some previous uterine disease.

At first it resembles a mild peritonitis, with the initial chill, repeated vomiting, pinched features, a small, hard and frequent pulse; diarrhœa or constipation, and pain in one of the iliac fossæ. In some cases the vomiting has been so violent that one might mistake it for an attack of cholera.

The pain is acute; it is increased by motion, by pressure and by respiration; it causes the patient to bend herself double, and urination and defecation are very painful. Bernutz compares it to the pleuritic stitch. This pain is usually seated in one of the iliac fossæ, but sometimes it is located in the hypogastrium. If, on practicing the "touch," we do not

find a tumor, nor a uterine displacement, there will be a great increase in the intra-pelvic pain on account of the manipulation.

For the first few days the pain and the febrile action continue; the pulse is small and hard, with the same heat of the skin as in pleurisy. Afterward, the general symptoms subside, the pain diminishes, and we begin to recognize in one of the culs-de-sac of the vagina a sort of puffiness, which is the physical sign of a sero-fibrinous collection, and which constitutes the local lesion of pelvi-peritonitis.

The changes which this tumor undergoes, the deviations of the uterus which it causes, and the dull pain also, are the symptoms proper to this stage of the disease.

In pelvi-peritonitis, unless it be in the puerperal form, the temperature is not usually very high, for it ranges at from 101° to 103°, rarely reaching 104°.

The pulse in this disease is frequent (as it always is in peritonitis), but it is not so *small* as it is in the diffuse form of peritoneal inflammation.—L.

The signs furnished by the "touch" and by palpation.—At the end of a few days we perceive a decided swelling in one of the vaginal culs-de-sac. This deposit is succeeded by an obscure sense of fluctuation. To this succeeds the possibility of determining the outline of the tumor, which is joined to the uterus, and from which it is separated by a furrow upon one of its sides. This tumor makes its appearance most frequently in the left latero-posterior cul-de-sac, but it may be seated in any other part of this region. By the "touch" we recognize at the same time a deviation of the uterus, which corresponds to the seat of the tumor, and which is changed or modified in proportion to the increasing or the diminishing of the size of the tumor.

A little later, when the disease has progressed, we can determine the existence of the tumor by palpation of the hypogastrium. This tumor presents the same peculiarities as

are disclosed by the "touch;" it occupies one side of the uterus, is almost always within the pelvic basin, and rarely extends beyond the horizontal ramus of the pubis—a sign which serves to distinguish pelvi-peritonitis from abscess of the broad ligament.

In exceptional cases the whole of the tumor in pelvi-peritonitis is retro-uterine, and being limited in front by the broad ligament, may be mistaken for an abscess of that ligament.—L.

This form of peritonitis runs a chronic course with exacerbations, which exacerbations are induced by the monthly periods, by fatigue and by venereal excess. The first or original symptoms reappear with these relapses, but they are less severe, and the tumor grows again. Metrorrhagia, or more frequently menorrhagia, leucorrhœa, and ulceration of the cervix uteri, accompany the pelvi-peritonitis; but the metrorrhagia depends directly upon this inflammation, and is really one of its characteristic features.

After a prolonged duration, pelvi-peritonitis passes into the cachectic stage. Anæmia, nervousness and a very painful hysteralgia belong to this period. From this time forward the hemorrhages are still more abundant, and are also very painful. The tumor becomes hard, irregular and bossolated, and the uterine deviations are very pronounced.

When the prognosis is favorable, the relapses and the menorrhagia cease; the effused fluid is absorbed; the tumor diminishes; and very soon there only remain some bands of connective tissue which anchor the uterus in its unnatural position, and which, like the false membranes in pleurisy, are often the seat of persistent pains.

When the cachectic state has set in, these patients are very apt to become tuberculous. Under these circumstances there is a particular symptom which gives rise to an appearance that

is quite peculiar. Just in proportion as the phthisis is developed the symptoms of pelvi-peritonitis improve; the pains diminish and the monthly flow is less copious; but if, on the contrary, the thoracic trouble is better, the pelvi-peritonitis resumes its intensity, the pains and the hemorrhage return as they were before the phthisis had set in, and during the future life of these patients there will be a sort of balancing or alternation between these two affections.

But as in pleurisy with the effusion of serum, the sero-adhesive form of pelvi-peritonitis may terminate in *suppuration.* With a violent febrile action the patient has excessive pains, whilst the tumor is considerably increased in size. The disease then progresses as we shall see in considering the purulent variety, for the case upon which this lecture is founded is an example of the purulent transformation of the effused fluid in pelvi-peritonitis.

The Mild Form.—This often begins its course with very acute symptoms resembling those of ordinary peritonitis. These symptoms subside, and we recognize the intra-pelvic tumor and the signs already given as proper to the preceding variety; but at the end of two, three or four weeks there is a very abundant menstruation, which relieves all the symptoms and terminates the disease.

The Chronic Form.—This form makes its onset obscurely, and exists for some time without attracting attention, and never presents that array of symptoms which would cause one to think of peritonitis. Once having developed itself, it very much resembles the common form of the disease, having the same aggravations, and the same course and termination.

The Purulent Form.—Bernutz calls this the regular pelvi-peritonitis. This form usually, but not always, follows labor

or abortion. Quite recently we have had a case which came spontaneously during menstruation.

The *début* of this form is violent; there is a severe chill followed by an increase of temperature which often exceeds 104°, with a pulse that is hard and frequent, shrunken features, a violent pain in the affected part, and nausea and vomiting.

In two cases which I have seen, and that were disconnected from the puerperal state, the pain was so intense that it was absolutely necessary to relieve it by hypodermic injections of morphine. These pains came in paroxysms, which caused the patient to cry aloud, and which resembled those of labor. They were accompanied by rectal and vesical tenesmus, and were very much aggravated by the desire to urinate and to go to stool.

In the first days of this disease, the peritonitis is very likely to become general, and this really constitutes one of its greatest dangers.

The expression continues to be bad; there are irregular chills and sweats; then the tumor shows itself; it grows much more rapidly and becomes much larger than in the other forms of this disease.

The abscess imparts to the "touch" and to palpation the signs that we have already described, and which vary with its location, but which usually present the evidences of decided fluctuation.

Like all other internal abscesses, this suppuration is accompanied by a peculiar febrile movement, and becomes the sea of an eliminating process. This process may go too far, and give rise to a diffuse peritonitis, or to a very great increase in the size of the tumor. But usually, after great suffering and an aggravation of all the symptoms, the abscess opens itself into one of the neighboring cavities,— the peritoneum, the

bladder, the vagina, the intestine, or, perhaps, either simultaneously or successively, into several of these cavities. During the subacute period of these abscesses we have sometimes observed the occurrence of malignant erysipelas, and of pernicious paroxysms which resemble those of the purulent diathesis in puerperal women.

Death often occurs in this acute stage, either from the violence of the fever, or from a complication of the peritonitis. If the abscess opens freely into the vagina or the rectum, the case generally terminates in a cure. This cure is sometimes rapid; but more frequently it occurs only after the purulent discharge has continued for some months, and when the general health is quite reëstablished. For the reason that the outlet for the pus is not free, the opening into the bladder is less favorable. Possibly it may give rise to the infiltration of the abscess with urine, but I have not observed it. If the opening into the intestine consists in a perforation which is too small, or too high in the bowel, as, for example, in the cæcum, the pus escapes with difficulty. In such a case the disease is interminable, and the women fall into a cachectic and a hectic condition, as in the case which I have shown you in my clinic. In passing into the intestine, the discharge often provokes a colliquative diarrhœa, which weakens the patient very decidedly, and contributes very much to bring about a fatal termination. In certain very bad cases, the intra-peritoneal abscess opens and closes alternately, at intervals varying from a week to several months, and, beset by a thousand dangers, the disease is prolonged for some years.

The Tuberculous Form.—Like the tuberculous pleurisy, this is distinguished from the chronic form, complicated with phthisis, by a single sign, which is, that the menorrhagia persists until it ends in tuberculous pelvi-peritonitis, whilst it ceases in pelvi-peritonitis complicated with phthisis.

Diagnosis.—Pelvi-peritonitis is sometimes confounded with abscess of the iliac fossæ, with abscess of the broad ligament, and with peri-uterine hematocele.

As there is in our ward a very good example of hematocele, I intend to give you its pathological history; and we will therefore reserve, for the present, the study of the differential diagnosis between it and pelvi-peritonitis.

Concerning inflammation in the iliac fossæ and abscess of the broad ligament, they are easily distinguished at first, because, when uncomplicated, they show no signs of peritonitis; because, in inflammation of the broad ligament, the tumor, which is recognized by the "touch," instead of occupying the culs-de-sac of the vagina, is located in the wall of that canal, where it is perceptible; because immediately under the anterior abdominal wall that tumor forms a kind of cake, which is not very thick, the limits of which are marked by palpation, and which Bernutz calls the abdominal breast-plate [*plastron*].

In abscesses in the iliac fossæ, if they are superficial, the tumor is not perceptible by the vagina, but extends directly toward the horizontal ramus of the pubis. When they are deep-seated and profound, there is retraction of the thigh upon the pelvis, through irritation of the psoas muscle; very often œdema of the labia majora, and a deep-seated swelling in the external portion of the iliac fossa, which afterward is felt in the lateral walls of the vagina, and toward the horizontal ramus of the os-pubis.

The differential diagnosis between pelvi-peritonitis and pelvic cellulitis is quite as important, but quite as difficult, in many cases, as it is to separate some cases of pneumonia from pleurisy. Indeed, there can be no doubt that they often coëxist.

In general, however, this, like other forms of serous inflammation, begins with an initiatory chill, which is almost always so violent in degree as to be accompanied by a chattering of the teeth. This symptom is lacking in uncomplicated pelvic cellulitis until about the time that pus has formed.

Pelvi-peritonitis is very apt to be accompanied by vomiting and by tympanitis, which, no matter how limited the lesion itself, soon spreads over the

whole abdomen. These symptoms are seldom found in idiopathic cellular inflammation about the womb and within the pelvis.

In the former, the increase of heat in the roof of the vagina is a less important symptom than the swelling. The neck of the womb is surrounded by a hard mass which, as a rule, is more prominent in the posterior cul-de-sac than it is laterally. By conjoined manipulation, this tumor, which is due to the effused serum within the peritoneum at its lowest portion in front, is readily felt behind the symphisis pubis. In pelvic cellulitis, however, the tumor is most often largest laterally, at the site of the broad ligament, whence it may extend along the sides of the vagina far down toward the vulvar outlet. The latter symptom is impossible in uncomplicated pelvi-peritonitis.

In our work on the *Diseases of Women*, 4th edition, 1879, at page 448, we have said: "It must be acknowledged, however, that the lines which separate these two disorders are not always distinct. For, whether it be due to the fact that the textures are contiguous, and that these lesions frequently coëxist, or that our present means of differentiation are imperfect, it remains that they may be combined without our knowing it, and that we are liable occasionally to mistake one for the other."—L.

Treatment.— Pelvi-peritonitis is a disease the special pathology of which is so recently known that we have no clinical and classical treatment for it. We therefore submit the following indications to our professional brethren with the promise and hope of aiding in the completion of this important work in therapeutics.

In the acute stage, the indications for treatment are drawn from the violence of the fever and the intensity of the inflammation of the pelvic peritoneum. *Aconitum*, *colocynth* and *cantharis* are the three remedies that are most appropriate at this period of the disease.

Aconite is the principal remedy. The old-school physicians prescribe it in this disease in the dose of one to two grammes of the tincture in twenty-four hours; and we must say very decidedly that, in this case, these strong doses do no harm, and that many of our school employ them in the same manner, and with the best results. In very acute and severe cases we do not hesitate to prescribe twenty to thirty drops of the mother tincture, to be taken within twenty-four hours; but

where the attack is milder and not so threatening, the lower dilutions (the first, second and third) have always been sufficient. Whatever the dose or the dilution, the aconite should be continued whilst the fever continues to be violent.

We have already said that the symptoms which indicate this remedy are derived more especially from the character of the fever, and from the serous inflammation. To specify the febrile characteristics which indicate aconite: there is, at the beginning, chill with palor, followed by violent heat with redness of the face, a full and frequent pulse, and excessive thirst. But the most important symptom, because it is especially characteristic of aconite, is anguish with unrest, a sense of impending death, and a fainting condition. These latter symptoms occur during the cold as well as during the hot stage.

All of these symptoms are shown in the physiological effects of aconite.

When this medicine is given in poisonous doses, the following symptoms, according to Dr. Richard Hughes, will be observed:* "In acute poisoning, the dilated pupils, the pale face, the quick and contracted pulse and the general coldness within and without, bespeak an excitation of the vasomotor nerves throughout the body, analogous to that which results in tetanus. In other words, we have a condition answering to the chill of fever, to the cold stage of ague, the collapse of cholera. When the reaction takes place, the condition of febrile heat succeeds that of chill; as Dr. Wood states, 'the circulation, respiration and general temperature are sometimes increased.' This is seen in such a case of poisoning as No. 10, of Dr. Hempel's series, but its power to induce fever is still more marked in the Austrian Provings."

* *A Manual of Pharmacodynamics*, translated into French by Dr. Guérin-Méneville, page 39. Paris, 1875.

In my experiments upon man and upon rabbits, made in conjunction with Dr. Jablonski, and published in *L'Art Médical*, 1871, aconite was given in doses of from ten to sixty drops, and we observed, as the first effect, an increase of the temperature and an acceleration of the pulse.

Aconite affords, therefore, in its physiological action, a picture of a paroxysm of fever from the chill to the heat, and its favorable effect is a still further confirmation of the truth of the law of similars.

But there are those who will not examine for themselves opinions that have already been pronounced, and who do not confess to being in the wrong when they condemn a doctrine without having examined it. M. Gubler is of that class, and his *Codex* seems to have been undertaken with no other object than to demonstrate the fallâcy of the law of similars. His pupil, M. Franceschini, has just published, under the inspiration of his master, a thesis upon *aconitine*, in which he pretends to show, experimentally, that this substance abolishes the sensibility, diminishes the temperature of the body, and slackens the pulse; whence he concludes that aconitine cures neuralgias, inflammations and fevers by its contrary effects.

In the face of these opposite and contradictory results, derived from the experiments of M. Franceschini and those of numerous *savants* who had already given the history of aconite, shall we clothe ourselves with skepticism when we repeat the axiom, *experimentia fallax?* No; but let us say decidedly, with Claude Bernard, that one experiment well made can never be annihilated by another experiment that is well made; and following this precept, upon which all the sciences of observation are founded, let us search in the experiments of M. Franceschini for the error of which this apparent contradiction is the fruit.

The experiments by which M. Franceschini believes it possible to demonstrate that, far from causing the well-known pains, the aconitine produces anæsthesia, prove absolutely nothing, because they are so harsh that in a few minutes the animal is put in a state of asphyxia; and everybody knows that asphyxia, whatever its cause, abolishes all sensibility.

In experiment No. 1, made upon a guinea-pig, the injection was given at three o'clock and fifty minutes. Six minutes after the animal is still extremely sensitive to painful impressions, but at four o'clock, *id est*, ten minutes after the experiment, "the symptoms of asphyxia declared themselves" (p. 14).

In the second experiment "death by asphyxia occurred in about six minutes" (p. 15).

Candidly, what conclusion can be reached in the study of sensibility from experiments that are conducted in this manner? And how can these experiments weaken those which have been carefully made, and which have demonstrated that aconite causes pain, especially a neuralgia of the fifth pair?

Our young author is not more happy in showing that aconitine does not cause an elevation of the temperature and of the pulse.

In the experiment No. 5 (page 34), the rabbit, under the influence of a poisonous dose, showed very plainly all the symptoms of febrile chilliness and of cold, noted by Dr. Richard Hughes. But when the rabbit has resisted the poison, and experienced a reaction, why should we leave him there, and not concern ourselves any further, either with his temperature or his pulse?

Finally, M. Franceschini is careful to demonstrate for himself the falsity of his own theory; for the truth is so powerful that when one acts in good faith he can do nothing against it.

In the clinical part of his essay we find the confirmation of the property which aconite certainly possesses, to elevate the pulse and the temperature also.

At page 24 is the unfortunate history of a patient poisoned by aconitine, and who, after a great many mishaps, finally began to react. Now, in this case the observer noted a slight increase of heat. But what caused this increase of heat, and what had become of the thermometers of the hospital Beaujon?

The cases given at pages 57 and 58 are more explicit, because the temperature was taken by the thermometer.

At page 53 the pulse alone was recorded, but the description leaves nothing to be desired; it was a case of rheumatism without fever. An injection of aconitine was given at 10.30, the pulse being 76. Half an hour later the pulse was 86. "The pulse-beat is increased; the respiration is accelerated, and the whole skin is more or less heated." It seems as if we had read again the passage which we have already quoted from Dr. Hughes.

At page 57 there is another case of acute articular rheumatism. The temperature was 99.6°, the pulse 103, when an injection of aconitine was given at 10.30. At 11 o'clock the temperature was 99.8°, the pulse 108; and at 11.20 (in less than an hour) the temperature was 100.5°!

Two days later, the temperature being at 99.5°, and the pulse 90, the injections of aconitine were repeated, and in forty minutes the temperature was 99.6°.

Is it not clear enough, and are we not justified in saying that an experiment which is well made is never deceptive? It is not the experience which deceives one, but it is the experimenter who may be deceived.

LECTURE XXI.

SUMMARY.—The treatment of pelvi-peritonitis, continued. Indications for *colocynth; case.* Indications for *cantharis, conium mac.;* pelvi-peritonitis and rheumatism, remedies for; the suppurative stage of; *aconite, china, arsenicum* and the *chin. sulph.* in; *hamamelis, thlaspi* and *sabina*, opiates, hot-water irrigation, hygienic care, and a good diet. Puerperal pelvi-peritonitis.

The Treatment of Pelvi-peritonitis—(Continued).

GENTLEMEN: *Colocynth* is a remedy which belongs exclusively to homœopathy in the treatment of pelvi-peritonitis. Dr. Ludlam* recommends this remedy, especially in inflammation of that portion of the peritoneum which covers the ovaries, *id est*, in pelvi-peritonitis. This indication is drawn directly from the localized action of colocynth upon the ovaries and upon the epididymis in physiological experiments. Dr. Richard Hughes relates that, in a case of poisoning by colocynth, autopsy has shown that *the intestines were glued together by a fresh formation of lymph.* In this manner the lesions as well as the symptoms show the appropriateness of colocynth in acute pelvi-peritonitis.

The special symptoms which should guide the physician and fix his choice upon colocynth, are: excessive pains in the abdomen, especially when this pain causes the patients to bend themselves forward; diarrhœa, rectal and vesical tenesmus and cramps in the legs.

Here is a case in which colocynth has been very efficacious:

CASE LVII.—Mrs. N——, aged thirty-eight, was admitted on the 20th of December into ward 2, No. 2.

*Vide *Clinical and Didactic Lectures on the Diseases of Women*, by R. Ludlam, M.D., etc., 4th edition, p. 137.

Of good general health habitually, she has been subject, since her youth, to very copious menstruation. In consequence of a fall upon the buttock when she was nineteen years old, she has had an habitual pain in the hypogastrium. She has never had a child, but about eight years ago she had an abortion at the fourth month.

On the 15th of last November she had just finished the monthly flow, which was as abundant as usual, when, without having acted imprudently, she was seized with violent pains in the abdomen, with chilliness, but no vomiting. At the same time a metrorrhagia set in and continued for one day. Then she had fever for five or six days, with constant pains in the hypogastrium. These pains were deep-seated and bruised and tearing in character.

She remained in bed until the 4th of December, when she was obliged to go and take care of a sick relative. She had no more fever from that time, but the pains which she had experienced from the first continued with the same intensity.

December 8. The menses returned as usual, eight days in advance. They continued until the 12th of the month, but her condition was not in the least improved.

December 17. The abdominal suffering has increased in violence. She has had such severe pains that she was obliged, on several occasions, to take hypodermic injections of morphine. At the same time she had chills, violent fever, vomiting and obstinate constipation, and was so ill that we feared a fatal result. We were sent for to visit her on the 20th, and found her with the following symptoms:

She complains of nausea and of suffering in the abdomen, which is distended, tympanitic, and so sensitive that a slight touch provokes the pain. The pulse is 96, and the temp. 101.2°. The expression is bad, and from time to time there are slight chills. *Colocynth*, 3d dil., six drops in twelve spoonfuls of water, one spoonful every hour, with a moderate diet.

December 21. The patient had some vomiting yesterday. The pains and the fever persist, and there is constipation. The same treatment.

December 23. The fever is entirely broken, but the pains in the abdomen are quite as severe, and during the night they

are even worse than during the day. She compares them to a gnawing of the tissues, and they force her to cry like one who is having labor pains. The urination is not painful, but the constipation is obstinate. *Colocynth*, 2d dil., in the same manner.

December 24. The pains return only at night, but they were so intense that the hospital assistant was called, and he gave her a hypodermic injection of morphine. The general condition is a little better than for some days. She says that there is a reddish-white discharge from the genitals. There is no more nausea, and the appetite has returned. *Arsenicum*, 6th dil. I forbade the use of the morphine.

December 27. The abdomen is a little less swollen and a little less sensitive; but the patient has had, during the night, some pains in the belly, which were more violent than ever before. *Colocynth*, 1st dil. An enema had no effect upon the constipation.

December 28. During yesterday she was very calm, but in the evening the pains returned. Moreover, she was obliged to urinate often, and with pain. *Arsenicum*, 6th dil., two drops in twelve teaspoonfuls of water, a teaspoonful every two hours.

December 29. She is better. Continue the *arsenicum*, 6th dil., ten drops.

December 31. After taking an injection she had a stool, then violent diarrhœa, with colic. *Arsenicum*, 6th dil.

January 3. The pain has localized itself on the right side, where we find a swelling which is very sensitive to pressure. The menses have appeared to-day. The diarrhœa is less. *Chamomilla*, 3d dil.

January 5. The menses stopped last evening. The diarrhœa is a little better. The vaginal touch discloses a tumor seated in the right lateral cul-de-sac, and which projects into the vagina. *Colocynth*, 3d dil., and she was permitted to eat a cutlet.

January 8. For some days the patient has had a return of the sanguineous discharge from the vagina. She has no more chills nor fever. The pains continue, but are less severe; the abdomen is tympanitic again, but the diarrhœa has ceased. *Cantharis*, 3d dil.

The pains diminished daily; at the same time the appetite, the sleep and the strength returned. Although the pains had almost entirely disappeared, yet I did not permit her to make her bed until the 19th of January.

In the early part of February the menses returned. They were very free, with clots, and were accompanied by colic. They continued for six days. The patient was examined carefully after the cessation of the flow, but, although the cervix was inclined to the right, there were no traces of the tumor.

The good effects of *colocynth* in this case appear to us to be incontestible. Here is a woman who, suffering habitually with the womb, was seized with the first onset of pelvi-peritonitis in the month of November; she recovered imperfectly, wearied herself with the care of the sick, and soon became more seriously ill, after the monthly epoch of December. This is the common history of women attacked with pelvi-peritonitis. The violence of the fever, the vomiting, and the intensity of the pain, comprised a list of formidable symptoms, which seemed to necessitate, while she was at home, the frequent use of morphine. When she came under our care we prescribed colocynth, and, under the influence of this remedy, the fever left after three days of treatment; then the pains subsided considerably during the day, but returned at night with such an intensity that our assistant thought himself obliged to resort to the hypodermic use of morphine.

In this case I stopped the palliative treatment, because *arsenicum* appeared to me to be indicated, as well for the violence of the abdominal pains as for their nightly aggravation. Under the influence of *arsenicum*, 6th dil., the pains were mitigated and soon disappeared.

I should remark that I have kept this patient in bed for about a month. It is very important in case of women attacked with pelvi-peritonitis to keep them as quiet as possible.

This patient came very near having a relapse, on account of being obliged to get up quickly while she had the diarrhœa. I was also very careful in making a direct examination, knowing that the touch is very painful to these patients, and that it may sometimes increase the inflammation of the peritoneum.

Cantharis seems to us to be especially indicated in this disease by the *usus in morbis*. The good effects obtained from blisters, and the heroic action of cantharides, homœopathically given in the treatment of pleurisy, suggest its use in the treatment of pelvi-peritonitis. Some physicians of our school have also advised cantharis in inflammation of the ovaries; but the Materia Medica does not give us the proper guidance for the use of this remedy in pelvi-peritonitis. Consequently we are reduced to the expedient of depending upon imperfect data, which cannot now be supplemented by positive details from the Materia Medica. What is the difficulty in finding the indications for cantharis? Is it because this remedy, in spite of all analogies, does not really correspond to the disease? Is it because of this that I have not obtained from cantharis, in the treatment of pelvi-peritonitis, what I have obtained from it in the treatment of pleurisy? In this last disease, the cantharis is a remedy which is almost always sufficient for the cure of the effusion; while in inflammation of the pelvic peritoneum, it has had almost no effect. I am accustomed to prescribe colocynth and cantharis in the third dilution, three drops in six ounces of water, one teaspoonful every two hours.

Some years ago we found the following paragraph in the *Clinical Memoirs upon the Diseases of Women*, by BERNUTZ & GOUPIL (New Sydenham Society's Edition, Vol. II, page 165):

"I ought to add that I have found *conium* a most valuable special narcotic to the genital organs. I give it so as just to produce slight derangement of vision, and a kind of hallucination. I have, however, seen many cases get quite well without there having been any apparent effect from the administration of the drug; so that I cannot feel certain that the beneficial results which seemed to follow its employment were really due to that."

Acting upon this hint, a careful study of the pathogenesy of conium in its relation to the parts involved in pelvi-peritonitis, and to the implication of the sexual and the menstrual functions in the same disease, revealed the fact that Bernutz had probably cured his cases with it. Experience has now taught us to rely upon it in these cases, especially when they are accompanied by a uterine colic that is directly connected with the escape of a leucorrhœal flow, or by a menstrual tympanitis resembling that of ordinary peritonitis; by aching pains in the hypogastrium, and forcing-down feelings like those of menstrual colic; pains like after-pains in the lower abdomen, or by pressing upon the uterus and cutting during micturition. It seems to be equally useful in the chronic and in the puerperal forms of the disease. Our preference is for the second decimal dilution.—L.

We have seen that in the course of pelvi-peritonitis the febrile action, after having yielded more or less completely, was very apt to return under the influence of the development of the disease, or from some external exciting cause. Whenever, in the course of pelvi-peritonitis, the fever recurs, it will be necessary to return to the treatment proper to the acute stage, and principally to the use of aconite.

We have long since been satisfied that a considerable share of the cases of pelvi-peritonitis are complicated with rheumatism. Not unfrequently the attack comes from a translation of rheumatism directly to the peritoneum. Sometimes an idiopathic attack is attributable to exposure to cold and wet, in which case, if there is a coincident arrest of the menses, the whole mischief is very apt to be referred to the stoppage of the flow, and not to the peritoneal lesion. It is very common to mistake the effect for the cause, and many of these cases have been unwittingly cured by *bryonia*, *belladonna*, *rhus tox.*, *colocynth* and *macrotin*.

Of late I have given the first decimal trituration of the *salicylate of soda* in some of these cases, with very decided benefit. It seems to be especially useful where there has been a metastasis of the rheumatic inflammation from the synovial, or from the other serous membranes, to the peritoneum. I have sometimes given it, also, in the second decimal trituration with excellent effect.

For the relief of the intra-pelvic pain and distress, especially when it is of a neuralgic or rheumatic character, this salt of soda is one of our best remedies; but the more acute the case, and the more decided the diminution in the quantity of the urine secreted, and the absolute increase in the proportion of uric acid contained in the urine, the better the indication.—L.

During the suppurative period, whether this fever is a symptom of idiopathic or of adhesive pelvi-peritonitis, tending to suppuration, *aconite*, *china* and *arsenicum* are the prin-

cipal remedies: *aconite* corresponds to the continuous fever, and *china* to its intermittent or remittent type. In these cases I have sometimes observed the occurrence of true pernicious paroxysms, and I have not hesitated to prescribe the sulphate of quinia in strong doses.

Certain physicians attribute to the sulphate of quinia an action which is specific against the purulent diathesis. Dr. Richard Hughes says, literally, that this remedy has the power to prevent the formation of pus. My own experience does not permit me to adopt this view, for I have too often seen the sulphate of quinia, given in a strong dose, fail in the treatment of this diathesis to accord to it the least anti-purulent virtue. Besides, these specific or quasi-specific properties which are attributed to remedies are almost always illusory. Remedies do not respond to a certain morbid species, but to indications which are drawn from the totality of the symptoms and lesions, and from the course of these morbid phenomena. The sulphate of quinia is not even a specific for intermittent fever, for it is not rare to encounter cases of this fever that are more or less rebellious to this remedy.

But if the sulphate of quinia is not specific, it is very often indicated by the intermittent type of the symptoms. Now, in a great number of cases of the purulent diathesis, and of diseases ending in suppuration, the fever assumes, in a more or less perfect manner, the intermittent type. In these decided cases, the methodical use of the sulphate of quinine causes a marked improvement, and often a cure. It is this peculiar and precious effect of quinine which has caused the illusion that we combat, and which has induced others to attribute to this remedy an anti-purulent property. In order to obtain the effects which it will produce, we must find its proper indications, and remember that the more decidedly the symptoms are intermittent, the more certain the action of this remedy.

In pelvi-peritonitis, when the fever which accompanies the suppuration is continuous, or nearly so, and when the difference between the morning and the evening temperature does not exceed 1.8° F., the aconite continues to be the principal remedy. But when the case is dangerous, you need not fear to give it in strong doses.

I remember a desperate case in which aconite was given in the dose of five drops of the mother tincture every hour for six hours, and in which all the dangerous symptoms were arrested promptly. There had been a relapse of purulent pelvi-peritonitis, with the escape of pus by the rectum and by the bladder. The fever, which had a remittent type during the first few days, had resisted the sulphate of quinia (which was badly borne and brought on vomiting); and this fever, without having a well-marked type, had several daily paroxysms, the chill and the heat alternating irregularly. At the moment of a chill I found the patient in a condition that was more serious than ever; the face was pale, and expressive of unrest and anguish; there was considerable agitation; fear of approaching death; vomiting; tendency to syncope, and icy coldness. All these symptoms recalled those of poisoning by aconite. That remedy, given as I have just told you, caused an improvement which was extremely rapid and permanent.

China and *arsenicum* have also been recommended during the suppurative fever. I am not quite familiar with the signs which govern the choice between china and the sulphate of quinia. In my own practice I am in the habit of giving the former to prolong the action of the latter. I prescribe from one to five grammes of the mother tincture to be taken in twenty-four hours.

As for *arsenicum*, I have not had occasion to extol it in the acute stage of suppuration. On the contrary, however, it is an

excellent remedy in suppurative pelvi-peritonitis which has become chronic. It sustains the patient's strength, favors reconstruction, and helps to retard the suppurative process. In these cases it should be given for months, with an intermission of from four to twenty days. My preference is for the first or second triturations. The arsenical mineral waters act in the same way.

As we have seen in the last case, arsenicum may also be indicated in other stages of pelvi-peritonitis.

Bryonia should not be forgotten or overlooked in this connection. What Baehr says of it (*Science of Therapeutics*, translated by Hempel, Vol. I, p. 515) is certainly true. "Hartmann's assertion that peritonitis cannot be cured without aconite, seems to us more applicable to bryonia. It comes into play at the most decisive period in the development of the disease, namely, when we desire to remove the effused fluid as soon as possible. . . . In comparing the second stage of peritonitis with the pathogenesis of bryonia, we shall find that, in the majority of cases, this remedy is indicated by its physiological effects upon the healthy. It is almost certain that, under the influence of bryonia, the exuded fluid is reabsorbed without causing any further derangement; hence, that no suppuration will take place. But the medicine should be used consistently; we cannot expect to obtain results in a day that can only be obtained in from ten days to a fortnight."

Apis mel. is indispensable if pelvic cellulitis complicates the case, and we desire to abort the tendency to all forms of pelvic abscess. If the effusion is lodged in the meshes of the areolar tissue, the apis will do all that is claimed for bryonia when the serum has been poured out as a consequence of peritonitis. But it needs to be given in a low form and frequently repeated.—L.

In chronic, non-suppurating pelvi-peritonitis, *arsenicum* is also an important remedy, because it may be used with great advantage against the abundant menorrhagias, which are a cause of debility to the patient. In such a case I give of *arsenicum*, 3d trit., one grain, twice daily, during the interval of the menses.

Hamamelis, *thlaspi*, *sabina*, and the other remedies for metrorrhagia should be consulted if the arsenicum fails.

There are times when the pains are so terribly severe that they cause the patient to scream aloud. In such cases we

should not hesitate to use hypodermic injections of morphine. These injections procure a relief from pain, and some hours of rest, which, even from a curative point of view, constitute a real advantage. But you have seen in our last case that one should not abuse this means of relief.

Of late we never find it necessary to resort to opiates in these cases. There is an expedient which has the double merit of relieving pain and of being of direct benefit in curing the inflammation, and that expedient consists in the use of very warm or hot water, in the form of a vaginal irrigation. It is always available, and will assuage the pain as promptly and more efficiently than morphine. Its use can be repeated as often as necessary without any harmful results; nor does it in the least interfere with the action of the appropriate internal remedies. Moreover, it is quite as useful in pelvic cellulitis and in hematocele as it is in pelvi-peritonitis; and, since these affections may merge, or are apt to be mistaken for each other, this surely is no small advantage.

To apply these injections (first recommended by Emmet), the patient should lie upon her back with the hips raised. She should be undressed, and go regularly to bed. Then place an old-fashioned English bed-pan beneath the hips, or bring them to the edge of the bed, and so arrange the rubber cloth beneath them that the water may flow into a basin or bucket upon the floor. The stream can be thrown by a syphon of plain rubber tubing, or by a syringe with a constant current. The temperature of the water, of which from two quarts to two gallons may be used at one time, may be gradually increased from 98° to 108°. The operation may be repeated as often as necessary without any bad effects. —L.

Proper hygienic care is very important in the treatment of this disease. In the acute stage the most absolute rest should be enjoined. In the chronic stage these patients should avoid fatigue, and venereal excesses especially; they should be reminded that each menstrual epoch may be an occasion for resorting to the same absolute rest that is proper and necessary in the acute stage.

A good diet, life in the country, the use of waters containing chlorinated soda, and warm salt baths, especially if they contain sea-water, will very decidedly aid in the reëstablishment of health and the complete cure of the patient.

Puerperal Pelvi-Peritonitis.

There is one form of pelvi-peritonitis occurring in lying-in women that sometimes gives the physician a deal of trouble. It is that in which there is an inflammation of the portion of the pelvic peritoneum which covers the bladder. Outside of the puerperal state, this disease is variously denominated *peri-cystitis*, *epi-cystitis*, and *ante-uterine pelvi-peritonitis*.

This is a local or circumscribed peritonitis, which is not usually septic, pyæmic or symptomatic, and which sets in some days after delivery. The flow of milk is apt to be arrested, but not so with the lochia. The liability to an attack seems to bear no especial relation to the severity of the labor, although it may follow a traumatic injury and irritation of the lower segment of the womb and of the cervix uteri. It occurs both in primiparæ and in pluriparæ. One of my private patients has had it in her three successive labors.

The commonly received view that peri-cystitis always follows general peritonitis, cystic, uterine, or cellular inflammation, will answer for the ordinary form of the disease; but it is not true of the puerperal variety,—nor is it often due in childbed to an extension of endo-metritis, or of salpingitis, to the peritoneal cavity. It is almost always an idiopathic affection. It may develop in such a manner as to involve the remaining coats of the bladder, and finally result in chronic cystitis. It is not a dangerous affection, providing it does not end in the perforation of the bladder, and in the extravasation of the urine, in which case it might cause death from diffuse peritonitis, or from urinæmia and septicæmia.

Its most common cause is the accumulation of urine in the bladder during the early period of the lying-in. Naturally enough the vesico-uterine excavation is more shallow in puerperal than in non-puerperal women. This is especially true for the first week or ten days after delivery, when its depth and situation are very much changed. Under these circumstances a comparatively small quantity of urine, retained in the bladder, may produce a mechanical effect that would not otherwise be felt, or be capable of doing the least mischief.

If this accumulation continues, whether it be through the oversight of the doctor, the carelessness of the nurse, or because the semi-anæsthetic condition of the soft parts after labor renders them more tolerant than usual, and makes the patient indifferent thereto, the effect is the same. The fundus uteri is forced away from the symphysis pubis, and the angle of its lateral deviation is very much increased. Its involution is arrested, and this is the prime condition for inflammation, either in the womb itself or in some of the neighboring organs.

In a considerable share of cases the uterus and its appendages escape, and the bladder becomes the seat of the difficulty. One of the first symptoms is an inability of the patient to void her urine. The labor may have been natural, and she may have done well in every respect for four or five days, or even for a week, after her delivery. Being able to pass the urine voluntarily, meanwhile, attention has not been directed to the bladder. Then, the physician and the nurse may have neglected to make any further inquiries concerning it, and if the patient has not had the usual desire to urinate for some hours, or even for a

day and night, there will be an over-distension that may act both as a cause and an effect.

The attack usually begins with a chill, which is not always so severe in degree as in the onset of the other forms of peritonitis. This chill is very apt to repeat itself. It is not usually followed by a very high fever, for, unless there are some septic complications, the patient's temperature averages about 100°, the highest figure being 102° or 102.5°. The chill, partaking more of the nature of a rigor, does not produce so profound an impression as it does in the case of the non-puerperal variety of pelvi-peritonitis. The pulse is not so slow as in the normal retardation during the puerperal convalescence, nor is it usually so rapid as in the diffuse form of peritonitis, or of metro-peritonitis of childbed. In this respect its distinctive diagnostic quality may be lost.

The kind and degree of pain varies in different cases. Sometimes it is brought on and increased by the inaction of the bladder and the retention of a considerable amount of urine. In this case it is sharp and lancinating, and is accompanied by an irresistible desire to urinate. Exceptionally this may be followed by involuntary urination. Again there is no suffering until the bladder has been emptied with the catheter, when its contraction causes a pain that may continue for some time after the water has been discharged. One of my hospital patients described this pain as very similar to that which is sometimes felt in cases of stone, when the bladder has closed firmly upon the calculus. These pains may change their location from time to time, or they may radiate, like a neuralgia, to either inguinal region, or upward toward the umbilicus. They are very much increased by motion, by downward pressure over the pubic region, and by upward pressure toward the symphysis, when the index finger is passed *per vaginam*. They are generally relieved by having the limbs drawn up. The meteorism is usually not so pronounced as in other cases of pelvi-peritonitis.

As a rule, there is no exudation, and consequently there is no intra-pelvic tumor, in this circumscribed form of puerperal peritonitis. The roof of the vagina is natural, or nearly so, unless it may happen that the womb has dropped very low on account of its faulty involution. In extremely rare cases, however, it is possible that an effusion which might be poured out from the inflamed peritoneum around the bladder and above the anterior cul-de-sac, might float backward, and be found in the lowest part of the peritoneal cavity, at Douglas's pouch, and behind the cervix uteri.

Treatment.—The first indication is to direct that the urine shall be drawn regularly every four hours during the day and night. This should be carefully and not roughly done. The patient should not be allowed to strain in the attempt to force the flow, nor to worry about passing it naturally now and then without the instrument. Nor should she be teased or disgusted with diluent drinks and such expedients as are designed to stimulate a free secretion of urine, for the fault is not with the kidneys. The bowels also should be kept open, or in a laxative state, for, if she has difficulty at stool, or with constipation, the worst results may happen to the bladder.

The more recent the date of the labor, if there are no septic or pyæmic complications, the better the indications for *aconite* and *arnica*, the good effects of which remedies are shown every day in our puerperal clinic.

Dr. Jousset's recommendation of *cantharis*, 3d dil., in pleurisy (see page

12*), is a very valuable one; but in this form of peritonitis we, also, have sometimes found the cantharis to have very little effect.

For the best of clinical reasons, we have great confidence in the internal employment of *terebinthina* in puerperal peritonitis. It is closely related in its effects upon the urinary organs to cantharis, and, like it, is also possessed of a wonderful influence upon the serous membranes. But, in our judgment, it is far better adapted to the peculiar condition of the blood, and to the state of vitality of lying-in women, which modifies the puerperal inflammations (even when there is no septic or pyæmic infection), than cantharis. This condition is very analogous to that which is met with in typhoid and low hemorrhagic states, as in typhilitis and dysentery. And we have prescribed it in this puerperal pericystitis with the same excellent results that we have several times had from its employment in peri-typhilitis. The abdominal and vesical symptoms given in the provings confirm its indication. Our habit is to order it in the second trituration.

Bryonia, bell., rhus tox. thlaspi, collinsonia can., are useful remedies under the indications already given.

We append the notes of a case of this form of pelvi-peritonitis which are condensed from the clinical records of the Hahnemann Hospital for 1879.—L.

Case 7043.—A. H——, American, a multipara, aged thirty-three, was taken in labor on the 12th of March, 1879, at 9.30 P.M. An anæsthetic was administered, and at 3 A.M. of the 13th of March, the os uteri being fully dilated, the delivery was completed. The child presented by the vertex in the first position, and was a living male child weighing six pounds. The circumference of the fœtal head was fourteen inches, the cord was twenty-one inches long, and the placenta weighed twenty-four ounces.

Previous to labor, the average temperature of this patient was 97.6°, and her average pulse was 88.

First day. Morning temp. 98.4°, and the pulse 75. *Aconite*, 3d dil., and *arnica*, 3d dil.

Evening temp. 98.4°, pulse 77. The after-pains have been quite severe; the urine has been drawn with a catheter. Continue the *aconite* and the *arnica*.

Second day. Morning temp. 97.4°, and the pulse 70. Severe after-pains. The same remedies continued.

Evening temp. 97.8°, pulse 75. The after-pains continue. *Aconite* and *arnica*.

*See, also, Jousset's *Éléments de Médecine Pratique*, Vol. II, page 278.

Third day. Morning temp. 98.2°, pulse 78. The after-pains are less severe, and she feels almost well. *Aconite* and *arnica.*

Evening temp. 101.4°, pulse 110. She had a chill this evening, with pains in the temples that are worse on motion. The skin is moist. *Bryonia*, 6th dil.

Fourth day. Morning temp. 101.8°, pulse 102. The milk is freely secreted. She has sharp, shooting pains in the region of the bladder, and great thirst. *Bryonia*, 3d dil., and *veratrum vir.*, 2d dil., in hourly alternation.

Evening temp. 102.6°, pulse 128. She has had another slight chill; is thirsty and restless; has severe pains in the uterus. Continue the same remedies.

Fifth day. Morning temp. 99.2°, pulse 95. She rested well during the night; this morning she is much more comfortable, but still she has considerable pain when passing the urine. *Arsenicum*, 6th dil.

Evening temp. 102.8°, pulse 110. She has sharp, shooting pains behind the symphysis pubis, which come and go suddenly; the nipples are chapped; the face is congested, and she has a throbbing headache. She also complains of excruciating pains while urinating, and is very thirsty. There is some tympanitis. *Belladonna*, 3d dil, every hour.

Sixth day. Morning temp. 100°, pulse 96. She is very much better. The pains have nearly ceased. *Belladonna.*

Evening temp. 102.4°, pulse 100. The patient has had another slight chill this afternoon, and now feels very chilly when turning in the bed. She has had no appetite since her confinement. *Veratrum vir.*, 3d dil, and milk punch.

Seventh day. Morning temp. 99°, pulse 90. Her tongue is coated and flabby, and shows the indentation of the teeth. *Merc. sol.*, 3d trit.

Evening temp. 100.8°, pulse 98. She has sharp pains in the pubic region, which are aggravated by motion, and is very thirsty. *Bryonia*, 6th dil.

Eighth day. Morning temp. 98.6°, pulse 84. She did not sleep well, is free from pain, but is very weak; the urine is retained, the tongue is still coated, and shows the imprint of the teeth. *Merc. sol.*

Evening temp. 99.6°, pulse 90. There is still retention of urine, with much burning about the meatus and along the course of the urethra; these pains come and go quickly. *Belladonna*, 3d dil. This evening she has, in addition to the other symptoms, darting pains along the inner border of the crest of the ilium, which are constantly increasing in severity. There are no head symptoms, but she is quite thirsty. The skin is moist. *Bryonia.*

Ninth day. Morning temp. 98.2°, pulse 89. She has sharp pains in the left temple, and her bowels have not moved. She has had no offensive lochia, and very little hemorrhage. She lies with her limbs fixed; the abdomen is not tympanitic, but there is some tenderness in the right inguinal region. She perspired freely all night. The urine is still retained. *China*, 3d dil., every two hours.

Evening temp. 100°, pulse 100. She had burning pains in the meatus this afternoon, which were relieved by *belladonna.* She now complains of a severe pain in the right iliac region, which shoots across the abdomen into the thigh and groin. *Bryonia*, 3d dil.

Tenth day. Morning temp. 99.4°, pulse 90. The patient rested well last night, but this morning she has some pain, beginning along the crest of the ilium on the right side, and shooting across the abdomen, as before. Locally, the right side of the vesical region is swollen and sensitive. The right leg is retracted. Her tongue is coated white, and flabby; there is no appetite, and the urine has to be drawn. *Bryonia*, 3d dil.

Evening temp. 100.6°, pulse 93. She has been more comfortable to-day; the bowels moved a little after an injection. The same remedy continued.

Eleventh day. Morning temp. 99.2°, pulse 90. Rested well last night; has considerable pain, however, to-day, in the meatus, shooting upward, and pains extending upward and across the abdomen. *Bryonia* and *cantharis*, in the 3d dil., alternately.

Evening temp. 99.8°, pulse 93. She has the most distressing pains when there is any accumulation of urine; otherwise she is quite comfortable.

Twelfth day. Morning temp. 98.8°, pulse 86. *Bryonia*

was given through the night, and she rested very well, but she still complains a little of the burning pains in the meatus; the appetite is improving; the lochia have almost disappeared. *Cantharis*, 3d dil., continued.

Evening temp. 99.4°, pulse 83. She still complains of pain along the course of the right ureter; cannot straighten her limbs or turn upon either side without pain. *Bryonia*, 3d dil.

Thirteenth day. Morning temp. 98.2°, pulse 83. There is no pain unless she turns upon her side or moves about, but there is a burning pain before and after urination; she has considerable thirst, some appetite, and her tongue is not so badly coated; the lochia are very scanty. *Merc. sol.*, 3d trit.

Evening temp. 99.2°, pulse 85. She feels that she is improving, although there is great tenderness in the bladder, and the urine is dark in color; Prof. Ludlam directed that the urine should be tested for albumen. *Bryonia*, as before.

Fourteenth day. Morning temp. 98°, pulse 76. She is gradually improving; there are no new symptoms; the tongue is somewhat coated yet, and there are indications for *merc. sol.*, which was given again.

Evening temp. 99.2°, pulse 80. The patient has nothing to complain of except great weakness; she is drowsy and stupid, and had no appetite for her supper.

Fifteenth day. Morning temp. 98.4°, pulse 81. Had a good night, and feels better this morning; the proper tests being applied, no albumen was found in the urine. Continue the *merc. sol.*, three times a day.

Evening temp. 98.8°, pulse 75. She complains of slight pain before the urine is withdrawn, extending across the abdomen from right to left. *Lycopodium*, 3d dil.

On the morning of the sixteenth day she was put upon *mercurius sol.*, 3d trit., which was continued with good effect for three days.

Nineteenth day. Morning temp. 98.8°, pulse 96. This morning the patient has some headache, is thirsty, and the right breast is painful. *Bryonia*, 3d dil.

Evening temp. 99.2°, pulse 86. The bowels moved to-

day, and there is a great deal of soreness. The urine was passed spontaneously. The same remedy.

Twentieth day. Morning temp. 98°, pulse 83. She complains of soreness in the bowels, and there is a slight tympanitis. *Belladonna*, 3d dil.

Evening temp. 99.4°, pulse 90. The same symptoms and the same remedy.

Twenty-first day. Morning temp. 98°, pulse 83. She thinks the soreness across her bowels is less severe, but feels as if everything would be pressed out of the pelvis; she has some pain in her back and head. *Merc. sol.*, 3d dil.

Evening temp. 99.6°, pulse 90. There is some pain in the back of the head. *Nux vomica*, 3d dil.

Twenty-second day. Morning temp. 97.8°, pulse 76. She complains again of a dull pain after urinating; the urine is very red, and there is a desire to pass it very often, but the amount is scanty; her feet are cold, and she perspires a great deal. *Veratrum alb.*, 3d dil.

Evening temp. 99.6°, pulse 85. She feels much better to-night in some respects, but whenever she attempts to sit up in the bed, the same pressure in the pelvis returns. At his clinic Prof. L—— failed to find any evidence of peritoneal effusion. *Verat. vir.*, 3d dil.

Twenty-third day. Morning temp. 98.4°, pulse 80. The patient rested very well and ate some breakfast; she has the same sensation, when sitting up, as yesterday, but the pain on urinating is less. *Apis mel.*, 3d trit.

Evening temp. 99.2°, pulse 77. The same symptoms and same remedy.

Twenty-fourth day. Morning temp. 97.8°, pulse 77. This morning she has stitching pains in her back and hips when she breathes. *Bryonia*, 3d dil., every hour.

Evening temp. 101°, pulse 94. She has had pain all day in the region of the uterus and the bladder; some thirst, and no appetite; there is great tenderness over the bladder. *Arsenicum*, 3d trit.

Twenty-fifth day. Morning temp. 100°, pulse 93. The patient rested well; has some pain after vomiting; there is less soreness, and some appetite. *Arsenicum*, 3d trit.

Evening temp. 100.8°, pulse 100. She has had stitching pains through the abdomen, and much thirst. *Bryonia*, 3d dil.

Twenty-sixth day. Morning temp. 100.6°, pulse 98. She still has stitching pains in the left side, below the ribs, when she breathes, and some pain connected with urination. *Cantharis*, 3d dil.

Evening temp. 103.4°, pulse 110. She has had three slight chills to-day, a throbbing headache through the temples and some pains in the abdomen, as in the morning; the bowels were moved by an enema; she has no appetite. *Belladonna*, 3d dil.

Twenty-seventh day. Morning temp. 98.6°, pulse 93. Has slept pretty well; has some pain in the right side. *Bell.*, as before.

Evening temp. 101.2°, pulse 98. There are no new symptoms.

Twenty-eighth day. Morning temp. 98°, pulse 80. No appetite, and some nausea; she rested pretty well, but has been chilly for an hour, and still has the burning, dull pain after urination. *Apis mel.*, 3d trit.

Evening temp. 99.2°, pulse 94. She is about the same; bowels were moved with an enema. The same remedy.

Twenty-ninth day. Morning temp. 98.6°, pulse 88. She rested well, and is better this morning. *Apis mel.*

Evening temp. 102.2°, pulse 114. She has had a chill this morning; she was very thirsty during the chill which was accompanied by a frontal headache; there are catching pains in both lumbar regions. *Bryonia*, 3d dil.

Thirtieth day. Morning temp. 102.4°, pulse 116. She had another chill at ten o'clock last evening, which continued for nearly two hours. She is now very thirsty and feels very weak; has some nausea, but was able to retain her breakfast. *Verat. vir.*, 3d dil.

Evening temp. 103°, pulse 116. Another chill this morning, after which she slept a little and perspired some. There was nausea and vomiting during the chill.

At six in the evening she had another slight chill. She now has frontal headache, considerable thirst, and there is great tenderness over the region of both kidneys, and pain and

soreness in them when trying to move. No more trouble with the bladder. *China.*

Thirty-first day. Morning temp. 100.4°, pulse 96. She has rested well all night, and thinks there is a little less soreness in the lumbar region. *Apis.*

Evening temp. 101.8°, pulse 100. Some pain in her back all day, and frontal and occipital headache. She perspires a great deal. *China.*

Thirty-second day. Morning temp. 99.4°, pulse 89. She has rested well, but is very sore across her back, and can scarcely move in the bed. *Apis.*

Evening temp. 101.2°, pulse 98. Had another chill at one o'clock, lasting over an hour, with thirst and nausea during the paroxysm. There is pain in the lumbar region. *Belladonna.*

Thirty-third day. Morning temp. 101.2°, pulse 98. She slept well, and has less pain and soreness. *Apis.*

Evening temp. 101.8°, pulse 102. She had another chill about one o'clock this afternoon. *Chin. sulph.*

Thirty-fourth day. Morning temp. 98°, pulse 98. Rested well, perspires during sleep, and has less soreness; appetite not very good. *Apis* and *china.*

Evening temp. 98°, pulse 87. No complaint of any kind. *China.*

Thirty-fifth day. Morning temp. 96.8°, pulse 68. She has buzzing noises in her head, but complains of no pain. *Apis* and *china.*

Evening temp. 97.6°, pulse 78. The same symptoms. No appetite.

Thirty-sixth day. Morning temp. 96.4°, pulse 78. She has cold feet, and perspires during sleep; there is very little pain or soreness now. *Apis* and *china.*

Evening temp. 98.2°, pulse 73. There is a little pain in her left side. *China.*

This woman improved slowly and steadily, with one slight relapse, under *apis* and *china* chiefly, until the fifty-first day, when she was discharged from the hospital in good condition.

LECTURE XXII.

SUMMARY. — Peri-uterine hematocele; hematocele and pseudo-hematocele; hematocele from rupture; hematocele from retention; vicarious hemorrhage. *Case:* menorrhagic hematocele. *Case:* differential diagnosis from pelvi-peritonitis, and from uterine fibroids. *Case:* treatment, *aconite*, *colocynth*, *arnica*, *belladonna* and *digitalis*.

Peri-uterine Hematocele.

GENTLEMEN: The clinical history of hemorrhages within the pelvis, and of tumors that may result from them, is still very imperfectly known. However, the facts collected by the French gynecologists, more especially by Bernutz and Goupil, are now very numerous. Bernutz, in particular, has examined them very critically and minutely*, and his labors will assist us in tracing the clinical history of these peculiar hemorrhages.

For the present we shall pass over the subject of the pseudo-hematocele described by Huguier, which has its seat in the cellular tissue of the broad ligament and of the pelvis. Its special pathology varies so much that, unless we could show you a patient who was ill with this form of the disease, it would be useless to burthen your minds at present with its details.

Some authors have recognized two varieties of hematocele, in one of which the effusion is poured into the peritoneal cavity, and in the other it escapes into the cellular tissue, that is, within the pelvis and around the internal generative organs. The first of these is styled the *true*, the *intra-peritoneal*, the *encysted*, or the *peri-uterine* hematocele; the latter, the *false*, the *pseudo*,—the *extra-peritoneal*, or the *non-encysted* hematocele. Some writers call the latter a *thrombus*. By drawing a parallel between the recto-vaginal fold of the peritoneum in women, and the tunica vaginalis testis in men, Dr. Bernutz concludes and insists that true hematocele can only take place within the peritoneum.—L.

* Vide the New Dictionary of Practical Medicine and Surgery, Vol. XVII.

For ourselves, we consider that, from the moment in which there is a hemorrhage into the serous cavity of the lower pelvis the case is one of peri-uterine hematocele. We do not wait until the blood has become coagulated and encysted by an incidental peritonitis before we give it the name of *hematocele*.

We know that the word hematocele means a *blood-tumor*, and that, properly speaking, there is no tumor while the blood remains fluid, and non-encysted. But we prefer to be less literal than to use two different names to specify the same lesion with a few hours' interval, when in fact a *hemorrhage* in the morning may be encysted and form a tumor which merits the name of *hematocele* in the evening.

From a clinical point of view, and as a teacher who should give his pupils a clear idea of the disease which he describes, I shall adopt the following classification of peri-uterine hematocele, viz: (1) *Hematocele from rupture;* (2) Hematocele from menstrual *retention*, and (3) *Menorrhagic hematocele*, or the *catamenial hematocele* of Trousseau. Possibly there are cases that could not be included in this classification, but they are either too rare or too imperfectly understood for me to mention them, nor would it be proper to do so in a special clinic.

The intra-peritoneal hemorrhage in this disease has been attributed to various sources. Thus Bernutz ascribes it to menorrhagia with a regurgitant flow of the menses through the oviduct; Nélaton, to the rupture of a Graafian follicle, and the gravitation of blood into the retro-uterine pouch; Virchow, to the rupture of the newly-formed vessels in the false membranes that have resulted from a local peritonitis; Peuch, Bichat and Devalz, to a rupture of the utero-ovarian vascular plexus; Tilt and Genouville insist that it comes from the ovary; Trousseau and Tardieu, to a sanguineous exhalation from the peritoneum; Tyler Smith, to an ovarian or Fallopian menstruation, which is vicarious in character; and Gallard, to the escape or dropping of the ovum into the peritoneal cavity, or, in other words, to the detachment of the ovum in extra-uterine gestation.—L.

I. HEMATOCELE FROM RUPTURE.

This form results most frequently from a rupture of the tubo-ovarian veins; but occasionally from a rupture of the

Fallopian tube, or of the ovary itself. It is characterized by an excessive pain which is located in one of the iliac fossæ, by the fainting condition which is proper to all internal hemorrhages, and, if death does not follow at once, by the very rapid development of an alarming peritonitis.

In this variety, properly speaking, we do not find the tumor, but a distension of the abdomen, from the accumulation of blood and from the early symptoms of peritonitis. It is only in case that life is sufficiently prolonged that the clot becomes encysted, the tumor forms, and, in the proper sense of the word, hematocele exists.

This is a very important distinction. Cases of hematocele in which the affection has taken on the sub-acute or the chronic form, and in which a large sized, semi-solid tumor has been formed, do not belong to this class. Being accompanied from the first by symptoms of a collapse that is due to a concealed intra-peritoneal hemorrhage, such cases are almost always rapidly fatal. They do not, as a rule, live long enough to permit the development of the secondary peritonitis that furnishes the cyst, or pouch, in which the effused blood is solidified when the hematomatous tumor is formed.—L.

The two following varieties are more frequently met with, and they are, in all respects, of more practical interest.

II. HEMATOCELE FROM RETENTION.

This is the title which Bernutz gives to hemorrhage within the lower pelvis, caused by partial or complete obliteration of the generative intestine, which interferes with the escape of the menses. In the first class, he specifies imperforate hymen and obliteration of the vagina and of the cervix; in the second, strictures of the neck of the womb. In these cases, the blood, which has accumulated in the uterus, overflows through the Fallopian tube, and discharges itself into the peritoneal cavity.

This mode of origin is literally true in case of complete retention, and we do not have need to copy the illustration of Barlow, contained in the *Monthly Journal* for 1841, in order to

understand how the blood, which is contained in the uterine cavity by a constriction of the cervix, or by atresia of the vagina, may accumulate therein each month until it shall finish by dilating the tubes and flowing through them into the cavity of the peritoneum.

But is M. Bernutz quite positive that the cases of hematocele, which follow a total suppression of the menses for one or more months, are due to the same cause? Has it been demonstrated that all these patients have a stricture of the cervix? Certainly not. Besides, in these cases, there are no symptoms of an accumulation of blood in the uterine cavity. The clinical truth is at once more simple and more obscure. A woman who has had a suppression, more or less prolonged, and who is not pregnant, is seized, at the time when the menses should appear, with decided symptoms of peritonitis and the rapid formation of an hematocele.

Now, in these cases, we do not believe it possible to explain the symptoms by the retention of blood in the uterus and by its passage, through the Fallopian tubes, into the peritoneum. Our reasons are, first, because the hematocele has not been preceded by the signs of retention; and secondly, because the narrowing of the cervix, when it exists, is not always sufficient to explain such a retention. In fact, it is quite common to meet with cases of cervical stricture that cause the most frightful dysmenorrhœa without ever producing hematocele.

There are exceptional cases, however, in which the hematocele evidently results from a partial or complete stenosis of the cervix uteri. We have had one of these under our observation for two years past. The facts were as follows: *Case* — Mrs. ——, aged twenty-eight, a slender, delicate woman, who had been married for six years, but without offspring, and with no history of an abortion, consulted us for the relief of a very severe headache to which she had been subject much of the time since her first menstruation at the fifteenth year. Of late, the headache had become decidedly menstrual, anticipating the flow some twelve to twenty-four hours, and being always somewhat relieved by it. But the monthly discharge was so scanty and escaped with such a stillicidium,

that she felt satisfied that the retention must have something to do with her suffering. She had long been subject to hemorrhoids.

I gave her remedies for some time, but without effect, and finally obtained permission to make a careful internal examination of the uterine cervix. She would not consent to this until she had satisfied herself that quite recently, indeed at her last period, she had felt something wrong and unusual within the pelvis. I felt the conical cervix crowded forward toward the symphysis pubis by a retro-uterine tumor, that was of irregular form and doughy to the touch. Around its outline the tissues were very tender. Unfortunately, I could not know how long this state of things had existed.

The tumor was bi-lobular, with a kind of sulcus between the lobes that could easily be felt by the rectal touch. This sulcus, indeed, corresponded in shape, size and direction with the rectum itself. She had had a great deal of sacral pain, and of dragging in the hips and the loins, but the bowels were regular. The sacral distress was usually very severe at the month.

There was an almost complete stenosis of the uterine cervix, for only the smallest sized sound could be passed through the internal os uteri. With the absence of the signs of pelvic cellulitis, and of an uterine fibroid, the case was diagnosticated as one of *menstrual hematocele*, due to an overflow of blood from the uterine cavity.

A careful dilatation of the uterine canal was begun and continued throughout the inter-menstrual period. When the month came around the flow was much more free, and she had very little headache. The strictest quarantine and rest were enjoined for a week during the period, and then the careful dilatation of the cervix was resumed. In three months the menstrual trouble and the headache had vanished, and through a free coffee-ground discharge from the rectum the tumor had almost entirely passed away also. For a twelvemonth now she has been quite well.—L.

We are led to believe, therefore, that in these cases there is an exhalation of blood within the peritoneum itself, as there may be a nasal, or gastric, or pulmonary hemorrhage in case of suppression of the menses; in short, that this may be a veritable vicarious hemorrhage. Case LVIII is an example of hematocele by retention, but one in which it is impossible to find any obstacle whatever to the escape of the blood from the uterus in the natural way.

Concerning the German idea which is revived in the theory of pachy-meningitis [*hematoma of the dura-mater*], and which holds that the false membranes precede the hemorrhage, and that this hemorrhage is due to the rupture of newly formed vessels in the false membrane, the study of the symptoms is

not in the least favorable to this *theory;* for in that case it would be necessary that the signs of pelvi-peritonitis should precede, for a long time, those of the hemorrhage, which is not true.

If the ordinary form of pelvi-peritonitis is common, and in many cases latent, as we believe it to be, and if adhesions may form without an acute illness, as they so often do in pleurisy, hemorrhagic peritonitis and hemorrhagic pleurisy should be much more frequent than they really are, providing Virchow's theory that the hemorrhage in hematocele depends upon a rupture of the delicate vessels in the neo-membranes were true.—L.

Whatever else may be said, this variety of hematocele has a beginning and a course which are characteristic.

After a suppression of the menses, which are more or less prolonged, and *at the moment of their appearance*, there is an acute pain in the center of the hypogastrium, with all the symptoms of a violent peritonitis, a chill, intense fever, pinched features and vomiting, which is sometimes intractable. This is what Bernutz calls a dramatic *début.* The encystment of the blood takes place very rapidly, and the tumor may sometimes form within thirty-six hours. This encystment is due to the peritonitis occasioned by the contact of the blood with the serous membrane. The process results in the formation of a sort of a pathological diaphragm, which is formed by the adhesions between the intestinal loops, the genital organs and the abdominal walls. Bernutz calls this formation a diaphragm, because it falls with each inspiration, and forces the blood into the vaginal culs-de-sac.

The tumor which is formed by the hematocele is large, and sometimes extends from the posterior cul-de-sac of the vagina as high as the umbilicus. It does not change its volume appreciably from one monthly period to another; but from settling more and more into the lower pelvis, it may seem to diminish at its upper part. It is the largest in one of the iliac fossæ; but it may send a prolongation into the

other one, and it always extends itself more or less in the median line. The uterine cervix is crowded forward and upward toward the pubis, and the rectum is compressed and more or less displaced.

This tumor has a doughy consistence; later it has a solid portion, with a consistence like that of a fibrous body, and also a portion which is soft and fluctuating.

The author has given an excellent description of this tumor. We have only to add that in some cases these hematomata do perceptibly diminish in size from time to time. If in our practice we can prevent a repetition of the flow, especially in menorrhagic cases, they will shrink as they become more solid, until finally they are removed by absorption, or by their discharge through some of the pelvic outlets. This fact may be confirmed by means of a careful bi-manual examination repeated now and then.

Exceptionally, also, and more especially when Nature is preparing a means of escape for their contents, there is such a degree of cellulitis about these tumors as causes them to feel very hard to the touch, and a local examination of them just at this time, through the vagina or the rectum, or both, may lead to their being mistaken for fibromata, or for some form of malignant growth.—L.

The symptoms of peritonitis subside, and from day to day there is considerable improvement. The pulse, however, remains frequent, and the features present the cachectic appearance that is proper to hemorrhages. At the next monthly return all the symptoms may reappear, the expression and pains are as bad as they were before, the tumor increases decidedly, and death may follow, on account of the peritonitis having become diffused. At other times the blood-cyst becomes the seat of a suppurative fever, and internal inflammation, and, as in pelvi-peritonitis with suppuration, the abscess may open into the peritoneum, the rectum, the vagina, or the bladder. If it opens into the peritoneum, the case rapidly terminates in death; if into the vagina or the rectum, it results in a cure; if the opening is too small, or located too high in the intestine, or if it opens into the bladder, the disease will pass into a state of chronic suppuration with hectic fever. Among these different openings, therefore, the most favorable

is that which communicates with the vagina. You have, however, seen one of our cases in which an opening into the rectum was followed by a prompt cure. These various terminations sometimes happen only after the third or fourth menstrual period.

In the most fortunate of these cases the termination arrives through an absorption of the blood-cyst, and this retrogressive process also begins during the menstrual epoch, and has a very rapid course. We shall cite an example of *Peri-uterine peritoneal hematocele.*

Case LVIII.—Madame C——, a cloth dresser, aged thirty-three years, was admitted to the hospital Saint-Jacques on the 21st of May, and discharged on the 21st of June, 1872.

This woman, who has had two children, is of general good health; her periods are rather scanty and too frequent.

On the 17th of May, at the beginning of the monthly flow, she was taken suddenly with a violent pain in the left groin, which compelled her to go to bed. During the night she had severe bilious vomiting and three solid stools, but no fever.

May 18 and 19. She was much better, and wanted to go to work again.

May 20. The pain returned, and was more severe than at first. She entered the hospital on the 21st.

The next morning the patient presented the following symptoms: slight fever, pulse 96, temp. 100.4°; the face is very pale; the abdomen is distended and sensitive, especially in the left iliac fossa; palpation discloses a swelling, which extends from the anterior spine of the left ilium to the margin of the womb. This swelling is more and more pronounced until it reaches the inferior part of the hypogastrium, where it forms a hard, non-fluctuating mass, and is absolutely dull on percussion. Urination is not difficult.

In the evening the fever was very much increased, the pulse 120, temp. 105.4°. *Aconite*, 2d dil., twenty centigrammes in 200 grammes of water, a teaspoonful every two hours.

May 23. The fever persists; the morning temp. was 102.5°, the evening temp. 103.25°. The same treatment.

May 24. The fever has diminished somewhat; morning temp. 101.6°; evening temp. 102.8°. By the vaginal touch we discover a hard tumor forcing itself into the left postero-lateral cul-de-sac of the vagina.

May 25, 26 and 27. Her condition is the same, the evening temperature being always one degree or more higher than in the morning.

May 28. The fever has subsided; the abdomen is not so distended, and is no longer painful. The puffiness has diminished, so that we can recognize the hematic tumor more distinctly. By the touch, we still find the tumor in the left cul-de-sac, and the cervix is raised and pushed forward. The *aconite* was continued, and the patient ordered to be better nourished.

June 10. There are no more functional troubles. The tumor is very circumscribed, and wedded to the left side of the womb. *Arnica*, 6th dil., was given until the 15th, when it was substituted by *belladonna*, 3d dil. The patient left on the 21st, still having a hematic tumor. The cervix is pushed forward against the symphysis pubis.

We saw this woman four years later, and there were no signs of the tumor.

III. MENORRHAGIC HEMATOCELE.

This form, which is the most frequent of all, happens in the case of those women who, for one cause or another, are subject to very copious menstruation. Trousseau styled this variety of hematocele *tubal*, because he believed that the mucous membrane lining the Fallopian tube was the exclusive seat of the hemorrhage. Bernutz thought, and properly too, that the increased exhalation of blood which causes this kind of hematocele took place from the uterine mucous membrane, as well as from that lining of the tube, and that the reflux of the blood was from the uterus into the peritoneal cavity.

In this form of the disease the symptoms of peritonitis are

much less intense. Indeed, in some cases they are so slight that Trousseau has denied the coëxistence of peritonitis.

During an attack of metrorrhagia there is a severe pain within the lower pelvis; this pain is accompanied by a slight fever, whilst the metrorrhagia is arrested, or at least the flow of blood is considerably diminished. At the end of some days the symptoms improve so decidedly that women often believe themselves cured, and begin to resume their usual habits. But the pains reappear; the external hemorrhage returns, increases, and prolongs itself indefinitely.

As in the preceding form, each catamenial epoch is the occasion of an exacerbation of the disease, and becomes the departure for similar results: increased growth of the tumor, a possible rupture of the cyst into the peritoneum, etc., and of the same modes of termination, absorption, suppuration or discharge into the neighboring cavities.

In his excellent monograph (*De l'Hematocèle Rètro-Utérine*, Paris, 1860), Voisin reports several cases that were due to the indulgence of coitus during menstruation; and other writers have attributed it to a violent shock or fright during sexual intercourse, to external abdominal injuries, to lifting and straining, and to too early exercise after an abortion.

It has been suggested that the menstrual blood, after having been retained in utero for a greater or less length of time, might be very poisonous when brought into contact with the peritoneum. Pure, healthy blood, it is said, would not induce peritonitis; but if the blood was depraved, either in the general circulation, or when it came into the peritoneal cavity from some special source, it would be very likely to cause a septic infection, as well as a serious inflammation.—L.

In the twenty-five cases which are included in the thesis of Auguste Voisin, the longest period required for the resorption of the hematocele was eight months. Velpeau observed a case in which the absorption of the clot required eighteen months. The following case offers an example of a much longer duration; and we can see no reason why this duration might not be indefinitely prolonged, or why the

blood-cyst might not continue as a tumor during the life of these patients. We believe, however, that this would be possible only after the change of life, for the menstrual return is frequently the occasion of a new development in, and of a change in, the blood-cyst.

Here follows a case in which two years and a-half from the commencement of the disease there still exists an hematocele, in the form of a tumor, which is as large as the head of an adult:

Case LIX.—Miss D——, now eighteen years old, had, at the age of fifteen, the form and all the appearances of a young girl who had passed through puberty, but the menses had not yet appeared. From that time, each month, at a fixed date, she had all the preliminary signs of menstruation—malaise, swelling of the breasts, pains in the loins and the lower abdomen—but without any sanguineous flow from the vulva, and with no sign of the accumulation of blood in the uterine cavity. After some months of this imperfect ovulation, and when this peculiar crisis was upon her, the young girl was taken suddenly with all the symptoms of a violent peritonitis. At the same time there appeared a hard, round tumor, which grew rapidly, and which reached beyond the umbilicus.

There had been no flow of blood from the vulva; the symptoms of peritonitis disappeared; the patient recovered, but continued to have an abdominal tumor which was as large as the head of an adult. This tumor presented no appreciable change in its volume, and became so indolent that the patient could walk and resume her usual habits. Six months after the *début* of the peritonitis, the menses appeared for the first time, and have since been irregular, somewhat free and painful. The tumor has not been modified by the establishment of the monthly flow.

Six weeks ago this patient was taken with sudden pains in the tumor, and I was consulted in her case.

She had every appearance of health. I only observed

that her hips were not as broad as they usually are in women, and that the abdomen seemed retracted. There was a tumor of the size already given. It was round, smooth, and occupied the median line just below the umbilicus, and a part of the left iliac fossa. I could not detect any fluctuation, and it had the consistence of a fibrous body. The tumor was painful to the touch only on the left and inferior portion. The vaginal touch shows that the patient is a virgin; it is difficult and very painful; the vagina is narrow; the cervix is in contact with the rectum, instead of being toward the symphysis pubis, and the complaints of the patient prevent me from finding its orifice. The rectal touch discloses but little, for the tumor occupies principally the anterior face of the uterus.

Differential Diagnosis. — Now that we have given the prominent features in the clinical history of hematocele, it will be possible for us to establish rules for the differential diagnosis between these tumors and pelvi-peritonitis.

If we consider the general symptoms exclusively, the purulent form of pelvi-peritonitis may be confounded with hematocele from retention, and adhesive pelvi-peritonitis with the menorrhagic hematocele.

In hematocele from retention, as also in purulent pelvi-peritonitis, we find an abrupt invasion, with all the symptoms of peritonitis. This is very natural, for in both cases there is a violent inflammation of the serous membrane within the lower pelvis. However, there are three differences in the totality of the symptoms. The *first* is that hematocele, like a peritonitis which is due to a perforation, begins very abruptly; the *second* is that the hematocele occurs during the menstrual epoch, whilst pelvi-peritonitis may set in at another time; and the *third* difference is that, after a frightful onset, hematocele, when it does not terminate in death from the first at-

tack, takes a course which decreases steadily until the next monthly period, while purulent pelvi-peritonitis has its periods of being better and worse at irregular intervals.

In its general symptoms the adhesive pelvi-peritonitis bears a strong resemblance to menorrhagic hematocele. In both cases the symptoms correspond with those of a mild attack of peritonitis. Hematocele always preserves its character as an affection with an abrupt onset and a regular course, improving after each menstrual period, and not becoming worse until the next regular epoch. But as the symptoms are less pronounced than in the form of hematocele which is due to retention, the symptom derived from their course alone is more difficult to understand.

The principal diagnostic sign is derived from the coincidence of peritonitis with menorrhagia, which menorrhagia subsides at first, then returns more or less decidedly, and continues almost indefinitely. This peculiarity of the brusque onset of a peritonitis within the true pelvis, with a menorrhagia, is *pathognomonic* of hematocele.

But the local symptoms derived from the examination of the tumor will furnish us other differential signs which are of great value.

These are the signs which are afforded by the tumor itself in a case of hematocele: the tumor is formed rapidly, and immediately attains the size which it will continue to have until the next menstrual return. This tumor may be of considerable size, sometimes reaching almost to the umbilicus; or it may descend deeply between the rectum and vagina, and almost always occupies the two iliac fossæ and the hypogastrium.

The form of this tumor is irregularly rounded, usually presenting a large protuberance in one of the iliac fossæ, another

in the hypogastrium and a third in the opposite iliac fossa. This form has been compared to that of a clover leaf; the pedicle of the clover dips down into the lower pelvis, of which it forms a cast like metal in a mold.

If the hemorrhage happens to occur when the rectum is loaded with fæces, the tumor may be molded into such a form as afterward to exempt the patient from rectal tenesmus, which usually is one of the most distressing symptoms in retro-uterine hematocele. And strangury may also be lacking as a symptom if, during the solidification and encystment of the tumor, the patient has invariably lain upon her back.—L.

The consistency of the tumor is no less characteristic; at first it is of a doughy softness, then of an elastic resistance which, according to Bernutz, is quite peculiar; later its texture ceases to be homogeneous, and we recognize some small bodies which are mixed with liquid; still later the tumor consists of two parts, one of which is round, hard, elastic, and which, in the case under consideration, was mistaken for a fibrous body; and of a fluctuating portion, which, when the patients recover, lessens from day to day.

In certain cases it is very important to differentiate the hematic tumor from an ovarian cyst. In so doing we should remember that the cyst of the ovary is of comparatively slow growth; that it is seldom accompanied by menorrhagia, or by symptoms of hemorrhage, or of peritonitis; that the tumor is most largely fluid, and that, whether the cyst be compound or single, its fluid portion increases from time to time. All of these signs are reversed in pelvic hematocele.

The diagnosis between the two is, however, more difficult if the ovarian cyst is small and accompanied by pelvi-peritonitis. For in this case it may be bound down and strangulated by adhesions, and as it fills it may cause such a bulging and prolapse of the retro-uterine pouch as shall give it a very strong resemblance to a large hematic tumor. We should, indeed, remember the possible distensibility of the pouch at the Douglas cul-de-sac, as described by Phillips, Barnes and others, in every such emergency.

In a very marked case of this kind to which I was called some years ago by my colleague, Dr. A. E. Small, the pelvis was almost completely filled with one lobe of an enormous multilocular ovarian cyst, which was so adherent as to be immovable, and which had forced itself downward until it approached the vulva. The poor victim soon died of an intractable dysentery, and a careful autopsy showed the tumor to have been anchored and compressed by very firm and vascular adhesions extending everywhere throughout the pelvis. In this case the abdominal cysts were also very large. The specimen is preserved in my cabinet.—L.

The hematomatous tumor differs from the tumor of pelvi-peritonitis, which is smaller, circumscribed, or at least less prominent in either of the iliac fossæ, decidedly fluctuating in the suppurative form of pelvi-peritonitis, presenting in both a special development which we have described at length, and which in adhesive peritonitis, at least, is characteristic.

It is much easier to recognize and to differentiate this tumor if we have known the condition of the parts involved almost immediately before its formation. If the occurrence of the swelling was coincident with the general attack, and took place, as it were, suddenly, the case would be clear enough; for in simple pelvi-peritonitis, and in pelvic cellulitis also, the effusion is not by any means so rapid.—L.

It remains to distinguish true from false hematocele or from hematocele of the broad ligament, and also from uterine fibroids.

Pseudo-hematocele is almost always contingent upon extra-uterine pregnancy; indeed, only two cases of pseudo-hematocele have been reported which are independent of that condition.

As in the true hematocele, the onset is abrupt, and occurs at the catamenial period; it is not accompanied by symptoms of genuine peritonitis, but by a pain in the hypogastrium, which is very much like that which occurs in case of inflammation of the broad ligament. The blood-tumor is entirely lateral and not prominent in the abdomen, whilst it descends very low in the vagina, from the walls of which, so to speak, its body is composed [Bernutz].

It is necessary to differentiate very carefully between uterine fibroids and hematocele, because these two affections have often been confounded. This mistake happened to Malgaigne, to Stoltz, and quite recently to the specialist who wanted to operate on our patient. In the case of which we are speaking, the diagnosis turned partly upon the symptoms of the tumor, which it would be useless to recapitulate, but chiefly upon the

incidental history. For example, we cannot understand how, in this case, one should have taken for a fibroid tumor one which, in a few months, had attained the size of the fœtal head, and which at the beginning had presented all the signs of a violent peritonitis.

Here are the details of this case:

Case LX.—Madame J——, aged thirty-four, was admitted into the private ward on the 9th of February, and discharged on the 27th of March.

This woman had enjoyed good health until the month of September. At that time the menses were suppressed without apparent cause. But from that moment she has had, every month, nausea and general malaise, which continued for some days, but without any sign of the accumulation of blood in the uterus.

On the 11th of December last, just when she should have had her courses, she was taken with chills, intense fever, very violent pains in the abdomen, and some vomiting. She was obliged to go to bed, and her physician treated her for peritonitis.

At the beginning of January she discovered that the abdomen was enlarged. The tumor which she found was chiefly on the right side, and was very slightly sensitive to pressure. At the same time she lost her appetite, and her strength diminished rapidly. Then, for the first time, she entered our wards.

Examination of the Tumor.—This tumor has the volume of the fœtal head at term. It presents two distinct parts: one, and the largest, is round, smooth, hard and elastic, with the consistence of a fibrous body, and located in the right iliac fossa; the other, which is smaller, is decidedly fluctuating, and occupies the middle region.

By the touch we find that the right and the posterior culs-de-sac of the vagina are filled with a resisting tumor, and the cervix uteri is carried forward and to the left side.

In the month of January the courses returned, but they were slight and very painful. The size of the tumor was not

changed. The patient went home again because we would not consent to an operation.

An exploratory puncture was made into the tumor about the last of January, and half a glass of blackish blood was withdrawn.

Some days later she was seized with chills and nausea, and on the 9th of February she returned to the hospital with a very intense fever.

In the hypogastrium, and along the mesian line, we recognize a half-solid, half-fluctuating tumor which extends into the right iliac region. The touch also discloses a tumor in the right posterior and lateral culs-de-sac. By the rectal touch we can make out the superior limit of this tumor. *Aconite*, in the mother tincture, five drops in 200 grammes of water, one teaspoonful every two hours.

February 10. Yesterday, during the day, the patient passed, per rectum, a quantity of black blood mixed with pus. The tumor seems to have settled somewhat. The same treatment.

February 15. She goes regularly to stool, and each time passes a large quantity of black blood. The diminution in the size of the tumor is perceptible. The same treatment.

February 20. The improvement continues, and the fever is completely broken. The appetite and strength are returning. *Belladonna*, 6th dil., two drops in 200 grammes of water, four teaspoonfuls daily.

February 24. The tumor is still becoming smaller. The stools contain some granulated blood. On account of a slight fever, the *aconite*, in the mother tincture, was resumed.

February 26. Where the tumor was located we now recognize a deep-seated, dough-like deposit. *Cantharis*, 6th dil., two drops.

The patient had no longer any especial symptoms. The sanguineous discharge had ceased. There was no further sign of a peri-uterine tumor, and she had grown fleshy. She left the hospital on the 27th of March.

The size and shape of the tumor, and the sensation of elastic hardness upon palpation had completely deceived the surgeon who had diagnosticated it to be a uterine fibroid, and

who had decided upon its extirpation. This mistake, which might have been so serious for the patient, would not have happened if our *confrère* had been careful with regard to the early history of the case, for a uterine fibroid never reaches such a great size in a few months; and besides, the formation of such a neoplasm is not accompanied by symptoms of subacute peritonitis. I will add that the direct examination of the tumor showed me that it was composed of two parts, one of which was solid, and another, and a smaller one, which was liquid. Now, fibroids never present this peculiarity.* The surgeon, perhaps, thought that we had been deceived by a false sensation of fluctuation; but the patient returned to her home and called another surgeon, who, for the sake of clearing up the diagnosis, practiced the exploratory puncture, or tapping, and who, by drawing off half a glass of blood, demonstrated the existence of a peri-uterine hematocele.

The results of this puncture were very fortunate for the patient. A slight inflammation of the cyst followed, which resulted in an opening into the rectum, and, as we have already seen, in the complete cure of the disease; but is this not the place to recall the maxim, *felicior quam prudentior?* For, instead of being moderate in degree, the inflammation might have been violent, or the opening, instead of discharging the contents of the tumor through the rectum, might have let them into the peritoneal cavity; and in either case a rapid death would have resulted from the surgical interference.

Two practical conclusions may be drawn from this case: (1) That, in making a diagnosis, it is indispensable to study the whole history of the case, and (2) that, unless there is a very clear indication for it, we should never touch an hematocele surgically.

* Excepting in rare cases of their cystic degeneration.—L.

This case is a very instructive one. The celebrated Malgaigne, of Paris, and the no less distinguished Stoltz, of Strasbourg, each mistook a pelvic hematocele for an uterine fibroid. The former did not discover his error until (in 1850) he had made an incision into the os uteri with the intention of enucleating the tumor; and Stoltz was so confident of his diagnosis that he made his patient's case the subject of several lectures upon fibrous tumors of the uterus. In the latter case the existence of the hematocele was not discovered until the autopsy was made.

Bernutz and Goupil could not decide, in a case at the Hôtel Dieu, whether it was an hematic tumor or a uterine fibroid; and several cases are on record in which a large hematocele was mistaken for an ovarian cyst. Indeed, in one case, recorded in the *Transactions of the London Obstetrical Society*, the operation for ovariotomy was actually begun under a misapprehension of this sort.

The great Nélaton, mistaking a pelvic abscess for a pelvic hematocele, punctured the tumor through the posterior wall of the vagina, and discharged an immense quantity of pus instead of blood.

Since it is only the ignorant quack who (in his own estimation) is perfect in diagnosis, the inference to be drawn from these and similar cases, of which there is no lack, is, that it is impossible always to know and to discriminate between the different kinds of pelvic tumors. By means of the aspirator, however, we can usually arrive at a more correct diagnosis in most cases than the most distinguished physicians and surgeons could once do without it.—L.

There is one more reflection which concerns the etiology and mechanism of pelvic hemorrhage in this particular case. The formation of this hematocele was preceded by an arrest of the menses for three months. Its onset came with the return of the monthly epoch, but was not accompanied by menorrhagia. How, therefore, shall we accept the opinion of Bernutz, who holds that the blood, being retained in the uterus through a mechanical obstacle to its natural outlet, escapes through the Fallopian tubes into the peritoneal cavity?

This woman had reached her thirty-fourth year without any serious derangement of the menstrual function. How could it happen that, suddenly, without being pregnant, and independently of uterine disease, there should be an insurmountable obstacle to the proper menstrual discharge, and that this obstacle should first cause the blood to be retained in the womb, and afterward produce the hematocele by its escape through the tubes into the cavity of the peritoneum?

I do not hesitate to say that, in this case, the hemorrhage occurred directly within the peritoneum, and that the hematocele should be regarded as a *deviation* of the monthly discharge.

The *treatment* of hematocele is included in three principal indications, viz: (1) To limit and to overcome the serous inflammation; (2) to favor the absorption of the effused blood, and (3) to prevent a repetition of the hemorrhage.

The remedies indicated for the peritonitis are *aconite* and *colocynth*. We reiterate what we have already said of them in the treatment of pelvi-peritonitis. The indications are the same, and we have nothing especial to add to what was said in the last lecture.

Can the absorption of the effused blood be hastened by remedies? We should not be too positive upon this point; for it is hard to say whether the diminution and disappearance of an hematoma, which takes place naturally when it is not interfered with, is hastened beyond a certain degree by the administration of medicine. However, we advise the use of *arnica* and *belladonna*, which appear to have favored the absorption of the effusion in case LVIII.

The whole attention of the physician should be given to counteract the possibility of another hemorrhage, and to applying the best means for its prevention. The relapsing tendency of the lesion shows itself with the return of the monthly cycle. During this period, therefore, the woman should be subjected to the most rigorous laws of hygiene. Absolute rest in the horizontal position is the rule, and *aconite* may be given to prevent the hemorrhagic congestion. Twenty drops of the tincture should be given in this case during twenty-four hours.

Digitalis is also indicated on account of its anti-hemorrhagic properties, and especially because of its action upon the uterus; but I do not know the signs which would lead you to prefer it to aconite.

At the moment of the hemorrhage *arnica* is the principal remedy; but *hamamelis*, *thlaspi bursa pastoris*, *secale cornutum* and other remedies for metrorrhagia may be indicated. At this period, also, the local application of ice to the lower abdomen is sometimes of great service.

We must insist upon what we have already said of *terebinthina* as a remedy for pelvi-peritonitis.* As an anti-hemorrhagic remedy, which is especially adapted to inflammation of the serous membrane about and within the pelvis, and to the peri-enteritis of the large intestine, it is better suited than any other to the conditions that are found in pelvic hematocele. Its power to relieve the peculiar pain and the extreme suffering that are incident to this disease, to abort the suppurative process in serous membranes, and to tide the patient over the whole difficulty, is very remarkable. It is especially appropriate to cases in which, from an alteration of its quality, the blood is likely to exude or to exhale into a serous cavity; cases of vicarious or deviated menstruation, which cause the effusion within the peritoneum, and to cases that are septic or typhoid in their character.—L.

If the blood-cyst is distended by a fresh hemorrhage, and the violence of the pain causes you to fear a rupture thereof, Nélaton advises to puncture it. This operation should be made from the vagina. This, indeed, is the only case in which you would have a warrant to interfere surgically, for otherwise the puncture is usually followed by violent inflammation of the cyst and the death of the patient.

In our day the hematic cyst can be tapped with the aspirator much more safely than was possible with the old-fashioned trocar. But still the operation is not devoid of danger, and is strongly contra-indicated in certain conditions. Thus it would not be safe or expedient while the effused blood continues in a fluid state, without being encysted, nor while the size of the tumor continues gradually to diminish and the patient's condition to improve, nor if the source of the hemorrhage, being catamenial and dysmenorrhœal or obstructive, still remains to reproduce the difficulty. Most authorities have regarded it as an "extreme resource."

* See Treatment of Pelvi-peritonitis, page 293.

But if the tumor has existed for a long time, and shows little or no disposition to be absorbed and to disappear; if the original cause of the hemorrhage in such cases is no longer in operation; if there is a very large accumulation, which is not too recent, but which causes great pain and pressure, with forcing pains like those of labor; if there are rigors and signs of suppurative fever; if the symptoms are those of septic infection, or typhoid in character, with a hyperthermic condition, there should be no delay in evacuating the tumor. I am opposed to putting it off very long, for when properly used it gives great relief and expedites the cure.

Some authorities, remembering that Nature most frequently discharges these tumors through the rectum when they are not interfered with, insist that they should be tapped from the rectal side. But this is not important. We select the most dependent part of the pouch, and discharge it with a large-sized aspirator needle.

Dr. Meadows says that: "In performing the operation of tapping we should be careful to thrust the trocar in far enough; in two of my cases the first tapping proved abortive, and I have no doubt that the reason of it was that I did not puncture deep enough. It is probable that some coagulation of the effused blood takes place circumferentially; this coagulated layer may in some places be very thick, and we must make allowance for that. At any rate, if it be a case fit for tapping, we need not be afraid of going pretty deep, and we ought certainly to push on until fluid is reached."—L.

Finally, if the hematocele becomes the seat of the inflammatory process, we should by all possible means limit that inflammation. *Aconite*, *colocynth*, *cantharis*, will be indicated as they were in the onset. Collodion and sometimes ice are very useful in arresting the violent and persistent symptoms. In this way the inflammation may safely pass to ulceration of the cyst at its inferior portion and its opening into the vagina or the rectum, with the result of a complete cure of the disease, as you have witnessed in Case LX.

There is a great dearth of well-authenticated cases of this disease in our literature. We insert the following communication, therefore, from our friend and fellow gynecologist, Dr. T. G. Comstock, of St. Louis, with a great deal of pleasure, more especially because he is a truthful witness, and the case has never before been in type.—L.

Case.—In July, 1878, Mrs. S——, a patient of Dr. Bahrenburg, was taken quite suddenly ill with slight hemorrhages and bearing-down pains, accompanied with tenderness in the pelvic region, loss of appetite, with faintness, exhaustion, and also more or less difficulty at times in passing water. Such

were her subjective symptoms for some days previous to my being called in consultation. This was during the excessive hot weather in St. Louis, a period that is never to be forgotten.

When I first saw the lady, after conversing with her, and before making any physical examination, it occurred to me that she had symptoms of peritonitis. Dr. B. had suggested to me that he thought she was suffering from retroversion. I found the patient quite anxious, with a pulse at 98 and a temperature of 101°, and upon a digital examination, the cervix uteri directed anteriorly, and behind it a swelling in the retro-uterine space. This swelling, which was sensitive, and though prominent was rather flattened yet seemingly fluctuating, made me at once suspicious of the existence of an hematocele. The patient was the mother of several children, and her attack followed a menstrual period.

I advised perfect rest and quietude, vaginal injections of warm water, *aconite* to be given internally, and, at bed-time, McMunn's elixir of opium.

The patient's condition remained much the same for several days, and by repeated vaginal examinations I found that the tumor was increasing, and that my opinion as to the diagnosis was being confirmed.

At the expiration of eight days, as the patient seemed suffering much with wandering and bearing-down pains, and feeling as if "she must pass something from the vagina," I advised instrumental interference, in order to evacuate the contents of the swelling. Dr. Walker was called in consultation, who agreed with me as to the existence of the swelling, but, with Dr. Bahrenburg, was disposed to regard it as containing pus, or, in other words, they thought that it was a pelvic abscess. This opinion was based upon the fact that the lady had complained at times of slight rigors, followed by an elevation of temperature, as indicated by the thermometer. Dr. Walker, however, advised the evacuation of the tumor.

With the assistance, therefore, of Drs. Walker and Bahrenburg, I proceeded to make the operation. Placing the patient upon her left side, with the knees drawn up to the abdomen, I introduced the perineal retractor of Simon (an instrument something like Sim's speculum), and drawing back the perineum,

so as to expose the most depending point of the swelling in the posterior wall of the vagina, then placing the sharp point of the canula of Dieulafoy's aspirator first in a solution of carbolic acid, I carefully punctured the swelling, introducing the canula into the Douglas cul-de-sac, where the fluid was collected. Immediately the air-pump of the aspirator was filled with blood. At this operation I drew off some five ounces of blood, and completed the operation by injecting a few drops of a weak solution of carbolic acid into the sac.

The patient bore the operation well, and after being replaced in bed expressed herself as feeling greatly relieved.

About six days after the first operation, I visited her, and, finding the swelling again prominent, I operated a second time, and drew off several ounces of blood, the last ounce being perhaps not so red as at first, but having more or less lymph mixed with it.

The patient made a slow convalescence, but did not materially suffer after the last operation. Some ten days afterward she had a discharge from the rectum of pus that was slightly sanguineous, as if from the evacuation of an abscess. This continued to flow for several days, and she finally made a perfect recovery.

The writer's experience includes six cases of hematocele, and all of them have opened spontaneously either into the vagina or the rectum. One case was after labor at term. All of these cases recovered, but usually it was after great suffering. In all of the six cases the patients were strong and healthy subjects.

I should advise, generally, in such cases, the expectant method of treatment. In the case above mentioned operative interference was resorted to simply to relieve the great pains of which the patient complained.—Comstock.

LECTURE XXIII.

SUMMARY.—Eczema: Definition. It is a symptomatic affection; eczema rubrum (pseudo-exanthematic); seat; scrofulous eczema, *case;* dartrous eczema, *case;* arthritic eczema, *case;* treatment: *Rhus toxicodendron* and *vernix;* pathogenesy and indications: *cantharis, arsenicum; case; plumbago, mezereum, dulcamara, viola tricolor, sepia, sulphur,* mineral waters. External treatment.

Eczema.

GENTLEMEN: ECZEMA is a cutaneous affection characterized by the eruption of vesicles or vesico-pustules, sometimes by the formation of fissures, by the exudation of a serous, sero-purulent or viscous liquid, and by the formation of crusts.

Not excepting hysteria, there is no disease which has been so variously defined as this. In a prize essay on *Eczema, its Pathology and Homœopathic Treatment,* by H. C. Jessen, M.D., there is a quotation of definitions from twelve distinguished authors and specialists, no two of which definitions are alike. Dr. Jousset defines it as being invariably a moist eruption; but Dr. Jessen believes that it also may appear as a dry eruption, where the formation of vesicles and the exudation of serum are so slight that there is no sensible moisture, but only an exfoliation of scales instead of the formation of crusts. This latter view agrees with our own observation and experience.—L.

This affection is always accompanied by itching, and by a burning sensation, from which it derives its name.

When we say that eczema is an *affection*, we declare that it is always symptomatic, and that one should always search for the disease with which it is associated.

We take especial pleasure in commending what the author has said of the constitutional origin of eczema; for in our day there is a strong tendency to regard it as a purely local affection. Perhaps this bias comes from a misapplication of Rindfleisch's remark that eczema is an analogue of catarrh of the mucous membranes. (He did not say, as some of our writers have made him say, that it was a real catarrh of the skin.)

But, nevertheless, in our judgment, Dr. Jousset's statement needs some

qualification. For while, as a rule, eczema depends upon constitutional causes, and is, therefore, a sympathetic affection, it certainly may arise from local irritants. Hebra has shown that the topical application of croton oil will always produce a genuine typical eczema.—L.

We are pleased that M. Bazin has followed the precepts of our school in trying to recognize the peculiar character of each of the varieties of eczema, and of their relation to a definite disease. And, if dazzled by the eclat of symptomatology, which holds that every symptom should carry the imprint and stamp of the disease to which it belongs, M. Bazin is sometimes too hasty in his conclusions upon so difficult a subject; if some of his distinctions are not really tenable, he should console himself by thinking that he has undoubtedly restored certain questions in dermatology to their proper ground, and that what he has not completed will certainly be achieved by his successors. He has built upon the solid ground of essentials in disease; and while his work may be improved it cannot be overthrown.

We admit with M. Bazin that eczema may show itself in three different diseases, viz: in dartrous affections, gout and scrofula; and we add that this affection can also be caused by poisons or by medicines. Rhus toxicodendron, rhus vernix, mercury, arsenic, croton oil, and cantharides, are veritable *eczématogènes*, and they really are the best remedies for this affection. In connection with the treatment we shall see that there is one eczema of sumac, another of cantharides, another of mercury, and another of arsenic; but as these differences have an especial relation to therapeutics, we shall not insist upon them for the present.

In very exceptional cases,—and it is a fact which is almost never mentioned by dermatologists,—eczema is associated with diabetes mellitus. We recently reported a case of the kind to the Clinical Society of the Hahnemann Hospital (see the *U. S. Medical Investigator* for March 15, 1879, or the *North American Journal of Homœopathy* for May, 1879). The case was that of a woman aged forty-three. The eruption, which spread over the genitals and the nates, would almost disappear and then break out again without apparent cause. There was no incontinence of urine, and no vaginitis. The patient was of a very cleanly

habit. She was also a victim to the most intractable neuralgia. The urine contained a considerable quantity of sugar.

In this connection, also, the following extract from Hebra is worthy of remembrance (*Lehrbuch der Hautkrankheiten Von F. Hebra und M. Kaposi*, 1874, Band 1, page 28): "In the diagnosis of skin diseases in women we must never forget to examine the genital functions; and we must not be satisfied with mere superficial questions, but the examination must be thorough, manual and even instrumental, if necessary; for the uterus and ovaries in women, like the stomach, liver and kidneys in both sexes, often prove to be affected simultaneously with the skin; and from a thorough investigation of these organs only, in many cases, is it possible to make a correct diagnosis of an affection of the skin."

In Dr. Frédault's work, *Des Hémorrhoides*, Paris, 1868, page 155, the author says: "A large number of cases of very serious eczema of the face that I have seen have been associated with hemorrhoids. Some writers cited by Montégre had recognized this relation long ago."—L.

In all the varieties of eczema there is a first period of inflammation and a period of desiccation. From the beginning there is an eruption of vesicles upon a red base which is more or less swollen. These vesicles consist in a lifting of the epidermis, and contain, at least for the first few days, a serum which afterward becomes more or less purulent. The vesicles are more or less pointed, more or less numerous, and coalescent. They break spontaneously, and the affection becomes humid. At this time the surface resembles the wound produced by a blister. The liquid, which varies with the different kinds of eczema, dries, and forms crusts that are always moist and yellowish, and which vary in thickness.

In the second stage the vesicles, or vesico-pustules, cease to form; the surface dries, and the eczema resembles either psoriasis or pityriasis. The skin is then covered with dry, scaly crusts, leaving, when they fall, a surface that is dry, smooth and reddish, and which looks as if it had been varnished. The desquamation becomes less and less abundant, the skin becomes pale and assumes its normal state, but for a long time a brownish tint persists as the last vestige of the disease.

The eczema in its first stage (inflammatory eczema) is denominated *eczema rubrum*. There are some varieties in which the eczema is so widespread and diffused that it resembles erysipelas; this is the *pseudo-exanthematic eczema*. The febrile action is more or less intense, and Hardy reports a case that terminated fatally.

Eczema impetiginoides is that form in which, little by little, the vesicles are replaced by pustules. For that matter, Hardy considers impetigo as a form of eczema.

The *eczema fissurum* is that variety in which the vesicles are replaced by fissures and cracks in the epidermis.

Finally, we also distinguish the disease according to its seat or location, as an eczema of the face, of the hairy parts, of the ears, of the extremities, of the breasts, and of the genital organs.

Scrofulous eczema is the variety which is the most characteristic of all that have been admitted by Bazin.

It is almost always of the impetiginous form, and is distinguished from other kinds by the presence of pustules of an abundant secretion, and by humid, thick, yellow crusts.

Here we have, according to Bazin, the common character of scrofulous herpes, a peculiarity which exists in the highest degree in eczema, *id est*, "the tenacity, the persistence in the same place; the regular order which they (the vesicles) follow in their propagation, extending themselves generally from the head and superior parts of the body to the inferior parts; their prompt distribution upon different portions of the body; the mode of development of the inflammatory process, which is essentially secretory and suppurative; the participation of the glands and follicles, and often also of the subcutaneous cellular tissue in this inflammatory process; the implication

of the lymphatic glands in the neighborhood; the absence of pain and of itching, at least of the violent and constant pruritus, which is increased by the warmth of the bed, and which often causes the patient to tear the skin with his finger-nails; and finally the marks which they leave after them." (*Lectures upon Scrofula*, page 176.)

To resume: the decided moisture of the eruption, a pruritus which is relatively slight, and especially the swelling of the lymphatic glands, constitute the chief characteristics of *scrofulous eczema.*

The *dartrous eczema* and *arthritic eczema* are much more difficult to distinguish from each other. The characteristic symptoms given by M. Bazin, of which we shall speak directly, have been very seriously criticised by certain renowned dermatologists, nevertheless we give the peculiarities assigned by M. Bazin to these two varieties of eczema.

Dartrous eczema, which Bazin calls herpetic, presents for its proper symptom certain anatomical features which are more distinct than with the other kinds; that is to say, in this variety only the elementary lesion is characterized by a vesicle upon an inflamed base. Besides, this form of eczema is usually symmetrical. But we should not accept this last symptom in its literal sense; for when eczema shows itself upon both ears, or upon both feet, for example, it is almost always more fully developed upon one side than upon the other. I will add that we have also observed cases of eczema in which the eruption was located upon the ears, and in which the lesion was perfectly symmetrical, in gouty and scrofulous subjects. The third peculiarity of the dartrous eczema, and one that is more marked than the symmetry of the eruption, is the character of the liquid discharge. At a certain stage, dartrous eczema is characterized by a serous exudation that

is extremely abundant. This exudation stains the linen of a grayish tint, and stiffens it in a manner that is quite peculiar. This peculiarity of the discharge is not, however, constant, for it pertains only to one stage of the disease; but while it does exist, it has a real diagnostic value.

The dartrous eczema causes the most atrocious itching of all the varieties of this affection. It has also a tendency to relapse and to become general.

Here is a case of dartrous eczema:

Case LXI.—Miss V——, aged thirteen and a half years.

The mother of this young girl is scrofulous. Her maternal aunt is herpetic and asthmatic. This patient, who has not yet menstruated, has enjoyed very good health until now. She is well developed, and shows no signs of scrofula.

The eczema, which is seated upon the dorsal surface of the great toes of both feet and in the spaces between them, began a month ago with itching and a decided redness of the skin. The eruption consisted of vesicles located upon a red and inflamed base. It yielded an effusion of a grayish-white fluid, which stiffened the linen, and there are a few thin crusts which are brownish, and which consequently contain a little blood.

The pruritus is continual and severe; the affection is most marked on the left foot; upon the right foot it continues to be imperfectly developed; it occupies exactly the same location on both feet. The fold of the groin shows no signs of glandular swelling.

This patient took *cantharis*, 12th dil., four globules in 100 grammes of water, four times a day. The external treatment for the first few days consisted of the application of starch poultices (*cataplasmes de fécule*).

She improved rapidly under the influence of this treatment. The eruption dried as the itching ceased. The dry potato starch was applied instead of the poultices.

December 11. The disease has taken a new turn. The patient complains of having had, last evening, a very severe itching, while at the same time new vesicles have appeared at the root of the great toe. *Arsenicum*, 12th dil., was substituted for *cantharis*, to be given in the same manner.

December 14. The arsenicum having had no effect, *cantharis*, 6th dil., was given, and the poultices were reapplied.

December 18. The vesicles on the dorsal surface of the toes have disappeared, and the crusts on the plantar surface of the toes are not so thick as they were. The exudation has diminished; the itching is not so severe. *Cantharis*, 6th dil., two drops each day.

December 20. The itching has returned and is much worse than before. The same medicine was continued, and the foot is to be enveloped with gummed silk.

December 24. There is much less inflammation; the base, upon which there are still some vesicles, is not so red as before, but there is quite an abundant effusion of serum. *Cantharis*, 6th dil.

December 27. There is a great improvement; the crusts are falling, and the exudation is diminishing. The same medicine was continued until she left the hospital.

The *arthritic eczema* is distinguished from the preceding by the lack of distinctness in its physical signs, and by its being less regular in its course. There are papules which are mixed with vesicles; the patch is usually rounded in outline, not symmetrical; it rests upon a violet-colored base, and is accompanied by a varicose condition of the skin. Arthritic eczema is much more dry than the other kinds of eczema; it is very persistent, and it never becomes general like the herpetic eczema. When it disappears, it is often replaced by another gouty affection, as, for example, of the heart, of the great vessels, of the stomach, etc.; and, finally, it sometimes leaves cicatrices, a thing which does not often happen as a sequel to the other varieties of eczema.

Now, gentlemen, these distinctions, which are not always found in practice, are more easy to make in a book than at the bedside of the sick; and I do not hesitate to say that the cleverest physicians are sometimes very much puzzled when they are compelled to make a differential diagnosis between the dartrous and the gouty eczema.

Of the symptoms given by Bazin, not one of them is absolute. Thus, in gouty subjects we have a symmetrical eczema. Moreover, the violet base and the varicose condition of the skin are observed especially in the eczema of the inferior extremities, and they are more frequently the sign of a variety of the location of the disease than of a nosological difference.

These difficulties, which we are the first to recognize in the distinction of the dartrous from the gouty eczema, cannot bring us to the legitimate conclusion that such a distinction has no real practical existence. Much less can we confound gout and herpes under the name of *uricæmia* (Gigot-Suard de *l'Herpétisme*, p. 170). But if the signs of the eruption are not always sufficient to establish the differential diagnosis between gouty and dartrous eczema, the totality of the symptoms presented by the patient will always decide which we have to deal with; and this is quite as important a point for the prognosis as it is for the treatment.

Case LXII.—Madame Vovet, aged fifty-eight years, was admitted on the 2d of December, and left the hospital on the 28th of February. She occupied bed No. 1 of ward 1.

This woman presented all the signs of the gouty constitution. Twelve years ago she began to have pains in the finger-joints. These pains returned, and were dull and lancinating nearly all the day, and were accompanied with slight swelling. From that time the fingers became deformed. The deformity is now very marked, and the fingers cannot be extended without difficulty.

The knees have also been the seat of pains, but they were much less intense in degree. The joints are not deformed, neither are there any concretions upon them. This woman is also subject to hemorrhoids, and to varicose veins of both legs.

For ten years she has had a great deal of itching in the region of the neck and of the arms. This itching is always accompanied by a redness of the skin, but without any eruption. The pruritus was not constant; it lasted eight days,

disappeared, and then came again. The temperature of the weather had no effect upon its return.

She has had the eczema upon both legs, for which she entered the hospital, for a year. When it began, the skin became red, principally on the internal surface of the legs. At that time some vesicles appeared, but there was no exudation.

The eruption is seated upon the anterior surface of the two limbs, and principally the right one, occupying the middle two-thirds of the member; the surface is red and violet-colored; the exudation is slight, and forms into pretty thick yellowish crusts. The whole extremity is the seat of itching and of burning pains.

December 2. *Plumbago*, 3d trit., twenty centigrammes in 200 grammes of water, four tablespoonfuls daily. Poultices of starch to be applied externally.

December 4. The crusts have fallen and exposed a dark-red surface, very wet, and surrounded with dilated veins. The same treatment.

December 13. The itching is excessively severe. Some of the vesicles have broken, and left little red and ulcerated patches. The exudation is slight. *Arsenicum*, 3d trit., twenty centigrammes during the day, and the starch cataplasm.

December 17. The patient complains of a burning sensation, especially in the left leg. *Arsenicum*, 2d trit., twenty centigrammes.

December 21. The vesicles have completely disappeared. There remains a large red and brilliant surface, with here and there some small ulcerations that give rise to an insufferable itching. *Arsenicum*, 2d trit., twenty centigrammes. The limb to be enveloped with gummed silk.

December 29. The redness of the skin has considerably diminished, but the itching persists.

January 1. The limb is enveloped in rubber-cloth, and the same medicine is to be continued.

January 6. The condition of the leg is better. There is little pain; some crusts are forming, and the exudation continues. *Plumb. europ.*, 3d dil.*

* This remedy, the *plumbago europeans*, or leadroot, is not to be found in most of our works on the Materia Medica. Dr. Jessen says that it grows in the

January 12. Continue the same remedy. To stop the itching, the limb was bathed with the following solution: plumb. europ., one gramme; water, fifty grammes; glycerine, fifty grammes.

January 14. No improvement. The crusts are quite as numerous. The itching is still worse. *Rhus vernix* in the mother tincture, ten drops during the day, and the rubber-cloth to be kept upon the leg.

January 18. The redness of the leg is much less marked; the crusts begin to fall, leaving a reddish, brilliant surface; the itching has diminished. The same remedy.

January 23. The improvement continues. There is almost no exudation. Same medicine.

February 2. The itching is less severe. The leg presents only some red points, which are not the seat of any exudation. The same medicine.

February 6. *Sepia*, 1st trit., twenty centigrammes.

February 13. There is a slight extension of the inflammation upon the external surface of the leg. The same medicine was continued, and a local application, consisting of the following solution, was ordered: glycerine, 100 grammes; alcohol, twenty-five grammes; sepia, 1st trit., one gramme.

February 20. The inflammation has almost entirely disappeared. At certain points the skin has resumed its normal color. The same treatment, including the rubber-cloth about the limb, was continued.

February 25. The skin has recovered its elasticity and its usual color; it is still the seat of a very slight itching. The same medicine was taken up to the day of her discharge.

Treatment.—M. Bazin, who understands homœopathy, and who believes that the nature and species of the disease should serve as the principal basis for the choice of the remedy,

southern part of Europe and in South America. The fresh root is acrid and vesicatory. It stimulates the secretion of the salivary fluids, and is a popular remedy for the toothache. In large doses it is poisonous, causing symptoms that resemble cholera, hemoptysis, etc. Lebrech and Wittman have given it in very small doses in hemoptysis with benefit. It is a remedy that deserves to be studied, and we only wish that the author of these lectures had said more about it.—L.

teaches that there is one kind of treatment that is proper for herpetic eczema, another for the arthritic, and a third for the scrofulous variety. We are far from believing that the therapeutics of eczema is so simple a matter, and think that here, as in all other therapeutic questions, physicians should be guided in the choice of a remedy by the totality of the symptoms presented by the patient.

We have seen that a large number of medicines have the power to produce a true eczema upon the skin. It is by the use of these substances that we shall establish the treatment of this affection.

Rhus toxicodendron is one of the substances which produces in the healthy person the most exact symptoms of eczema. "The result of the absorption of emanations from the sumac takes place in a few hours, and sometimes only after several days. It consists in itching, swelling, redness, pains and pustules more or less vesicular upon the region which has been in contact with the vegetable particles, and even upon those parts in which there has been no contact, as upon the face, the scrotum, the eyelids, etc. The observations of Fontana, Gonon, Amouroux, Van Mons, and the experiments of Orfila, tend to prove that the most active principle of the rhus toxicodendron is that which is disengaged in the form of gas, when it does not receive the direct rays of the sun." (Cazin, *Des Plantes médicinales indigènes*, pp. 1033 et 1034.)

It is easy to find in the description of this independent author, who is not suspected of being a homœopathist, quite a faithful image of eczema in its inflammatory stage.

"The celebrated Fontana reports having touched at three different times, with an interval of several days, some leaves of the toxicodendron, from which he experienced certain troublesome symptoms. Four or five days later, the eyelids, the tips of the ears, and the face generally, became swollen,

and appeared as if filled with a watery fluid. *The spaces which separate the fingers became red, and covered with little vesicles that were filled with a transparent humor;* the epidermis fell in little scales, and there was a *terrible smarting for fifteen days*, with an *insufferable itching*, which continued fifteen days more; the pulse was very much excited." (Orfila, *Toxicologie*, page 133.)

Lavini, twenty-five days after the application of two drops of the juice of the rhus toxicodendron on the first phalanx of the finger, had the following symtoms: "A great heat in the mouth and in the fauces; rapidly increasing swelling of the left jaw, of the upper lip, and of the eyelids, the following night; great swelling of the forearms, which increased to double their natural size; skin leathery, with insufferable pruritus and great heat. Four days after there appeared upon the hands, and especially upon the forearm, *some pustules very much like those of the itch;* some of these pustules in breaking exuded a *limpid humor*, which by inoculation upon the forearm reproduced other pustules." (*Loc. cit.*, page 133.)

Now, these "*pustules*," which are so similar to those of the itch, and from which a limpid humor escapes, are *true vesicles.*

The rhus toxicodendron is, then, the homœopathic remedy *par excellence* for the eczema rubrum; and the more nearly this disease resembles erysipelas the better will be the indication for the rhus toxicodendron.

The vesicular eruption upon a red patch, with internal pruritus followed by pains in the thighs after the patient has scratched them, is the marked indication for the rhus toxicodendron, whether the eczema be dartrous or gouty. Agitation and a febrile state strengthen this indication.

The *rhus radicans*, which, according to Bosc, is only the rhus toxicodendron of an older growth, and the *rhus vernix*, have the same properties as the rhus toxicodendron. Dr. Cretin has contributed very decidedly to popularize the use of the rhus vernix in the treatment of eczema. He prescribes it in the mother tincture, in the dose of twenty drops during the day.

Cantharis, which, according to Dr. Richard Hughes, can produce pustules upon the skin by its dynamic action only, is a remedy that is very analogous to rhus. I always use it in the dartrous eczema during the inflammatory stage, and I have made numerous cures with it. I have prescribed this remedy in from the sixth to the twelfth dilution.

Arsenicum is also a remedy for eczema, as we learn from the following passage taken from Hahnemann: "Whitish, pointed pimples, containing a watery liquid at their summit, which come on with decided itching like the stinging of a gnat, on the hands, between the fingers, upon the lower abdomen; scratching causes the liquid to escape and the itching to cease." (Symptom 1046.) Burning, itching, and desquamation, are the other symptoms noted by Hahnemann. Imbert-Gourbeyre has published a monograph upon the arsenical eruptions, which I recommend you to consult, and which demonstrates the power of arsenic to cause eczema.

As for the effects of this medicine in eczema, we have only to refer to the practice of the old-school physicians everywhere to be assured that arsenic and arsenical waters are considered by them as a kind of specific for this disease.

The indications that lead us to prefer arsenicum to other remedies for eczema, are: its chronic nature, its period of dry desquamation, and the burning pruritus. It is, therefore, a remedy which we give after the rhus or cantharis.

Here is a case of *arthritic eczema* taken from my private case-book, in which arsenicum finished the cure which was begun by the cantharis and rhus vernix:

Case LXIII.—M. F——, a man of forty-eight years, of a very robust constitution, was seized within two years with a symmetrical eczema of both the ears. M. Bazin had diagnosticated the case as arthritic eczema, because the patient had been subject to headache and to hemorrhoids. The alkaline treatment did no good; a season at Royat produced an aggravation, and the patient consulted me on the 17th of October, 1873.

Both the ears were attacked, the right one more than the left; they are thick, very red, stiff and very humid; they resemble the surface of a blister. I prescribed *cantharis*, 12th dil., six globules in 200 grammes of water, two spoonfuls daily; and for the protection of the excoriated surfaces a liniment composed of ten grammes of water, one of glycerine and two drops of the tincture of cantharis.

October 25. He is a little better, but he made such complaint of the liniment that it has not been used except at long intervals. I prescribed powdered starch for the excoriated surfaces. *Cantharis*, 6th dil., two drops in 200 grammes of water, two spoonfuls daily.

November 4. The patient does not get on very well. Stop the liniment entirely, and give *mezereum*, 2d dil., twenty centigrammes in 200 grammes of water, two spoonfuls daily.

November 13. The mezereum has not succeeded. Resumed *cantharis*, 12th dil. and 30th dil., which was continued until January, 1874. The patient improved decidedly. The surface is dry, but the ears are thick and stiff. *Arsenicum*, 12th dil., to be taken as the cantharis. *Arsenicum*, 6th dil., and afterward in the 3d trit., was continued until the 16th of February, when, because the acute stage returned, *cantharis*, 12th dil. and 6th dil. were given again.

April 8. The *cantharis* constantly improved the acute stage of the disease, but without effecting a radical cure. I then prescribed *rhus vernix* in the mother tincture, four drops daily; *sulphur*, 12th dil., having been given without result.

The rhus vernix was continued all the summer, except during an interval of a fortnight, when *plumbago* was tried, without any benefit, and on the 15th of September the eczema presented no longer the fiery redness or the exudation, but had become perfectly dry. I then returned to *arsenicum*, 1st trit., twenty centigrammes in 200 grammes of water, two spoonfuls daily.

October 14. He has taken the arsenicum for a month, and is very much improved. Wishing to hasten the cure a little, I ordered thirty, instead of twenty, centigrammes of the first trituration. The patient experienced nausea, diarrhœa, thirst, and burning pains in the stomach, and I suspended the remedy.

October 28. *Arsenicum*, 30th dil., at intervals, until January, 1875, when the affection seemed to be cured.

During the winter the eczema returned, but in a very slight form. Arsenic., 1st trit., in the dose of five centigrammes, sufficed to arrest it. This man remained entirely well during the summer of 1875 and the winter of 1876.

In the monograph to which we have already referred, our neighbor, Dr. H. C. Jessen, has compiled a curious and suggestive table, showing the comparative frequency with which twenty of our most prominent writers on eczema have prescribed each of the fifty remedies mentioned by them. Rhus tox. and arsenicum were advised by all; sulphur, by nineteen; mercurius sol., by seventeen; graphites and sepia, by sixteen; dulcamara, calcarea carb. and clematis erecti, by fifteen, and so on through the list.—L.

My friend, Dr. Frédault, has called the attention of the profession to the employment of *plumbago* in the treatment of humid eczema, and that remedy has been somewhat successful; but the indications for it are not very definite.

According to Cazin, plumbago is a rubefacient and vesicant of a decided character. When used for the itch, it sometimes causes general eruptions, and a young girl who had tried it was, so to speak, skinned alive.

This brings us to speak of *mezereum*, *dulcamara* and *viola tricolor*, which are especially indicated in the eczema impetiginoides, so common among scrofulous persons. The same is also true of *sepia*.

Mezereum, daphne mezereum, has been studied by Hahnemann, but it was traditionally used in the treatment of scrofula, and its external employment was, and still is, very common for blistering purposes. According to Cazin, this is its effect upon the skin: "Its action is slow; it produces rubefaction only at the end of twenty-four hours, and vesication after forty-eight hours. It causes an *insupportable itching*, a papular eruption, and an inflammation around the part upon which it is applied. This wet exudation escaped twice daily, and abundantly, until eight or ten double compresses were saturated. The secretion is truly marvelous in its abundance. The surface which is attacked swells and forms a great many little outlets for the escape of the serum. One of the advantages of these issues is that the skin returns to its natural state without leaving cicatrices of any sort." (Cazin, *loc. cit.*, page 370.)

Hahnemann speaks of a pruritus which is aggravated by scratching and by taking off the clothes; and also of an eruption of pustules and of diffuse, itching pimples with desquamation over the whole body. (Chronic Diseases, Vol. II, page 563.)

The extreme abundance of the serous exudation caused by *mezereum* is also an indication for this remedy in the acute stage of the dartrous eczema.

Dulcamara.—Bertrand of Grenie, and Carrère of Gardes, extol this plant in the treatment of eczema, and Cazin reports the radical cure of a case of scrofulous eczema of the right leg by the internal use of a strong decoction of the twigs of the dulcamara.

This author cites only two symptoms as pathogenetic effects of the dulcamara which are related to eczema, *id est*, a tingling in different parts of the body, and sometimes a pruritus of the genital organs (*loc. cit.*, page 403).

In Hahnemann's Chronic Diseases we find principally the

symptoms of urticaria, with nightly aggravations; but the following symptoms may be related to eczema: herpetic crusts upon the whole body (356), exudative eruptions upon the cheek (94); and Hahnemann notes expressly the herpetic eruptions with glandular swelling (page 198). Jahr copies Hahnemann, and adds: "Eruption of itching pustules, which pass on to suppuration and become incrusted, especially upon the inferior extremities, upon the posterior part of the body."

It is easy to recognize in these pathogenetic signs the picture of the impetiginous eczema, which is proper to scrofulous subjects. In these cases we are accustomed to alternate the *dulcamara* with the *viola tricolor*, and to employ them in from the first to the third dilutions.

Viola tricolor.— This is also a traditional remedy against scrofula, the eczema impetiginoides of scrofulous subjects, and especially for that variety which is so frequently met with in infants, commonly called milk-crust. Strack, of Mayence, gave it in powder put into milk in cases of milk-crust. He pretends that at the end of four days, when taken by healthy persons, the *face becomes covered with thick crusts.* (Cazin, page 809.)

Jahr gives, as pathogenetic symptoms, miliary eruption all over the body, crusts upon the face, with burning itching, especially at night, and the exudation of a viscous yellow pus, with swelling of the glands of the neck.

Dr. Richard Hughes declares that he has never needed any other remedy for milk-crust, and that he has given it with success in the impetigo of adults. He uses the sixth dilution in the first case, and the first decimal for the latter.

But I repeat that my principal remedy for the impetiginous eczema of scrofulous persons is *dulcamara.*

Exceptionally this and other favorite remedies for milk-crust will fail, because of a slight syphilitic taint. In such cases we have had the best results from *mercurius jodatus* in the third decimal trituration.—L.

CASE LXIV.—*Eczema Impetiginoides.*—Miss Mary G——, aged sixteen, admitted on the 26th of December, 1875. This young girl, who has not yet menstruated regularly, seems to be endowed with a vigorous constitution, but she has a scrofulous appearance. For four or five years past she has been subject to herpetic eruptions, which continue for a month or two, disappear, and then return again at certain intervals. There are no hereditary antecedents. Her father was accidentally killed, and her mother is still living and in good health.

The affection of the skin, for which she is admitted into our wards, began about two months ago. It is located upon both sides of the head, upon the ears in the mastoid region, and extends for some distance upon the sides of the neck. There are very few vesicles; but the region occupied by the eczema is covered with thick yellow crusts, beneath which the skin looks as if it were injected.

The local symptoms are limited to a slight itching. The neighboring glands are swollen, but not painful.

The general condition of the patient is good. The menses have appeared for the first time, but they are not quite natural. *Plumbago europ.*, 3d dil., was prescribed.

December 27. No change in the local condition. *Rhus vernix*, mother tincture, 10 drops during the day.

January 6. *Rhus vernix*, 12 drops.

January 14. The patient seems a little better. The crusts are less numerous and not so thick. In a small part of the region occupied by the eruption the skin has resumed its natural color. *Rhus vernix*, 15 drops during the day.

January 21. The improvement of the last few days does not continue. The same remedy.

January 24. The rhus vernix having done no good, we decided to give *dulcamara*, 3d dil., 2 drops each day.

February 1. There is a very decided improvement to-day. The crusts, which had increased, are falling. The itching is less acute. *Dulcamara*, 2d dil., as before.

February 5. The eruption is stationary. *Viola tricolor*, 3d dil., two drops daily.

February 11. *Dulcamara*, 3d dil., was resumed.

February 17. Under the influence of the last remedy the

exudation upon the skin ceased; the skin is more supple and less dry. *Dulcamara*, 2d dil.

February 20. The marked improvement, which commenced some days ago, continues; there is no longer a new formation of crusts; the skin is less red and dry. *Dulcamara*, 1st dil., two drops daily.

February 23. The itching, which has persisted until now, has ceased; the glandular swellings have disappeared. *Dulcamara*, mother tincture, five drops during the day.

February 25. The same remedy.

February 28. The condition of the patient is very satisfactory; the skin recovers little by little its normal color and elasticity. The same remedy.

The treatment by dulcamara having been changed for another, the patient became worse. A month ago a new eruption of the impetigo appeared, which has yielded to *calcarea carbonica* in alternation with *orpiment*. The regular establishment of the menses seems to have finished the cure of this case.

Sepia is a remedy that belongs exclusively to our homœopathic literature. Its pathogenesy yields the following symptoms: *Pruritus, with vesicles upon a red base on all parts of the body,—face, eyelids, hands, feet, axillæ, the vulva, arms, ears and hairy scalp.* According to Dr. Cretin, sepia corresponds especially to the crusts, and to eczema complicated with lichen; but my own clinical experience leads me to conclude that it is particularly useful in scrofulous eczema.

Sulphur.—I very seldom prescribe this remedy in eczema proper, but reserve it for prurigo and for those affections which are apt to follow the suppression of an eruption.

Considering that the provings of *natrum muriaticum* are so rich in the symptoms of eczema, it is a little odd that its use is not more general in the treatment of this affection. One of the worst cases of eczema that we ever saw was in a lad of fourteen years, who was brought to the meeting of the Illinois Homœopathic Medical Association, in May, 1865, by the late Dr. M. D. Coe. Three years before the boy had contracted the habit of eating large quantities of common table salt, and there was no doubt that in his case the eruption, which was very extensive and severe, was due to this cause. I have seen two other cases that were milder in degree, but which evidently had their root in this same kind of a *pica* or false appetite.—L.

Shall I say something to you of the use of mineral waters in this affection? The practice of Bazin seems not to be very successful, for I often see his patients who have taken these waters upon his prescription but without any benefit. Gigot-Suard has made some very thorough experiments with a view to reach the especial indications for the Cauteret waters in eczema, but I cannot detail them in a clinical lecture, nor call your attention to a sufficient number of cases to make it worth your while to study them. It is enough to know that we may cure this disease without having recourse to mineral waters.

One word, in closing, upon the *external treatment* of eczema. Generally, I am entirely opposed to this treatment; and, after having tried for several years the practice of applying the same remedy locally that was being given internally, I have come to renounce it altogether — not as being harmful, but useless; but while it is useless and sometimes dangerous to treat eczema by topical applications, it also is sometimes well to resort to such local measures as will soothe the incidental suffering, although they are not curative. Baths of starch water, and simple poultices, allay the inflammation in the acute stage of eczema, soothe the patient, and are not harmful by reason of interfering with the internal treatment.

There are cases of eczema in which the too frequent bathing of the parts for the sake of cleanliness is very injurious. Water is sometimes almost poisonous, and should be kept away and the crusts allowed to dry and drop off.—L.

In some cases the pruritus causes a torture from which it is absolutely imperative to free the patient. The application of an impervious covering, either of caoutchouc, or of a similar tissue, has been of great service in our hands, and has procured for our patients the desired relief. This practice, borrowed from the Hospital Saint Louis, is entirely inoffensive, and does not in any way interfere with the action of our homœopathic remedies.

LECTURE XXIV.

SUMMARY.—Typhoid fever of a benign form, *case*. The ordinary form, *case*. The diagnosis of typhoid fever; prodroma; thermometric tracings in typhoid and inflammatory fevers, variola, pneumonia, and acute phthisis. Value of the thermic record; it gives a startling picture of the *ensemble* of the disease. The diagnostic value of these records, and their confirmation of the doctrine of critical days. Bilious and mucous fevers are nosological errors. The acute catarrh of the stomach is nothing more than the old theory of universal gastritis proposed by Broussais. The pretended gastric symptoms belong to stomatitis, an affection which is common to the most varied diseases. The ordinary form of typhoid fever prolonged, *case*. Importance of this form.

Typhoid Fever.

GENTLEMEN: Since the beginning of January we have had three cases of typhoid fever in our wards. The first was an example of the benign type, and was entirely cured by the fourteenth day of the disease; the second was of the common form, and reached the apyrexia on the twentieth day; and the third is a good illustration of the common form very much prolonged. This last patient had a decided remission of all the symptoms on the twenty-sixth day; on the thirtieth day the fever returned and continued until the fortieth day. We shall take advantage of these three cases to give you some practical rules concerning the diagnosis and treatment of typhoid fever.

In the first place, we will call your attention to the history of the young girl who was attacked with the *benign form* of this disease.

CASE LXV.—This young girl, of very good health formerly, had lived in Paris but two months. She took her bed on the 31st of December, but for ten days previous had had the prodroma of her disease, *id est*, anorexia, bleeding from the nose,

a general malaise, extreme lassitude and a pain in the posterior cervical region. These symptoms anticipated the benign type of typhoid fever with which she has been seized.

To-day there is a moderate degree of prostration. She complains of a severe headache, especially in the frontal region, of vertigo and of singing noises in the ears.

The mind is almost intact, the ideas being only slightly confused. The hearing is considerably diminished. There is complete anorexia. The tongue is covered with a light and whitish coating in the middle, but the tip and borders are red.

The patient has no diarrhœa; the abdomen is distended and very sensitive, and we can very readily detect a gurgling in the right iliac fossa.

Muriatic acid, 3d dil., was prescribed, of which three drops were to be put in 200 grammes of water, one teaspoonful to be taken every three hours during the day, and *belladonna*, 3d dil., in the same manner during the night. The diet to be strict.

January 5, seventh day. The night has been somewhat disturbed. She has had a slight delirium. On the skin of the abdomen there are some red lenticular spots, which disappear under pressure by the finger. The same treatment. The morning temp. 101.3°, pulse 96; evening temp. 102.9°, pulse 112.

January 6, eighth day. The patient has been more tranquil than during the previous night. The spots are more numerous than they were yesterday. By auscultation of the lungs we find only sibilant râles, which are very numerous. The same treatment. The morning temp. 101.8°, pulse 96; evening temp. 102.9°, pulse 104.

January 7, ninth day. The patient had some diarrhœa this morning. The headache has entirely disappeared. The pulse is strong and dicrotous. The same treatment. Morning temp. 100.4°, pulse 88; evening temp. 101.8°, pulse 100.

January 8, tenth day. The general state of the patient is very good. She answers questions which are addressed to her, and is not nearly as deaf as she has been before. The same treatment, with the addition of some porridge. Morning temp. 99.7°, pulse 96; evening temp. 101.1°, pulse 96.

January 9, eleventh day. There is complete anorexia this morning; the thermometer indicates only 97.5°, the pulse is 84; evening temp. 101.1°, pulse 96.

January 10, twelfth day. She continues to improve; the appetite has returned. Morning temp. 99°, pulse 88; evening temp. 102.2°, pulse 100. The same treatment, including the porridge.

January 11, thirteenth day. Morning temp. 99.1°, pulse 84; evening temp. 98.6°, pulse 96. *China*, 6th dil.

January 12, fourteenth day. The fever is entirely broken; the tongue is moist and quite clean. *China*, 6th dil.

January 13. The patient continues to improve. The china was continued until January 23, when she left, after having been in the hospital about twenty days. A remarkable production of head-lice coincided with this cure.

We come now to our second case, which is one of *typhoid fever of the common type.*

Case LXVI.—B——, aged twenty-five, was admitted on the 12th of January, and discharged on the 14th of February. (Men's ward, No. 4.)

This young man has complained since the 1st of January of a general malaise, extreme lassitude, and headache with loss of appetite. These were the symptoms which he had prior to the 7th of January, when he was forced to take to his bed.

Three or four days ago he had a severe chill, and several times during the day, yesterday, he had slight attacks of nose-bleed.

To-day he complains of a violent headache, but has no pain in the abdomen; the appetite is entirely gone; the tongue is white in the middle and red at the tip and borders.

January 12, sixth day. In the evening the thermometer marked 101.8°, and the pulse 104. *Muriatic acid*, 3d dil., three drops during the day; broth.

January 13, seventh day. Morning temp. 101.1°, pulse 96; evening temp. 101.8°, pulse 96; the night has been quite calm; this morning some rose-colored lenticular spots, which disappear on pressure by the finger, were observed upon the surface of the abdomen. The same treatment.

January 14, eighth day. Morning temp. 101.5°, pulse 80; evening temp. 103.6°, pulse 96. He was slightly agitated during the night; the general condition, however, is good; he has had some fits of coughing, but auscultation reveals nothing abnormal. The same treatment.

January 15, ninth day. Morning temp. 101.8, pulse 84; evening temp. 103.6°, pulse 96. The patient complains very much of headache. *Muriatic acid*, 3d dil., and *belladonna*, 3d dil., alternately.

January 16, tenth day. Morning temp. 101.5°, pulse 84; evening temp. 102.5°, pulse 100. The patient declares himself decidedly better.

January 17, eleventh day. Morning temp. 101.5°, pulse 96; evening temp. 103.3°, pulse 96. He has some diarrhœa; the abdomen is sunken and slightly painful to pressure. The same treatment.

January 18, twelfth day. Morning temp. 100.4°, pulse 84; evening temp. 101.5°, pulse 84. The diarrhœa continues, there is some stupor, and the patient responds with difficulty to questions which are put to him. The same treatment.

January 19, thirteenth day. Morning temp. 100.4°, pulse 84; evening temp. 102.2°, pulse 88. Same treatment.

January 20, fourteenth day. Morning temp. 99.7°, pulse 84; evening temp. 102.2°, pulse 92. The diarrhœa has diminished somewhat; the stools are liquid and of a fœtid odor. The same treatment; porridge.

January 21, fifteenth day. Morning temp. 99.7°, pulse 68; evening temp. 102.5°, pulse 84. This morning the patient had a slight epistaxis. On account of a slight fever, of the remittent type, which he has had for two days, he was given *china*, 6th dil., two drops during the day.

January 22, sixteenth day. Morning temp. 99.7°, pulse 68; evening temp. 102.4°, pulse 84. The diarrhœa has almost entirely ceased; the general condition of the patient is good. The same treatment.

January 23, seventeenth day. Morning temp. 99.5°, pulse 68; evening temp. 101.8°, pulse 88. The evening paroxysm persisting despite the *china*, I gave *chininum sulph.*, 1st trit., twenty centigrammes, during the day. He was also allowed an egg.

January 24, eighteenth day. Morning temp. 99°, pulse 68; evening temp. 100.4°, pulse 88. The fever continues to subside daily, and the patient begins to have a little appetite. The same treatment, with a little meat.

January 26, twentieth day. The evening paroxysm has disappeared; medication was suspended, and the patient was allowed to eat some porridge and an egg.

January 30. He continues to improve, but still has a little headache. *Belladonna*, 30th dil., twice daily.

February 5. The belladonna has cured the headache. The patient gained his strength rapidly, and left on the 14th of the month.

A physician, belonging at that time to the hospital service, had decided that this was a case of *gastric catarrh*. Some of you questioned the correctness of the diagnosis when it was said that the young girl who convalesced on the fourteenth day had typhoid fever; and on that occasion something was said of *mucous fever*. It is, therefore, important that I should tell you upon what signs I based my diagnosis of typhoid fever in these two cases; and also that I should once more speak of certain names and titles of disease which have no scientific value. *Mucous*, *gastric* and *bilious* fevers and *gastric catarrh* are names which frequently cover up but do not conceal an indifferent diagnosis.

Formerly the differential diagnosis of typhoid fever at its onset was chiefly based upon the existence of prodromata that were lacking in other continued and eruptive fevers which resembled it, and also in the ephemeral and inflammatory fevers and in variola. The malaise, the headache, the sadness, the diminution of strength and of spirits, a troubled sleep, loss of appetite, and especially epistaxis and a tendency to diarrhœa, are the symptoms which, continuing for from eight days to a fortnight, constitute the prodroma of typhoid fever. Now the ephemeral and inflammatory fevers and variola have

only the most insignificant premonitory symptoms, for the fever usually begins abruptly.

The brusque onset which is almost always wanting in typhoid fever is, therefore, a good differential sign. The condition of the skin, the stomatitis, with a tongue which is whitish in the middle and red at the tip, were symptoms that we have sought for carefully, and of which we have taken the precise signification in difficult cases.

But, we must say, emphatically, that where the prodroma were absent, *id est*, in serious cases, the diagnosis in the beginning was often very difficult.

Only a few years ago it was really very embarrassing, in many cases of this fever, not to be able to make a certain diagnosis for the first week or two. When we were in college a venerated professor told us that the best way of recognizing it was to give the patient a moderate cathartic, and if it operated excessively, the case was almost certain to be one of typhoid fever.—L.

At the present day the diagnosis of typhoid fever is stamped by the thermometer with a mathematical certainty. The exact record of the temperature gives us such a correct idea of the febrile movement that we can recognize, without difficulty and without the possibility of error, the most delicate shades of this affection; and you are aware that it is upon these shadings that our differential diagnosis must always depend. Without doubt, we have known for a long time that the febrile action was more brusque in its onset, and that it reached more promptly its maximum of intensity in inflammatory fever and in variola than in typhoid fever; but whilst the frequency of the pulse has been our only measure of the fever, the differences in the course of this affection were not always perfectly recognizable, and consequently the differential diagnosis was wanting in certainty. Observations with the thermometer have taught us the exact character of the febrile heat in the different fevers, and for the purposes of differential diagnosis these qualities may be stated in the two following propo-

sitions: in inflammatory fevers, variola, and pneumonia, the highest degree of temperature, say 104°, at the least, is reached by a continuous ascension during the first days. But in typhoid fever that degree is attained only after the fourth day, and by an ascent which is composed of a morning remission and an evening exacerbation.

Thus you will observe that an ascension which is abrupt, rapid, without very decided morning and evening alternations, characterizes the febrile movement of an inflammatory fever, of variola and of pneumonia. A progressive ascension, in which the heat of each morning is above that of the preceding morning, but below that of the preceding evening, so that the curve represents a stairway, is proper to typhoid fever. It is, therefore, easy when we have the thermic tracings of the onset of the disease to make the differential diagnosis between typhoid fever, variola and pneumonia.

There is one other disease with which typhoid fever is very easily confounded, and that is acute phthisis. In this disease the thermic record will not settle the question of its symptomatology, because the fever of acute phthisis has a remittent type.

To conclude, the typhoid fever is the only disease in which the thermic chart shows a period of regular ascent during from four to five days; followed by a period of regular oscillation, which varies from nine to twenty days, and which terminates by a descending oscillation of several days more. The thermic chart will, therefore, suffice completely in the diagnosis of typhoid fever.

This is very plain and very true; for excepting in case of internal hemorrhage, and of the various puerperal diseases, there are no affections in which the value of the clinical thermometer as an aid in diagnosis is better illustrated

than in typhoid fever. Its application to the study and treatment of this fever alone marks an era in practical medicine.—L.*

We should remark, gentlemen, that modern researches upon the temperature of fevers, and the tracings by which they are expressed, have the great advantage of embodying, and of presenting in an image which is perfectly recognizable, the characters and the totality of the febrile movement, so that a glance upon the chart permits the mind to seize instantly the nature, the different complications, the gravity and the duration of the disease.

The author has overlooked a peculiar advantage to be derived from clinical thermometry in this and in other forms of disease. Not only is this mode of recording our cases, so far as it goes, more accurate than any other, and therefore an indispensable and invaluable aid to clinical experience, but it offers a means of reference to cases that we have had, and that others have had, in former years and elsewhere, as a guide and a study in the future. A collection of such records in typhoid fever would furnish a safeguard against the mischief of trusting to memory, or even to the old-fashioned written reports, when we come to refer to our experience in its treatment.—L.

Another advantage of these thermometric studies is, that they permit us to make such clear and precise distinctions between the fevers which belong to similar diseases. Thus it is, for example, with the fever which is proper to a local inflammation, with that which belongs to the typhoid fever, and with that which accompanies small-pox. General pathology is therefore right in teaching us that these symptoms receive a peculiar character from the diseases upon which they are secondary; and this grand law, upon which all symptomatology rests, is singularly confirmed by modern studies in clinical thermometry.

This study of heat in fevers gives an unexpected confirmation of the old doctrine of critical days.

* See an essay on the *Temperature and the Pulse in Puerperality; being an analysis of Fifty Cases treated in the Puerperal Wards of the Hahnemann Hospital*, of Chicago, by R. LUDLAM, M.D., etc., in the Transactions of the American Institute of Homœopathy, for 1878, p. 489.

According to the tradition which is the most accredited, the critical days are the 4th, 7th, 11th, 14th, 17th and the 20th day, or the 21st, according to some authors. You will observe that these days happen sometimes in the middle, sometimes at the end, of each week. Now, the reading of a large number of thermic charts will prove to you that the *defervescence*, as the modern barbarians style it, occurs usually on the 4th or the 7th day in pneumonia; that the chief modifications of temperature in typhoid fever have almost always occurred on critical days.

Jaccoud says that "the chief thermic modifications which mark the passage from one period to the other correspond to the middle or to the end of a week, the time being counted from the first day of the disease. This singular coincidence is a rule which is very rarely broken." (*Clinique*, page 584.)

By the use of clinical thermometry in typhoid fever we are also notified of accidental complications, such, for example, as hemorrhage from the bowels, peritonitis, perforation of the bowels, meningitis, the formation of abscesses, etc. The reader will find a very interesting and thorough exposition of this subject, most carefully and beautifully illustrated, in Vol. II of LORAIN'S great work, *De la Température du corps humain et de ses variations dans les diverses maladies*, Paris, 1877.—L.

Are not the middle and the end of the week precisely the critical days, and why should we call this coincidence "singular," or be astonished at it? Experience has shown that diseases have definite conditions, which are characterized by a totality of symptoms and of determinate lesions, and that they are subject to a proper evolution. If each disease has its own evolution, wherefore should we be astonished that its course has a certain regularity, for it is, the contrary that would be "singular."

Our second patient, B——, came to us during the remission at the end of the first week with a temperature of 102°; the first half of the second week was marked by an aggravation, 103.3°; the second remission was in the middle of the

second week, 100.4°; there was a new aggravation at the end of the second week, and at the middle of the third, 102.6°; then a final remission in the middle of the third week, or the seventeenth day of the disease.

The young girl, who was attacked with the benign form of the fever, was admitted during the aggravation at the commencement of the second week (103°); there was a remission on the 10th and 11th days, an aggravation on the 12th, and decided convalescence on the 14th day. The gradually ascending course of the febrile curve, and the duration of the prodramata, made it impossible to mistake the typhoid fever in these two cases; and the accuracy of the diagnosis was confirmed by the appearance of the lenticular spots.

The exceptionally short duration of fourteen days in typhoid fever is a fact admitted by all authors, but we believe that we have much more frequently observed it since we adopted the homœopathic treatment. It is certain that this duration is very short; but, whilst it may last fourteen, and, sometimes, only eleven, days in the benign form of this fever, nevertheless the essential peculiarity of this type is the moderate intensity of the fever and not its period of duration, for we have often seen cases of this kind that required three weeks for their development.

These are the cases of abortive typhoid which, with the synocha, comprise the mucous and bilious fevers of the *vulgum pecus* who abound in the lower ranks of the profession. Practitioners who have forgotten the little they learned at college, where they were victimized by the necessity of preparing for their examinations, instead of learning their true import, are too ready to pick up the commonplace title instead of making a careful diagnosis, and will not readily abandon such vague and unscientific terms as *bilious fever* and *mu-*

cous fever. In this manner these unfortunate phrases are becoming more and more common. There is no such thing as *mucous* fever. There are only three continued fevers (at least in Paris), the *ephemeral*, the *synochal* and the *typhoid* fevers. Before any other continued fever can be added to this nosological group, its existence must be actually demonstrated; and where are the observations, where the descriptions, where the researches in symtomatology which establish the mucous fever as a distinct species, and which settle the differential diagnosis between this disease and the snyochal and typhoid fevers? Such records do not exist, and it is, therefore, useless to encumber our literature with expressions that are improper, and which only serve to deceive and mislead.

I know that the opponents of the doctrine of fever, as it was held by the French physicians in the first half of the present century, included in their ranks some who were more influential than those who talk in our day of mucous fever. They taught that the synocha, cases which we style abortive typhoid fever, and ephemeral fevers, should be classed with catarrhal inflammation of the stomach, and that they are examples of acute gastric catarrh. These followers of Broussais have tried to found their opinion on certain gastric symptoms which are almost always present in the continued fevers. The redness and the coating of the tongue, *id est*, the stomatitis, the anorexia, the nausea, the vomiting, the pain at the pit of the stomach, the sub-icteric hue of the naso-labial groove, constitute so many signs of the lesion of the digestive organs, and should be considered a certain proof of a catarrhal inflammation of the stomach, whence the conclusion that the synochal and ephemeral fevers are forms of gastric catarrh.

We have given, in all their force, the arguments of our opponents: let us see what they are worth.

The symptoms upon which the theory of gastric catarrh is founded are common to all fevers; and typhoid fever, especially, shows them in a very marked degree.

The stomatitis, with coating of the gums and the tongue, exists in the eruptive fevers, and even in the intermittent fevers, and vomiting is a frequent symptom at their onset. Shall we say, therefore, that the typhoid, eruptive and intermittent fevers are only attacks of acute catarrh of the stomach? Let us be cautious, for we shall find the same symptoms of stomatitis and of gastric distress, and in a high degree, in angina, in pneumonia, in erysipelas, and, in a word, in all febrile affections. Shall we say that all these diseases originated in acute catarrh of the stomach? Why should we oppose the doctrine of Broussais, if we are going to recognize once more a universal gastritis?

I will add that these conditions of the mouth and tongue, the *saburral* state of the ancients, which M. Davasse has so well described, and which he has properly referred to an inflammation of the mucous membrane of the tongue and of the gums, are so slightly related to a gastritis that an inflammation developed by a carious tooth, or by a burn, may cause them, and that the least inflammation of the tonsils is accompanied by a very decided coating of the tongue.

This is actually true, for these coatings of the tongue, far from representing a bilious condition, or a saburral or gastric state, are produced by an inflammation of the mucous membrane of the tongue, and by the epithelial desquamation which necessarily follows it. This dead epithelium imbibes something from all the liquids which pass the mouth, and shows the most varied colors, from white to brown through all the shades of yellow, and it is necessary to be thoroughly incrusted with

the doctrines of Galen in order to find in this yellow color the proof of a bilious affection, and to take the tongue as the mirror of the stomach.

Thus, on the one side, all the febrile diseases present the symptoms upon which it has been attempted to found the existence of an acute catarrh of the stomach; on the other, the coatings of the tongue prove only one thing, viz: that the inflammation is in the mouth and not in the stomach. The first argument shows the fallacy of the theory of acute gastric catarrh; in fact, it is absurd to maintain that diseases which are so different are all due to gastritis. The second argument upsets the basis of the theory by proving that the pretended gastric symptoms are only buccal and not gastric. Let us therefore return, unequivocally, to the adoption of a system of fevers which is an honor to French medicine, while at the same time it is a model of clearness and precision.

The author's emphasis commends his argument. If any set of physicians should be interested in accurate diagnosis, it is the members of our school of practice. An intelligent prescription presupposes and necessitates, so far as possible, an intelligent idea of the case in point. A loose and shambling diagnosis cannot ripen into a trustworthy clinical experience. There was a time when our patients would rely upon us to carry almost any kind of a case to a successful issue without asking what the disease really was, and in what it differed from something else; but that day has passed, and general terms, like those which Dr. Jousset criticises, will not always satisfy them (nor should they) that we know just what we are about.—L.

Here we have a case of ordinary typhoid fever *of a very prolonged type:*

Case LXVII.—M. Rodou, aged fifteen years, was admitted to No. 4 of the men's ward on the 31st of January, and discharged on the 30th of March.

This young man has usually had very good health, and has never been out of Paris.

On the 24th of January he was taken with a very severe headache, a general malaise, and a weakness in all the limbs;

but he continued to work until the 27th, when he took to his bed. From that time he had noises in the ears and some diarrhœa, but no epistaxis. The diarrhœa continues; there is complete anorexia; the tongue is covered with a whitish coat, and red at the margins; pressure in the right iliac fossa does not provoke pain; there are no spots upon the abdomen, but auscultation detects some sibilant râles in the thorax.

The diagnosis was not doubtful, and we gave *muriatic acid*, 3d dil., three drops in 200 grammes of water, one tablespoonful every three hours during the day, and *belladonna*, 3d dil., in the same manner for the night. A plain diet was also ordered.

January 31, fifth day. Evening temp. 102.2°, pulse 100. The same treatment.

February 1, sixth day. Morning temp. 103°, pulse 104. The night has not been very much disturbed; this morning the prostration of strength is very marked. Evening temp. 104.7°, pulse 108. The same treatment; broth.

February 2, seventh day. Morning temp. 103.3°, pulse, 100. The diarrhœa persists; the stools are watery and of a putrid odor. Evening temp. 104°, pulse 104. The same treatment.

February 3, eighth day. Morning temp. 102.5°, pulse 96. There was a slight delirium during the night; the general condition, however, is pretty good. Evening temp. 104°, pulse 104. The same treatment.

February 4, ninth day. Morning temp. 103°, pulse 96. Some rose-colored, lenticular spots are seen upon the abdomen. Evening temp. 103.3°, pulse 104. The same treatment.

February 5, tenth day. Morning temp. 100.2°, pulse 96. He has had some fits of coughing; there are sibilant râles all over the chest. Evening temp. 103.3°, pulse 104. The same treatment.

February 6, eleventh day. Morning temp. 102.2°, pulse 96. The diarrhœa has considerably diminished, and the tongue looks better. Evening temp. 103.6°, pulse 104. The same treatment.

February 7, twelfth day. Morning temp. 102.2°, pulse 100; evening temp. 103.3°, pulse 104. The same treatment.

February 8, thirteenth day. Morning temp. 100.4°, pulse

92. The patient is doing well; the diarrhœa has ceased, and the appetite returned. Evening temp. 102.5°, pulse 100. The same treatment.

February 9, fourteenth day. Morning temp. 100.8°, pulse 84; evening temp. 101.5°, pulse 83. The fever having very much diminished, he was permitted to have some soup.

February 10, fifteenth day. The improvement continues, and an egg is allowed him. Morning temp. 100.4°, pulse 84; evening temp. 101.8°, pulse 92. The same treatment.

February 11, sixteenth day. Morning temp. 100.4°, pulse 92; evening temp. 102.5°, pulse 100. Another egg.

February 12, seventeenth day. Morning temp. 99°, pulse 92; evening temp. 102.2°, pulse 100. The same treatment.

February 13, eighteenth day. Morning temp. 98.6°, pulse 92; evening temp. 101.8°, pulse 100. The fever having become intermittent, twenty centigrammes of *chininum sulph.*, 3d trit., was prescribed.

February 14, nineteenth day. Morning temp. 97.8°, pulse 84; evening temp. 101.5°, pulse 88. *Chininum sulph.*, 1st trit.

February 15, twentieth day. Morning temp. 97.8°, pulse 76; evening temp. 101°, pulse 88. The fever has diminished; the patient is gaining strength; he is to have a little meat, with the same treatment.

February 16, twenty-first day. Morning temp. 98.25°, pulse 80; evening temp. 100.75°, pulse 62.

February 17, twenty-second day. Morning temp. 98.25°, pulse 72; evening temp. 100.5°, pulse 88. The temperature is almost normal, and the general condition is excellent. All medication was suspended.

February 20, twenty-fifth day. The patient has a little diarrhœa. *Phosphoric acid*, 3d dil.

Although the patient had no fever for six days, it returned on the 23d of February.

February 24, twenty-ninth day. Last evening he had a very intense fever. Through deceiving the nurse he had gratified his appetite by eating some cakes which had been brought to him. Morning temp. 103.6°, pulse 108; evening temp. 104.75°, pulse 112. *Arsenicum*, 6th dil., two drops in 200

grammes of water, a tablespoonful every three hours, with a strict diet.

February 25, thirtieth day. His general condition is very bad; there is considerable prostration, with complete anorexia. Morning temp. 103.25°, pulse 108; evening temp. 104.75°, pulse 112. The same remedy.

February 26, thirty-first day. Morning temp. 103°, pulse 112; evening temp. 104.5°, pulse 108. The patient is no better, but has all the signs of a relapse. There is stupor and diarrhœa, with gurgling in the right iliac fossa. *Muriatic acid*, 3d dil., and *belladonna*, 3d dil., to be given as they were in the onset.

February 27, thirty-second day. A new eruption of the lenticular spots has appeared upon the abdomen. The same remedy.

March 1, thirty-third day. The patient is very ill to-day, and has been delirious all night. *Arsen. metal*, 3d trit., and *rhus tox.*, 3d dil.

March 3, thirty-fifth day. The general condition is better, and the diarrhœa has ceased. The same treatment.

March 7, thirty-ninth day. The improvement continues; the tongue, which was dry and rough, is becoming moist. The same treatment.

March 9, forty-first day. The patient is fully convalescent.

Now, gentlemen, we are happy in having had the opportunity of illustrating the protracted form of ordinary typhoid fever. This form, which is still too frequent, exposes the patient to the risk of deceiving even the most experienced physician. It is necessary to distinguish it with care from cases of the ordinary type, in which the fever continues long after the third week, because of the development of an enteritis, of a broncho-pneumonia, or of some other affection that may be consecutive upon the typhoid fever. When the common form of this disease is really prolonged, it is characterized by the fact that the disease begins its course the second time; the lenticular spots often reappear; and certainly the intestinal affection recommences and runs anew through all its stages.

LECTURE XXV.

SUMMARY.—Typhoid fever, *continued;* the different varieties of; clinical importance of this subject; necessity of a careful diagnosis of the forms of this fever, even for the homœopathic physician; treatment; indications for *belladonna* and for the *muriatic* and *phosphoric* acids, *arsenicum*, *ipecac.* and *baptisia*. These fevers never cut themselves short; *regimen*. Dr. Small's experience. The meningo-encephalitis of typhoid fever.

Typhoid Fever — (Continued).

GENTLEMEN: I cannot permit this occasion to pass without insisting upon the clinical importance of recognizing the different forms of typhoid fever. In our *Eléments de médecine pratique* (Vol. I, page 220) we have recognized three forms of typhoid fever: the *benign* form (latent, abortive); the *common* form, which includes three varieties, viz: the *common* form, properly so called; the common form *prolonged*; and the common *putrid*. You have seen in this clinic cases of the first two varieties. The putrid form of typhoid fever is frequent in certain epidemics. It is characterized by a considerable febrile heat, an early prostration and stupor — which are more intense than in the other kinds — and by a tendency to gangrene and to hemorrhages. This is the putrid fever of the ancients, and the *adynamic* of Pinel. Finally, the third form of typhoid fever is that which is malignant, and of which there are three types, viz: the *foudroyante*, or the *ataxic*, of many authors; the *hemorrhagic*, or the petechial; and the *slow nervous* form, which was described by Huxham.

There is a great difference between this classification proposed by the organic pathologists and that of the modern humoralists. The former have divided typhoid fever into

three kinds, according to the predominance of certain cerebral, pulmonary, or abdominal affections; and hence they speak of cerebral, pulmonary and abdominal typhoids. Now, typhoid fever, in most cases, is either successively or at the same time cerebral, abdominal and pulmonary. We cannot, therefore, accept as a principle for the classification of the forms of a disease, a basis which is so variable as the predominance of either of these affections in typhoid fever.

Concerning the spurious divisions that have been made, sometimes by the humoralists, sometimes by the solidists, of the last century, being purely hypothetical, they are very imperfect. Let us take, for example, the best authenticated among the authors who accept this classification. Chomel admits five forms of typhoid fever,—the inflammatory, the bilious, the mucous, the nervous, and the ataxic, or the adynamic. Valleix made a very just criticism of this classification in his *Traité de Pathologie:* "The first form is the *inflammatory typhoid* fever. It exists *especially at the onset*, and is characterized by the fullness and frequency of the pulse. Who cannot see that a type of fever which shows itself only at the beginning is something very odd? The disease could therefore have all the forms: at the onset, inflammatory; later, bilious; still later, nervous; and finally, adynamic. It is evident that such distinctions are of no account.

"But, more than this, even when the patients have the symptoms that I have indicated, are they not decidedly enfeebled? There is, therefore, adynamia; but have they not also vertigo, agitation, and troublesome dreams? There must be ataxia, therefore. Have they not also a coated mouth and tongue, nausea, and sometimes vomiting? These are bilious symptoms.

"I could in this manner review all the conditions which have been specified as characteristic of these different types, and I would always find that the symptoms of typhoid fever are

united in them to a degree which is more or less pronounced, and that if, at the first, some of them appear to be masked by others, a slight examination will soon discover them." (Valleix, *Guide du Médecin Practicien*, t. I, page 33.)

I have left it for Valleix, the friend of Chomel, to criticise his classification of the forms of typhoid fever in as severe a manner as it could be done; for it is always best, when such a thing is possible, to *leave the dead to bury their dead!*

This is very sharp, especially when we who follow get the benefit of the debate between two such men as Chomel and Valleix. There is force in what the former has written; and the latter has contributed something to our knowledge of typhoid fever while castigating his friend. It is very unfortunate that medical controversy is not always so fruitful of good.—L.

Let us now recall, in a few words, what we have taught in our treatise on general pathology, that the varieties of disease are constituted by a totality of symptoms and of lesions, which form states and conditions that are absolutely distinct from each other, from the commencement to the end of the disease, and that these forms cannot be changed into each other any more than the different morbid species can be so changed. For example: the benign variola can never become malignant, the discrete variola never becomes confluent; whence we conclude that the classifications of typhoid fever, which have been made in despite of these conditions, are not satisfactory.

The clinical advantages that result from a natural division of the forms of typhoid fever pertain chiefly to its prognosis and its therapeutics.

It is not difficult to understand the prognosis in the benign form, and also that of the common malignant form; or to know that the chronic type, or the slow nervous form, will have a longer duration than the other forms, and that, in the ataxic variety, death may happen in a few days.

But the importance of a proper classification of these types

is not less evident in the special therapeutics of typhoid fever. Indeed, it is to the confusion of these forms that we owe the conflicting statistics and the consequent uncertainty with regard to the different methods of treating this disease. We understand that, whatever remedies are given, the results will always be favorable or unfavorable, according to the series operated upon, and whether they contain a greater or less number of the milder or more serious cases. It is the absence of this distinction of forms which explains the temporary success of the anti-phlogistic treatment as a substitute for that which is tonic. It is also to this imperfect classification that we must attribute the popularity of Brand's system of treatment, which was said always to cure the typhoid fever, but which was afterward rejected, because, besides the difficulty of its application, it very often failed to effect a cure.

The homœopathic physicians would be wrong to conclude that they might dispense with searching for, and studying out, the forms of this disease, because their method of treatment, based upon the state of the patient under treatment, renders it unnecessary to occupy their minds with the type of the disease in order to find the best indicated remedy.

We have often referred, and especially in Lecture X, to the necessity of the diagnosis of the morbid species for a correct and satisfactory idea of the indications furnished by the totality of the symptoms; and we have given the details of an unfortunate blunder in the choice of remedies in pneumonia, where the error was entirely due to the absence of diagnosis. It is, therefore, unnecessary further to insist upon the importance of diagnosticating the *form* of a disease, which is only a final analysis of it, or a more precise diagnosis of the particular case in point.

These observations are very practical. The intelligent traveler in a civilized country could not very well dispense with a study of its geographical peculiari-

ties, or the astronomer with the observations and the calculations that have been made and recorded in his department; nor can the doctor get on very far without access to the maps and charts and the clinical experience of his professional brethren.

But, in order that our experience may serve as a guide for ourselves and for those who shall come after us, it should be reported and recorded with the greatest care and discrimination. The apparent conflict in the experience of physicians in the treatment of typhoid fever, and of many other diseases, would soon cease if they were always careful to note the peculiar phase and type of the affection, the form that it assumed under different circumstances, and all the hygienic conditions that multiply or modify the chances of recovery, with or without treatment.

For there are doubtless many cases of typhoid fever that would get well without any medicine whatever; but it is equally certain that many other cases of the more serious type of the disease would not recover if left to themselves. It is not fair or just, therefore, that physicians should report their success in an indiscriminate manner; for in that case their conclusions would mislead others, and their aggregated experience would not satisfy anybody.

Yet this is exactly what has been done in the therapeutics of typhoid fever; and there is no better evidence of the fact than we find in the long list of remedies that have been advised in its treatment. It is a wretched compromise, and not a compensation, to have a hundred remedies thrust upon our notice when ten or twenty would answer the purpose, if we always had a clear idea of what we were trying to do, and of what others had already accomplished.—L.

Treatment.—In closing this lecture I desire to call your attention to some peculiarities in the treatment of typhoid fever.

Muriatic acid, 3d dil., and *belladonna*, 3d dil., given alternately, the former during the day and the latter at night, constitute, according to Teste, the best treatment for this fever. Clinical experience has very often confirmed its value, and whenever the typhoid fever occurs with the usual brain and abdominal symptoms, it will be sufficient. But I must warn you against falling into a routine treatment which may be adopted in advance, and which is thought to be suited to all cases alike. We must search carefully in order to learn where phosphoric acid may take the place of muriatic acid, and in what class of cases both these remedies may be substituted by arsenicum. It is hardly necessary to add that, in those cases in which the cerebral symptoms have passed away, the belladonna need not be given any longer.

Muriatic acid is indicated by a greenish, frequent diarrhœa, which is sometimes involuntary; by gurgling and the development of a great deal of gas; by stomatitis, with swelling of the gums and extreme dryness of the mouth, and also by great adynamia.

In typhoid fever occurring in *puerperal subjects* we have found the muriatic acid to be worthy of the greatest confidence. In addition to the symptoms above noted, it has done us good service where there was a great deal of rumbling, with a feeling of emptiness in the abdomen; sticking pains in the iliac, inguinal and ovarian regions; diarrhœa, with burning or bleeding at the anus; chilliness and coldness of the extremities; a colliquative perspiration; an aphthous condition of the mouth and the tongue; watery stools, with muttering and unconsciousness, even while awake; great prostration and threatened paralysis, and a disposition to slide down in the bed.—L.

Phosphoric acid, the indications for which in typhoid fever are not given by Hughes, is a remedy which is quite as important as the muriatic acid. The symptoms of a case of poisoning by phosphorus are very similar to those of typhoid fever, and the action of phosphoric acid is very analogous to that of phosphorus. The involuntary stools, which are of a pale rather than of a deep green color; the involuntary urination, the tympanitis, and the very marked debility, are the principal symptoms which indicate the phosphoric acid.

The almost colorless stools, the palor of the face, or paleness of one cheek while the other is red; the hemorrhagic tendency, with epistaxis, bleeding of the gums, hemorrhage from the bowels, or petechiæ, would cause us to select phosphoric acid in preference to muriatic acid.

The alternation of *bryonia* and *rhus tox.* is a kind of traditional prescription in typhoid fever, like that of phosphorus and bryonia in pneumonia, of ipecac. and china in uterine hemorrhage, of nux vomica and sulphur in hemorrhoids, and of aconite and arnica in the early puerperal statè. Whether it is scientific, sensible, logical, or even commendable, that these two remedies, or any others, shall be given in this way, makes no difference with the facts in the case. For it so happens that, in years gone by, the resort to rhus and bryonia in alternation in this fever made more reputation for homœopathy throughout the West and the South than the prescription of any single remedy, or mode of treatment that has been adopted in this or any other disease, has ever done.

Whether we are so rich in resources that we can afford to throw this one away is a question that should be carefully settled at the bedside. For ourselves, in a practice of nearly thirty years, in which we have treated our share of cases of genuine typhoid fever of all types, we have had the good fortune never to lose one of them; and in the most of these cases our chief reliance has been upon the third attenuation of these two medicines, given alternately, sometimes as often as every hour, but usually at intervals of from two to four hours.

For this reason, and because so many of our brethren throughout this whole region of country and all over the world have done, and are doing, the same thing to-day, we are very skeptical of the dicta of those who declare that such an experience is impossible. We cannot say if the single remedy and the higher potency would have answered equally well; but it is absolutely certain that they could not have given us any better results.—L.

Arsenicum is the great remedy for typhoid fever of a grave type at its full period of development. The arsenical fever is characterized by excessive heat with a small, feeble and very frequent pulse. In very bad cases the pulse is irregular, although the heart still beats, and finally ceases; the face is pale, changed, unnatural, and sometimes livid; there is great debility, with trembling of the limbs, and a tendency to fainting; rapid emaciation, anguish; the anxiety is soon followed by the typhomania, *id est*, by a mixture of delirium and stupor, in which the patient unconsciously talks in a manner that is unintelligible; the mouth is dry, the lips are sooty; the tongue is so dry that it is painful to move it; there is grinding of the teeth, and, in the worst cases, a kind of paralytic dysphagia; an irrepressible thirst, which, despite the dryness of the mouth, is soon followed by complete adypsia; a greenish brown, very fœtid, copious, and often involuntary, diarrhœa, and a paralysis of the bladder. The arsenicum may be given in from the sixth to the third dilution, and repeated every three hours.

But the muriatic and phosphoric acids, belladonna, and arsenicum, do not constitute our only therapeutic resource in typhoid fever; they are merely the principal remedies in the period of its full development.

At the onset, *aconite* and *ipecac.* are often indicated. *Bryonia*, *phosphorus* and *ipecac.* are also indicated when the pulmonary complication is predominant.

In the mild form of cerebral typhoid, with stupor, indifference to what is going on, or what is done with him, or a low delirium, with tenderness of the epigastrium, heavily-loaded urine, pains in the walls of the chest, and cough on deep inspiration or upon motion, *bryonia* is sometimes of the greatest benefit; but it may need to be given for several successive days before there is any perceptible or decided result.

In a coincident peritonitis, *belladonna*, *rhus tox.* or *terebinthina* may be of the greatest service. In three cases of this kind great relief was experienced from painting the abdomen thoroughly with Latour's oleaginous collodion. The lighter emollients may also be useful.—L.

Opium, *hyoscyamus* and *stramonium* are often called for instead of *belladonna* in the cerebral complications. *Ipecac.*, in the 1st dil., in copious epistaxis, and *phosphoric acid*, 3d dil., in intestinal hemorrhage, are excellent remedies.

Other important remedies in the hemorrhage from the bowels in this disease are *nitric acid*, *hamamelis*, *china*, *terebinth.*, *erecthites* and *ledum*. Our dependence has been chiefly upon *nitric acid* in the second dilution. *Nux vomica* is the remedy for epistaxis occurring during the course of this fever in hemorrhoidal subjects.—L.

But I shall not undertake to expose the complete treatment for typhoid fever at this time, for I prefer that you should consult the works on practical medicine and the Materia Medica.

I should, however, say a word of a remedy which you have seen me prescribe for two of our patients, which is the *chininum sulphuricum*. The sulphate of quinia, in the third trituration, is indicated at the termination of typhoid fever, when the fever takes a perfectly remittent type; but it is only *at the end* of the disease, and when the paroxysm is not serious, that this remedy is appropriate. For the pernicious chills which may happen at the height of the disease, and more rarely at its decline, the quinine should be pre-

scribed in larger doses. We have found this remedy in all forms to be without effect against the remittent type of the fever, which is sometimes observed at the *onset* of the disease.

The Condition of the Bowels.—Experienced practitioners of our school of medicine do not need to be told that the old-fashioned canonical purge that formerly has slain so many puerperal women is no longer necessary, but is really harmful, in the treatment of typhoid fever. The best rule of practice in these cases is to let the bowels alone, for if there are any discharges of which the system should be rid, it is safe enough to say that they will find a means of escape when the diarrhœic stage comes on; and to worry and annoy the inflamed and ulcerated patches in the small intestine for the mere sake of forcing a stool, when the patient has eaten nothing and the bowel needs rest, is foolish and hazardous. It is foolish, because it is unreasonable; and risky, because it may provoke such a lax condition of the bowels as cannot afterward be controlled.

There is no question, in our mind at least, that, under the new dispensation in medicine, the annoying complications and sequelæ of this and other eruptive fevers are not half so frequent as they were under the old method; and it would not be very difficult to show that a large share of the present immunity of our patients from a contingent hemorrhage from the bowels, from peritonitis and from chronic diarrhœa, and extreme debility as consecutive upon typhoid fever, is due to the fact that we never find it necessary to purge them during the whole course of the disease.—L.

You have, perhaps, been surprised that I have not ordered a remedy which, at present, is very much in vogue among homœopathic physicians—I refer to the *baptisia tinctoria.* The reason is because *I am suspicious of new things*, and because the eulogies that have been written upon this remedy seem to me to be exaggerated, and to rest upon a wretched confusion of gastric fever with the typhoid fever.

The pathogenesis of *baptisia* has, however, certain symptoms which might induce you to try it in the first stage of typhoid fever, viz: "the weak and tremulous feeling, the quick (90), full and soft pulse; the internal and external heat with thirst; the headache, and tendency to delirium; the tongue yellowish brown in the center, red at the edges; the constipation alternating with diarrhœa." (Hughes' Manual of Pharmacodynamics, page 131.)

But you are not to believe that, with this remedy, any more than with others, you can abort a typhoid fever, or limit its duration to the first stage thereof. Claims of this kind are based on errors of diagnosis.

Although I have been abused for holding that one cannot strangle a disease, I must still repeat this axiom in general pathology. We may abridge a disease by shortening the duration of each of its stages, and by destroying certain of its symptoms; but we do not prevent its evolution. Take the variola, for example. Do you know a remedy that will prevent the febrile stage, that of the eruption, that of suppuration, and finally, that of desquamation? *Vaccine*, which is the most powerful remedy known to us, has produced the varioloid, or a modified variola; and it has been claimed that in variola, modified by vaccine, the suppuration is lacking. This should be a case in which a therapeutic agent has strangled a disease, *id est*, suppressed one of its stages and cut it short. But I observe that this language is not literal. The stage of suppuration is not suppressed: it is only shortened and modified. In fact, the pustules do suppurate in varioloid; but this stage is very short, and, what is very important, it is not accompanied by fever.

The effect of a previous vaccination in the treatment of variola is the strongest illustration known in therapeutics of the power of a remedy over the course of a disease; but this powerful agent only modifies and abridges the different stages of a disease—it cannot suppress them. If you have read what has recently been written on the treatment of typhoid fever by cold baths, you will be convinced, moreover, that the most substitutive treatment is powerless to prevent the evolution of this disease. The physicians who have been most enthusiastic over Brand's treatment have freely acknowledged that, even in the most favorable cases, the cold bath has not prevented the

development and the *duration* of the disease. The febrile heat is reduced, the delirium ceases, the appetite, the strength and the sleep return from the beginning of the treatment, and even in the period of its fullest development; but the disease continues its evolution during three, four, or more weeks.

The sulphate of quinia — that hero among remedies, that pretended specific which is claimed to be infallible — may abort the febrile paroxysm, but it will not strangle the disease. It is quite clear that in the mild and in the pernicious forms, where the disease has a very short duration, to arrest the paroxysms is equivalent to cutting short the disease; but the truth is, that in these forms the development of the disease is rapid. If you abridge a type which is naturally short, you will suppress a complication that might have been fatal, as in the pernicious fever; but the modified symptoms which follow the use of the quinine, and which often necessitate its continuance, demonstrate that, even on this favorable ground, we do not put an end to the disease.

But when we speak of the *common form* of the intermittent fever, which is vulgarly called the autumnal fever, quartan fever, etc., you will see that to cut short the paroxysm is not to abort the disease. In fact, it frequently happens, in countries where fevers prevail, that there are cases which, in spite of quinine, continue for a year, eighteen months, or longer; and if the patient does not change climate, or the doctor does not change the remedy, the ague cachexia is developed. No, we do not strangle diseases, and for the very simple reason that we do not make the cures. It is the living organism which cures itself; it is Nature, as Hippocrates has said, and Nature cures in her own way, *id est*, by the developments which are peculiar to herself.

According to this doctrine, what is the use of medicine? Medicine *inclines* the organism toward the cure, and puts it

in the way of a cure. As my friend, Dr. Cretin, has said, medicine is the railroad-switch that turns the train from danger to safety. You will, perhaps, find this rôle very modest; but it is true, and that is enough for me. The father of medicine has expressed the same idea in the noble language which was proper to him: *Natura medicatrix; medicus interpres et minister.*

Diet.—I should put you on your guard against the too rigid diet of patients with typhoid fever, to which physicians are inclined. When I was an interne of the hospitals of Paris, from 1842 to 1848, those patients were put upon an *extreme diet* during the whole course of the fever. We did not allow them a single dish of broth during the three to six weeks that the fever continued. To-day the maxim is, that we must nourish our fever cases; and the custom, in some cases, is to give them cutlets and beefsteak in the very height of the disease.

You should avoid these two extremes; soups, milk, or very clear porridge should form the diet in typhoid fever so long as the fever continues, and you can vary the quantity and quality of this food according to the digestive ability of each patient, and also according to the predominance of this or of that symptom. You may find that the intestinal difficulty will require an absolute diet for some days. Some patients can more easily digest milk, others broth, and others porridge; let the individual preference decide between them.

Dr. Tucker, of this city, recommends* a mode of preparing beef-tea by combining it with ice cream, which may be grateful and acceptable in some cases of this and of other diseases. He takes 120 grammes of cream, 30 grammes of sugar, 8 grammes of the extract of vanilla, and 8 grammes of beef-juice. (He generally uses Johnson's beef-juice, but that squeezed from a good beefsteak will answer.) These articles are frozen by the confectioner, or it can be made at home.—L.

*The *Chicago Medical Journal and Examiner* for July, 1879, page 38.

When the disease is of long duration, a little wine is necessary. When the debility is more and more pronounced, Bordeaux or any other mild wine, with a little water, will sustain the patient's strength until the fever has run its course. We have just said that the bowel affection should be your guide in the choice of an aliment. Now the brain symptoms play the same part in regulating the use of wine and of alcohol. Remember that in typhoid fever there often exists a true meningo-encephalitis, in which case the alcoholic preparations are contra-indicated.

Drinks.—In this fever, more than in any other, and naturally enough, our patients are very likely to want to drink very often, and to crave a change in what they drink. We should try and minister to their comfort as much as possible in this way, for the old-fashioned, barbarous method of making the sick as uncomfortable as possible, in this as well as in other respects, and of putting them through a species of purgatory because they happen to be in our clutches, is very cruel and unkind.

As a rule, even when there is considerable diarrhœa, acid drinks are not only grateful, but also beneficial. A mild lemonade that is not too sweet, an orangeade made in the same way, the juice of fresh fruit, or currant or raspberry jelly put into water, the water off stewed prunes, or apples, or raisins, or peaches, or water that contains a little old cider, or wine, or a few drops of vinegar, make quite a list from which to select. Of course they should be given in moderation.

It is a good plan, as a rule, to have the drinks of a nourishing kind. The acids supply one need of the organism under the circumstances, just as they do in the eruptive fevers; but the patient's strength must be sustained, and it cannot be done quite so well in any other way as by insinuating the food, little by little, with the drinks that he would, could and should have. And, now that the doctors have learned that good milk is not poisonous, we can allow our typhoid-fever cases to take as much milk as they will in broken doses with their drinks. For this purpose, plain, fresh country milk, diluted with good water, may be taken or sipped very often. It is not only nourishing, but bland and soothing to the inflamed mucous surfaces, and it is grateful by coating them with a thin protective pellicle from the action of the air. Of course the acid drinks and the milk should not be given at the same time or very near together. The koumiss will answer very well when fresh milk is not available.

We append a brief communication, which embodies the experience of Prof. Small in the treatment of typhoid fever, as related in his lectures on Theory and Practice in the Hahnemann Medical College of this city.—L.

"Since we commenced our professional labors in Chicago and vicinity, twenty-three years ago, we have encountered quite a number of cases of typhoid fever.

"According to our observation, the adults who are attacked with this disease are of that class which is easily impressed by malarious influences,—the greater proportion of which are those of a nervo-bilious, or nervo-sanguineous temperament.

"Children, without regard to temperament, being more tender and susceptible, have apparently been equally the subjects of the disease.

"During a practice of all these years, we have no recollection of attending a solitary case in a person of a purely sanguine temperament. Nevertheless, we have treated many cases of the class first mentioned, with uniform success, when it has not been complicated with other dyscrasiæ.

"After making our diagnosis and seeing that our patients were placed in the best possible conditions for recovery, if we have found them complaining of severe pain in the head, with a dry, hot skin, and an accelerated, full pulse, without appetite, and a yellowish-white coating upon the tongue, we have invariably prescribed *aconite*, repeating the doses every two or three hours, until the force and frequency of the pulse became reduced and the skin became more soft and inclined to moisture.

"If the pain in the head had only become dull and the patient was inclined to coma, the coating on the tongue inclined to assume a darker hue, and, as is usually the case, he did not wish to be moved, we gave *bryonia*, repeating the doses every two or three hours, until we obtained some kind of a reaction.

"If a more prostrating stage of the disease ensued, attended with muscular soreness or stiffness in the lower extremities, we changed to *rhus tox.*, which, after a few doses,

seldom failed to break up the disease. Sometimes directly, and again after forty-eight or seventy-two hours, a normal secretion would show itself on the margin of the tongue, and the thick, black coating upon the dorsum of that organ would begin to crack and come off in scales. The clammy and almost fœtid taste would be dissipated, the senses of taste and smell return, and become normal, food and drink were relished, and the excretions from the kidneys and bowels soon presented healthy characteristics.

"In a majority of uncomplicated cases of average severity, the above treatment was all that was required. We usually rely upon the third decimal attenuation of the remedies, and having been uniformly successful, without questioning the utility of the higher and the highest attenuations in the hands of others, we prefer to stand upon the firm ground which we have, for nearly forty years in all, found to serve us so well.

"In connection with the use of aconite, bryonia and rhus tox., which we regard as indispensable remedies in such cases as we have described; when slight or serious complications arise we have called into requisition *belladonna*, in the first stage, when there was any indication of congestion or chilliness, or when the pain in the head was so severe as to be attended by a furious delirium.

"We have also resorted to *phosphorus* when, from physical examination, we found the evidence of an ulceration of the mucus coat involving the glands of Pyer; and *arsenicum*, also, in case of distention and a tympanitic condition of the bowels, and when there is great prostration and *offensive discharges* from the bowels.

"We have employed the *baptisia tinctoria* when the odor of the breath was so offensive and sickening that even the nurses regarded it cruel to be obliged to stay in the

room, and this in spite of the use, meanwhile, of the best disinfectants.

"In some instances we have employed *gelsemium* in the early stage, when the pains in the head were neuralgic, and shooting from temple to temple; and in those cases that were complicated with torpidity of the liver and constipation of the bowels, we have prescribed *mercurius vivus* first, for several doses, and then have given the *nux vomica* or *podophyllin*, until we have seen a change in both.

"For those typhoid conditions that come on and disappear, as if cerebro-spinal meningitis were threatening, we have found no remedy that has served us so well as the *eupatorium perfoliatum*.

"Such cases as seem to come on gradually without any pain whatever, except a sense of weariness and fatigue, with a loss of appetite, not much acceleration of the pulse, but a sunken expression of the countenance, a collection of sordes on the teeth, the tongue covered with a thick, dark-brown coating, and a suspended nutrition and a rapid loss of flesh, with a thick, brick-dust sediment in the urine, and a tedious constipation, respond favorably to the first dilution of *bryonia*, twenty drops in half a goblet of water, and a teaspoonful to be taken every hour. After the fever, in cases of this kind, as well as in all other varieties, has subsided, and the appetite is not quite restored, *china*, third dilution, will act usefully in promoting recuperation and a rapid convalescence. As soon as the appetite is fully restored, neither tonics nor stimulants nor medicines can be of any further service. Solid food should never be forced down the throat of a patient when the appetite repels it and when the system is not in a condition to dispose of it."

Meningo-Encephalitis in Typhoid Fever.

The love that the doctors have for metaphysics has always inclined them to receive with favor the most fanciful explanations of the nature of disease. At the present day it is sufficient to refer this whole question to *blood-poisoning;* and typhoid fever, being due to a poisonous influence, why should we be any more surprised to observe a delirium in this fever than in other diseases of a similar kind? Such folly prevents the study of the symptoms and lesions of the brain, the meningo-encephalitis of typhoid fever, and causes practitioners to overlook them, even when the disease may have gone so far as to cover the convolutions of the brain with a layer of pus. I can only treat this question in an incidental way, but I will, however, give a brief outline of the history of this affection.

Chomel, Louis, Barth, and some of their contemporaries, unite in denying the existence of this form of meningitis in typhoid fever. It was in vain that Piedagnel described it to them, and enlarged upon the ramollissement, the adhesions of the superficial layer of the central convolutions, and the kind of *ulcerations* that form upon the surface of the brain in consequence of those portions which are adherent to the gray matter. Piedagnel was not a teacher; he had no authority, and when he discovered a fact the *observers* and *statisticians* refused to examine it, and they have continued to declare that the delirium of typhoid fever is of nervous origin, sympathetic, and caused by changes in the blood. In other words, when it becomes a question of studying the symptoms and of locating the lesions, they wander back to proximate causes, precisely as they did in the time of Galen.

Where Piedagnel had stranded, Dr. J.-P. Tessier could not succeed. The former was not an authority, the second

was under suspicion, so that his descriptions, with the proof attached, at the clinic of the Hotel-Dieu, and his teaching at the Practical School, failed on account of the obstinacy of these same pathologists, who could not be induced to study a lesion which their school had not the merit of discovering.

The monograph, which I published upon the same subject in 1856, in the *L'Art Médical*, necessarily elicited no response because of its place of origin.

But, when M. Quinquaud, of the Biological Society, and M. Popoff, of the laboratory of Recklinghausen, discovered these lesions, in 1874, the professional attention was immediately drawn to this subject. * * * *

What was the school represented by the *L'Art Médical* in comparison with the Biological Society, and Tessier as compared with Popoff, of the Recklinghausen laboratory? And wherefore, after we were so obstinate as to hold to our own views in spite of the opposition of our enemies, although they were very powerful, do we continue to-day to be the defenders of positive and experimental therapeutics? * * * *

It is not possible that all the schools can discover, in 1874 and 1876, what was minutely described in 1845 and 1856. This is our revenge, and it is sufficient.

The symptoms which characterize the meningo-encephalitis of typhoid fever are: delirium, jerking of the tendons, and partial paralysis. The delirium is not a simple, transient, nocturnal delirium, from which the patient is easily aroused when one speaks to him, but it is continuous. It may be violent, with crying, agitation and efforts to get out of the bed; or it may, on the contrary, be mild and mixed with sopor. Its distinctive symptom is its continuity. The functions of the cerebral convolutions are decidedly deranged, and it is impossible to get him out of his delirium.

The twitching of the tendons is caused by very slight convulsions. The partial paralysis is incident to the advanced development of the lesion. The muscles of the eye, of the tongue, of the pharynx, and the sphincters, are most apt to be paralyzed.

We shall reproduce in this connection the lesions that we have very minutely described in *L'Art Médical:*

"If we carefully lift the membranes of the brain, we find that the pia-mater is red, thick, and more or less infiltrated with a bloody liquid. This redness is caused by arborizations at a right-angle, and by small ecchymoses, which, in certain cases, are so close together that the membrane presents a uniformly red color. The lesion is especially marked upon the free borders of the double fold which the pia-mater forms in order to pass between the convolutions, and also in the triangular space at the point where the two layers of the pia-mater are doubled to unite with the visceral layer of the arachnoid."

But the lesions of the brain, which are observable after the membranes are removed, are much easier to recognize and are much more important. They may be observed when the brain has been thoroughly washed.

"This lesion is made up of small, rounded, irregular ecchymoses, which vary in size, but which are always very small. They are of a bright red color, and form a spot which cannot be washed off. In certain places these ecchymoses are so near together that they form a patch that is uniformly red. But this abnormal discoloration does not constitute the entire lesion, for there is also a diminution in the consistence of the brain tissue. This very superficial softening, which is easily recognized by its wrinkled appearance, and the unequal surface (like that of a tomato) of the diseased convolutions, is much more pronounced than the ecchymosed spot, and more extensive also.

"Sometimes the softening is so marked that, in spite of every precaution, the parts are broken down and confounded

with the pia-mater, even when there are no real adhesions, but simply by a defect of the proper cohesion."

When the patient succumbs to a stage of the disease which is very much advanced, "the pia-mater sometimes presents a real dropsy, and the *firm adhesions unite with the pia-mater to those points in the gray matter which are also diseased.*" (*L'Art Médical*, t. IV, page 2 *et suiv.*)

The microscopical researches which I have made since the publication of this paper confirm the inflammatory nature of the lesion in this febrile delirium.

In closing, I have a word of reply to a singular method of reasoning by M. Louis. This excellent observer denies the existence of the lesion which produces the delirium in typhoid fever, because similar lesions have been found in patients who have died from other febrile diseases with delirium. But the conclusion that should justly be drawn from this double fact is, that meningo-encephalitis is an affection which is common to all those febrile diseases that are accompanied by a continuous delirium. This is what we have most decidedly established in our Mémoire by autopsies made in cases of pneumonia and of acute phthisis.

LECTURE XXVI.

SUMMARY.—Of pneumonia, *case*. Rapid termination of the disease. Lack of defervescence. Importance and difficulty of the diagnosis. Of individualizing and of curing by name or title. *Arsenicum* and *tartar emetic*. *Case* of pneumonia with absence of the usual signs. No defervescence. Critical days. Necessity of examining all febrile patients by auscultation. The expectant system, and the errors and fallacy of its statistics. The boasted success of Dr. J. Hughes Bennet. Puerperal pneumonia, *case*.

Pneumonia Cured on the Ninth Day.

GENTLEMEN: In a former lecture we have already spoken of pneumonia and of its classical treatment by *bryonia* and *phosphorus*. *À propos* of two cases which you have lately seen in the men's ward, we shall resume this very practical subject to-day. These two cases have been very serious in their nature; both of them were difficult of diagnosis, and in both, bryonia having failed, we had recourse to *arsenicum* and *tartar emetic*. This is the first of these cases:

CASE LXVIII.—M. Charles B——, aged forty-eight, was admitted on the 31st of January, and discharged on the 20th of February. (Men's ward, No. 3.)

The antecedents of this patient have been bad, and his general condition on being admitted into the hospital was very unfortunate. He tells us that for ten years past he has taken cold in winter and summer, and that generally he coughed for several months together. Ten days ago he was forced to take to his bed. Although he is not sensibly emaciated, and has never raised any blood, yet he looks like one with phthisis.

From the beginning of winter his health had been very good, and he had not had the least sign of trouble, when, four days ago, he was suddenly seized with severe chills. The next day he had some cough and a violent dyspnœa, which has not left him since that time.

The observable symptoms do not accord in their gravity with those revealed by auscultation; he appears to be seriously ill; there is a profound adynamia, and the face is red and swollen; the breathing is difficult, and the fever intense. On the evening of his admission the temp. was 103.1°, and the pulse 124.

The cough is frequent, and the expectoration difficult; the sputa are not characteristic, but white, purulent, slightly aerated and somewhat tenacious. There is a complete loss of appetite, with a foul tongue.

Percussion shows a slight dullness over the middle lobe of the right lung; and auscultation detects some loud and sibilant râles on both sides of the chest, but more especially upon the right one.

February 1, fifth day. Morning temp. 101.7°, pulse 96; evening temp. 102.5°, pulse 96. *Bryonia* and *ipecac.* 12th dil.

February 2, sixth day. Morning temp. 101.3°, pulse 104; evening temp. 102.9°, pulse 108. The patient had been very restless during the night; the dyspnœa was as bad as at the beginning, and the debility still more pronounced. The expectoration is a little more copious, and the sputa more sticky.

This morning, auscultation reveals a tubular souffle at the summit of the right lung, but the sonorous râles are still observable throughout the whole of this lung. *Tartar emetic*, 1st trit. He was also ordered two large spoonfuls of brandy.

February 3, seventh day. Morning temp. 102.5°, pulse 108; evening temp. 103.1°, pulse 108.

To-day the general condition of the patient is very bad; the temperature is very high, and he complains of a constant oppression in the right lung. Besides the blowing sounds, there are crepitant râles. *Tartar emetic*, 1st trit., during the day, and *arsenicum*, 3d trit., at night.

February 4, eighth day. Morning temp. 101.6°, pulse 100; evening temp. 101.8°, pulse 96.

The general condition of the patient is not improved, but the temperature has fallen nearly one degree, and auscultation reveals, instead of the souffle, a mixture of the mucous and crepitant râles. The sputa are bloody and viscous. *Arsenicum*, 3d trit., alone.

February 5, ninth day. Morning temp. 99.9°, pulse 60; evening temp. 98.9°, pulse 64. As the thermic curve shows that the temperature has fallen to the physiological point, the general condition of the patient is much better than it was yesterday.

Now the sputa are quite characteristic; they adhere to the bottom of the vessel, and have the color of barley-sugar. There are sub-crepitant râles in the right lung. *Arsenicum*, 3d trit.

February 6, tenth day. The temperature remained at 98.5° both morning and evening. The dyspnœa of which he complained has ceased. We still hear some moist râles in the lung, but we also perceive a slight souffle of expiration at its apex. *Arsenicum*, 3d trit.

February 7, eleventh day. The patient is going on well. He was allowed to eat some porridge, and to drink a little wine and water; there is a very copious diarrhœa. The same treatment.

February 8, twelfth day. The appetite is returning very decidedly, and the expectoration is becoming less and less copious. Continue the *arsenicum*, 3d trit., and give him an egg.

February 9, thirteenth day. The respiration in the diseased lung is normal again; the mucous râles have entirely disappeared.

February 11, fifteenth day. The patient still continues to have a mucous expectoration; the cough, however, is infrequent. *Tartar emetic*, 1st trit.

February 14, eighteenth day. He coughs and expectorates less than before; the digestion is very well performed. The same remedy was continued for two more days, and the patient left entirely cured.

Now, here is a case of pneumonia occurring in a man who was worn out and ill, which terminated on the ninth day, and the convalescence from which was complete after eight days. Seventeen days have therefore sufficed for the disease and for its convalescence. When these patients were subjected to treatment by bleeding *coup sur coup*, by blisters, and by large doses of *tartar emetic*, such rapid results were unknown.

It is worthy of remark that, in this case, properly speaking, there was no defervescence, since it required seventy-two hours for the temperature to return to its normal state. In fact, on the seventh day the temperature was 102.5° in the morning, and 103.1° in the evening, *id est*, it varied only six-tenths of a degree during the day. On the ninth day it fell one degree, but it was not until the tenth day that it reached the normal point of 98.5°.

It is also worthy of note that, in the case before us, the ninth day (which in pneumonia is the most pronounced of all the critical days) marked the term of the morbid evolution.

The diagnosis was beset by a difficulty which is not often encountered in such diseases as have their proper physical signs; for, although auscultation was practiced every morning and evening, yet it did not give us the characteristic signs of pulmonary hepatization until the sixth day of the disease. Until that time, we had only heard the râles proper to bronchitis, and therefore diagnosticated the case as one of grave bronchitis. What was the cause of this anomaly? Undoubtedly it was the adynamic state of the patient, and the feebleness of the respiratory movements.

Discrepancies in physical diagnosis are quite as possible in pulmonary disease as elsewhere, and under different conditions. The case corresponds with the detection of uterine deviations. One physician examines a case and fails to find any displacement. The next day another physician may be equally positive of the existence of prolapsus, or of some version or flexion of the organ. Both were right and both were wrong if either insisted that a mistake had been made in the diagnosis. With the change of conditions, diseased or abnormal states had developed that were not recognizable at first and under different circumstances. A little common sense would often keep physicians from getting into a snarl in these matters, and more careful observation will make us all more charitable.—L.

When our patient had reached the sixth day, the diagnosis suddenly illuminated the whole pathological picture, and with a positive proof of the lesion, the therapeutics ceased to be doubtful and uncertain. The treatment was immediately

changed to the two remedies which are suited to a dangerous form of pneumonia, viz: *tartar emetic* and *arsenicum*. When the fever was intense (103.1°), the prostration very profound, and the nightly agitation had afforded the principal indication for it, the *arsenicum* was given alone, and it established the convalescence. We also prescribed that a small quantity of brandy should be taken, and we believe that the moderate use of alcohol has not been without its influence in the happy issue of this case.

It is especially in the pneumonia of old people, senile pneumonia, in some forms of typhoid pneumonia, and in this disease, occurring in patients with a broken-down constitution and unpromising antecedents, as in Case LVIII, that alcohol in some form is of excellent service. We could cite a number of cases from our own experience in which, judiciously given, it certainly was the means of saving life.—L.

This example also shows you, gentlemen, that it is not necessary to restrict or to limit the treatment which we apply to all diseases of the same kind. We must study earnestly the indications which are furnished by the symptoms of the *individual case;* this is what I call *individualizing*, in the true medical sense of the word.

You should, in fact, guard yourselves against two errors, one of which consists in founding the indications upon certain symptoms that are proper to the sick person, and in taking no account of the diagnosis, the other in making, as it is sometimes styled, a cure by the name of the disease, or by the use of a treatment which is arranged beforehand for all the diseases of the same name or kind, without reference to the particular indications in each case. After the first of these methods one might prescribe *chamomilla*, for example, in tuberculous meningitis, croup, or the colic, if *the child is quiet only when it is carried in the arms.* In the latter case one should not obstinately treat such a pneumonia, as we have just detailed, by *bryonia* and *phosphorus*, else the patient will be very apt to die.

Spinal Sclerosis with Intercurrent Pneumonia.

Here is a second case of pneumonia, which bears some resemblance to the preceding one.

Case LXIX.—M. Georges P——, aged thirty-six, admitted on the 3d of February, 1876. (Men's ward, No. 6.)

This patient, who was attacked, some days after his entrance into the hospital, with pneumonia, asked to be treated also for a spinal affection from which he had suffered for about two years. He was a janitor, and had lodged in a damp room; but he had never been very ill, and declared most positively that he had not been of dissipated habits.

This disease had set in abruptly, with such a weakness of the limbs that it was impossible for him to walk, except for a very short time, without great fatigue. He had had bruised pains in both legs; but never had experienced the sharp, terrible pains that are usual in locomotor ataxia.

From the beginning of his disease there was a continual oppression, with occasional fits of violent suffocation. He had also had vertigo for some time. Now we find him with the following symptoms: The general condition is pretty good; there is, however, a slight emaciation of the lower extremities. When his eyes are open he walks with comparative ease, and the legs have not the irregular and jerking movements that occur in locomotor ataxia; but when his eyes are bandaged he walks with the greatest difficulty, and threatens to fall at any moment.

There is an habitual constipation, urination is difficult, and he cannot empty the bladder entirely.

The cutaneous sensibility is preserved, and so, also, is the muscular sensibility; for some time, however, his vision has been a little weak. He was given *phosphorus*, 12th dil.

This remedy was continued, but without improvement, until the 10th of February. The night before he took a little walk in the hospital court, and afterward complained of a violent headache and of great oppression. He also had fever, the temperature being 101.3°, and the pulse 100.

February 10, second day. The patient complains severely,

but is not so oppressed as during the night, and does not cough. Morning temp. 101.1°, pulse 120; evening temp. 101.3°, pulse 120. *Aconite*, 6th dil.

February 11, third day. Morning temp. 101.8°, pulse 108; evening temp. 103.25°, pulse 112. He is not doing so well; he does not cough, and there is no sign of an acute affection of the lungs. The same remedy.

February 12, fourth day. Morning temp. 104°, pulse 120; evening temp. 104°, pulse 112. The fever is intense; the patient had some bleeding from the nose during yesterday, and this was followed by a pretty frequent cough. Auscultation of the back part of the thorax gives a negative result. *Aconite*, 6th dil.

February 13, fifth day. Morning temp. 103.25°, pulse 112; evening temp. 103.6°, pulse 120. He continues to cough, but raises nothing; the headache of which he complained at first is better.

February 14, sixth day. Morning temp. 101.6°, pulse 112; evening temp. 103.25°, pulse 112. At our morning visit there was an adherent, yellowish, sticky sputa, which clung to the bottom of the vessel, and which was a little streaked with blood. Auscultation of the thorax, both anteriorly and posteriorly, revealed an intense souffle, which was located in front and in the upper portion of the right lung; there were no râles. *Bryonia*, 3d dil.

February 15, seventh day. Morning temp. 102.5°, pulse 116; evening temp. 103.25°, pulse 120. This morning the general condition of the patient was very bad; the souffle extends both in the front and behind; there is complete prostration, and the tracheal râle can be heard at a distance. *Tartar emetic*, 1st trit., for the day, and *arsenicum*, 3d trit., for the night.

February 16, eighth day. Morning temp. 101.6°, pulse 100; evening temp. 100.4°, pulse 100. There is a decided improvement in the patient's condition; the dyspnœa is less marked, and the facial expression is better. During yesterday he had a slight epistaxis; to-day auscultation discloses blowing, sub-crepitant and crepitant râles. The same prescription.

February 17, ninth day. The fever is completely broken; the evening temperature was 99.6°; the respiratory souffle has disappeared. *Arsenicum*, 3d trit.

February 19. He still coughs a little, and complains of a slight pain in the right side. There are some mucous râles in the chest. *Bryonia*, 3d dil.

February 22. He coughs but very rarely; the pain in the side has left; his strength returns very slowly. *Phosphorus*, 6th dil.

February 25. Last evening he had a slight oppression, with a pretty sharp pain in the epigastric region. *Nux vomica*, 3d trit.

February 28. Respiration in the right lung is normal, but he still coughs a little; the digestion is better, but not perfect. The same remedy.

The patient had no more symptoms, but continued to improve during the month of March.

In this case the diagnosis has been very difficult, on account of the absence of the usual signs of pneumonia; neither cough, nor expectoration nor pain in the side were present. Perhaps we were wrong not to have practiced auscultation more thoroughly. The seat of the hepatization, above and in front of the chest, is so rare, that we have spoken of it; it certainly helped to prolong the error in diagnosis. The disclosures of the thermometer were those proper to pneumonia. There was a rapid rise of the temperature, without oscillation, to 104°.

We should at least feel as kindly toward the failures of physical diagnosis as we do toward the failure of our remedies, when we do not obtain the desired result from their employment. If we depend upon them to the exclusion of others, the signs revealed by auscultation and percussion are no more reliable than the general symptoms. For one is the complement of the other, and both are necessary.

The author's point is well taken, but he might have added that there are two forms of pneumonia in which one would almost certainly be misled, if he should rely to any considerable extent upon this mode of examination, more especially in the early stage of the disease. These two kinds of pneumonia are the pneumonia of infancy, or of early childhood, and that which occurs in the puerperal state.

In *infantile* pneumonia, a careful physical examination of the child's chest, more especially of the front part of the thorax, is often impossible; for nothing short of a profound anæsthesia would keep the youngster quiet and overcome

his opposition. Add to this the fact that, in the lobular form of pneumonia, the lesion may be so limited to the interior of the organ, and so covered by the healthy lung tissue, as practically to be beyond the reach of the ear and of the pleximeter. In such a case we cannot, therefore, depend upon the physical signs exclusively, any more than we could upon the subjective sensations of the patient, when the little one is not old enough or wise enough to tell us how or what he feels.

We shall add a clinical talk on *puerperal* pneumonia at the close of this lecture.—L.

In this case we have to remark also that there was no proper defervescence. On the seventh day the temperature was 103.25°; on the eighth day, 100.4°, and on the ninth day, 99.6°. Here was, therefore, a regular, although rapid, decrease of the temperature.

Besides the last peculiarity, there was the termination on a critical day, the ninth day of the disease, and the rapidity of the convalescence, which was complete after two days.

The prostration and the oppression complained of were the symptoms that led to the choice of the *tartar emetic* and *arsenicum*. We believe that it will not be useless to recommend physicians to practice auscultation with care in all those patients who have fever, even when they have no cough nor pain in the side. You have just seen two cases which illustrate the importance of this precept.

The Expectant Method and its Fallacies.

You know, gentlemen, that pneumonia is one of the acute diseases which has served for a clinical demonstration of the efficacy of the homœopathic treatment. This demonstration has been established upon such numerous and well-authenticated facts that our opponents have vainly tried to destroy the force of the argument. The most radical objection, and that which has found most favor, consists in claiming that pneumonia is a benign affection, with a natural tendency to recovery; that the success of homœopathic remedies is that of the *expectant* system; and that by this expectant method we may cure almost every case of pneumonia.

Our opponents have not reflected that if the spontaneous cure of pneumonia was of every-day occurrence; if the expectant treatment lost only eight or ten per cent, the old-school treatment would be murderous, for in the hospitals of Paris the mortality from pneumonia is generally increased to thirty or thirty-five per cent. But these marvelous results of the expectant method in the treatment of pneumonia are founded upon an undoubted fallacy; and we must in good faith have done with the fantastic and lying statistics which the enemies of progress in therapeutics so constantly quote, in order to undermine the success of homœopathy in the treatment of pneumonia.

The author of an anonymous article upon *Alcohol in Therapeutics*, which was published in the *Bulletin général de thérapeutique* for October 16, 1875, cites some statistics which are very inaccurate and untruthful. This table is printed in the *Leçons cliniques de l'hôpital de la Charité*, by Dr. Jaccoud (page 70). It is as follows:

I. PNEUMONIA TREATED BY VENESECTION.

From Edinburgh,	698 cases;	mortality,	34.52 per cent.
From Dietl,	85 cases;	mortality,	20.40 "
Total,	783	mean mortality,	27.06 "

II. PNEUMONIA TREATED BY TARTAR EMETIC.

From Rasori,	648 cases;	mortality,	22.06 per cent.
From Dietl,	106 cases;	mortality,	20.70 "
Total,	734	mean mortality,	21.98 "

III. PNEUMONIA UNDER A MIXED TREATMENT.

(From groups of cases by Laënnec, Grisolle and Skoda.)

Maximum mortality,	16.00 per cent
Minimum mortality,	12.05 "
Mean mortality,	14.25 "

IV. CASES OF PNEUMONIA WITHOUT TREATMENT.

Collected by Dietl, 189 cases; mortality, 7.4 per cent.

V. PNEUMONIA TREATED EXCLUSIVELY BY TONICS.

Collected by Bennett, 129 cases; mortality, 3.10 per cent.

We have already replied (*L'Art Médical*, 1862), to the argument drawn from the use of the expectant method in the treatment of pneumonia; and we have shown that, in pneumonia treated by homœopathy, instead of recovery by defervescence, as with those which are left to expectation, there is *usually* a gradual subsidence of the symptoms; that the pain in the side diminishes before disappearing; that the pulse falls each day a certain number of beats before reaching the normal state; and that the febrile heat itself does not fall abruptly from 104° to 98.5°. We then said, and now we repeat it, that it is wrong to judge of the merits of the expectant method by the results obtained by Dietl during the first year (1849), for he had a fortunate group of cases, of which he lost only 7.4 per cent. If we mean to get at the truth of the matter we should study the following series: Thus, in 1852, the mortality increased to 9.2 per cent, and in 1854, to 20.7 per cent.

We must also make note of the experiments of Bordes, who, in 1855, cured 22.0 per cent; those of Schmidt, who lost 23.0 per cent, and finally in the *Archives* of Virchow (XV, 3 B. und 4 Heft, p. 210), that Brander, of Copenhagen, had a mortality of 31 per cent under the expectant treatment.

The total of these statistics gives us 18.88 per cent as the result obtained by the expectant method in the treatment of pneumonia, and a very sad result it is.

We must say, therefore, that it is very untrue to claim that 7.4 per cent expresses the mortality of pneumonia when left to simple expectation, for the true figure is 18.88 per cent.

These facts have already been quoted by the author (see page 100), but their echo in this connection gives additional emphasis.—L.

If we acknowledge to our opponents that this triumph has been too easy and too quickly accomplished by Dietl, we must say that Bennett has obtained results that are still more surprising. His treatment exclusively by restorative medicine gives a mortality of 3.10 per cent in a total of one hundred and twenty-nine cases. What shall we now say of the success of homœopathy in the treatment of pneumonia? Can we do better than to save 3.10 per cent in those who have pneumonia?

For a long time I have wanted to say what I thought of this English *clinicien;* and since he has recently died, it is proper to make his funeral oration with a freedom that belongs only to history. I will make it in three words which pertain strictly to the subject before us:

(1) Bennett did not know how to practice auscultation; (2) he arranged his own statistics, and (3) far from treating his patients who had pneumonia *exclusively* by restorative means, Bennett gave them a host of remedies.

For these three reasons, which are well established, the claim of 3.1 per cent mortality in pneumonia is an outrageous fraud. How is it possible that experienced physicians have not discovered this deception? Who does not know, indeed, that in the hospitals of Paris the mortality from pneumonia almost every year exceeds 30 per cent? How is it possible that a man could obtain the fabulous result of 3.1 per cent, especially if one takes the pains to read his cases and to observe the singular treatment to which he submits his patients; but in France nobody has taken the trouble to investigate this matter.

Now, for my own part, I am going to prove, first, that Dr. Bennett practiced auscultation very badly, and for evidence we may read some rare cases of pneumonia that are given in his clinic. The expressions of râle, of souffle, of dullness, which have a meaning with our French authors, are, in Bennett's Clinic, used without precision, and it is very difficult to understand the extent of the lesion in the case of the patients who are the subjects of his clinic.

Dr. Hughes Bennett calls his treatment of pneumonia a restorative medication. Now this plan of treatment is usually composed of beef-tea as an aliment; then of neutral salts, of antimonials and diuretics, of ammoniacum, of tartar emetic, and sometimes of dry-cupping.

This is a kind of *expectant* treatment, of which the druggists would never make any complaint.

It was by means of this *restorative* treatment that Bennett had only four deaths in 125 cases, and as these deaths were in complicated cases, he suppressed them and reports 121 cures in 121 cases, the mortality being reduced to zero (p. 320). * * *

Besides those four deaths, which were due to complications, the author also speaks, at page 315, of thirteen complicated cases which he has not counted; then, at page 318, of some other cases that were brought in in a dying state; finally, Dr. Bennett does not include in this list those cases in which the treatment was begun or finished by his *confrères*. Thus, as the result, 13.4 per cent out of seventeen complicated cases terminated fatally, without counting those which were brought in in a moribund state, and those also of which the treatment had been begun or ended by his associates.

I believe, therefore, that we shall not be extravagant or unjust in estimating 25 per cent of mortality instead of the zero of this very boastful teacher.

This very plain talk of our author should be of real service to the cause of clinical medicine. A mere idle boast that any particular system of treatment is best suited to the cure of so grave a disease as pneumonia does not and can not satisfy the earnest physician who desires to do his whole duty by his profession and his patients, and to place himself rightly upon the record. The numerical method is full of fallacies; and when we come to figures (unless we are very careful to qualify our reports), the quacks always have the advantage.

The real safeguard against deception is a careful statement and analysis of the symptoms, more especially of the physical or objective symptoms, in any case or class of cases. And Dr. Jousset is just, as well as keen and discriminating, when he proves that Bennett's statistics are worth but little because his record of the physical signs of pneumonia is loosely and carelessly drawn.—L.

The success of the homœopathic treatment of pneumonia remains, therefore, as a proof of the value of this system; and the falsehoods as well as the illusions furnished by statistics have only helped to increase the value of this argument by demonstrating its reliability.

Puerperal Pneumonia.

The following case, and the clinical remarks upon it, were brought to the attention of, and delivered to, my class in the Hahnemann Hospital, of this city, April 9, 1877. They will serve still further to illustrate the teaching of our author upon the subject of pneumonia, and more especially the difficulty of diagnosticating it, in some cases, in its early stage.—L.

As members of the clinical classes which have accompanied me to my ward in the hospital for the especial study of the puerperal diseases, you will all remember Case No. 2,098. It was one of puerperal pneumonia, and possessed many points of practical interest. Despite our best efforts, the poor woman died. An autopsy was held last evening; but before showing you the results of that examination, I will refresh your memories with a very brief history of the case.

Case 2,098.—Aggie M., aged twenty-three, came to the hospital thoroughly wet from walking in a snow-storm. Ten minutes after her admission she was delivered of a still-born male child at the seventh month. She had had two full-term children before. Excepting the signs of a bad cold and a very troublesome dry cough, which she said she had had for several

days, her condition was good. On the second day the lochia, which had been very slight and offensive, disappeared, and did not return until the morning of the fifth day, when it came for a little, and then ceased altogether. She had no chill until the afternoon of the fifth day, and no pain in the chest until the eleventh day. The chill was repeated on the twentieth day. The pain began over the right lung, and extended to the left. It was worse when coughing, and from lying on the right side, and finally spread over the abdomen, and was accompanied by diarrhœa. During the night of the fifteenth day she complained bitterly of pain in the left ankle, which was swollen, but not discolored. For twenty-four hours that ankle was exquisitely sensitive, and then the pain subsided. On the morning of the fifth day she had a dizzy headache, with slight epistaxis. From the first there were circumscribed flushes, of a carmine hue, on the cheeks, but the general complexion was dusky. Until the eleventh day the most careful physical examination, frequently repeated, failed to elicit the signs of pneumonia. She did not expectorate anything, but swallowed the mucus, like a child. This evidently caused the vomiting, which began at the end of a fortnight. On the seventeenth day she had hoarseness, which continued, and the stools became more frequent and offensive. A typhoid condition supervened. On the twenty-first day she raised some bloody mucus, containing a small quantity of pus. The breathing grew more difficult, the stools involuntary, and she died on the morning of the twenty-fourth day.

The autopsy, made with the assistance of Messrs. Rockey, Laning, Myers, Todd, Barker and Pillsbury, of the medical class, revealed an abscess filling three-fourths of the upper lobe of the right lung, and a smaller one, involving the internal and external surfaces of the left ankle. The liver was healthy. There was a clot in the right auricle of the heart, but, so far as we could discover, there were no thrombi in the pulmonary vessels. In patches the mucous surface of the small intestines was ulcerated, and almost gangrenous. The uterus and its appendages were undergoing the proper changes. There were no traces of uterine phlebitis.

This record omits the treatment, of which you already have the details, in order that I may call your undivided attention to other points in the clinical history of this disease.

Puerperal pneumonia is comparatively a rare affection. It may be either primary or secondary. In the first of these varieties it may have existed before delivery, as it undoubtedly did, but in a latent form, in this instance. The secondary pneumonia of childbed is very apt to terminate in abscess, and if my experience is a reliable criterion, the same is true of idiopathic puerperal pneumonia in those who miscarry with still-born children after the sixth month.

Secondary puerperal pneumonia most frequently succeeds or complicates the pelvic or abdominal diseases of the lying-in state, viz: peritonitis, metritis, metro-phlebitis, and inflammation of the broad ligament. In case of metastatic abscess occurring in the lungs, the lesion is the consequence of embolic infarction, or of obliteration of some of the pulmonary vessels.

Primary puerperal pneumonia may be due to the same causes that will produce an attack of pneumonia in the non-puerperal state. Its most powerful predisposing causes are: the existence of bronchitis developed by pregnancy, and the rapid evolution of tubercles which is sometimes hastened by the same condition. It seldom begins with a chill, and it may be latent.

The pneumonia of childbed is sometimes epidemic. In its secondary form it may commence as early as the fifth, or as late as the twentieth, day. In either case it is caused by an extension or translation of the disease from other viscera. The local causes which invite or suggest its development are the occurrence of very small purulent deposits,

of metastatic abscesses, or of tubercles in the pulmonary tissue, or the previous existence of pleurisy.

There is a variety of this secondary pneumonia which was first described by Hervieux, in 1867, which he styled the *hypo-pleuritic*, caused by contact of the lung with an inflamed pleura.

The local symptoms of puerperal pneumonia are the same as in ordinary pneumonia. The only exceptions to this rule are in case the lesion is masked by pleurisy with extensive effusion, or is limited to one or more of the lobules of the lung. Our patient had lobular, instead of lobar pneumonia, and hence the obscure nature of the attack, the absence of the proper physical signs, and of expectoration, and the lingering nature of the disease. She was ill from the date of her delivery, with an unmistakable primary pneumonia, but the local symptoms did not correspond until the eleventh day.

Now, whether this limited, lobular inflammation was due to an infarction, or the blocking up of a small pulmonary vessel by a floating shred, which was detached from the thrombus, that we found, on the autopsy, in the right auricle of the heart, I cannot say. It may have been, for this is not a post-mortem clot.

Whatever its direct cause, the disease was circumscribed and essentially latent. You remember our search for the physical signs of pneumonia; crepitus, sub-crepitus, bronchial respiration, absence of the vesicular murmur, and dullness on percussion could not be recognized. We were equally certain that it was not hypostatic. My friend, Prof. John C. Morgan, visited her with me on the ninth day, and subjected her to a very critical examination, but failed to detect any physical trace of pneumonia. It was only when the lesion had spread and come toward the surface of the lung, when it had ceased to be lobular and had become lobar, that she

began to complain of pain on coughing and in lying on the affected side, to expectorate like an adult with pneumonia, and to offer the proper physical signs of that disease. And this did not occur until the eleventh day.

If this had been a case of secondary pneumonia, the absence of these signs might easily be accounted for. If our patient had first been ill with some pelvic or abdominal inflammation, and afterward with pneumonia, the evolution of the chest symptoms would certainly have been delayed. But it was not so. Neither the house physician's record, nor the revelations of the scalpel, show that she had any primary disease outside of the thorax.

The course and duration of the disease confirm our view of the case. If puerperal pneumonia follows a serious attack of peritonitis, phlebitis or of endometritis, it usually terminates fatally within three days. The same is true of the metastatic abscesses in the lung, when the patient has a marked purulent diathesis.

More than this, the general symptoms of secondary puerperal pneumonia very readily assume the typhoid character. If our patient had had that form of the complaint, the typhoid symptoms would certainly have appeared a fortnight sooner than they did. A knowledge of this fact will sometimes give you a great advantage in the treatment of puerperal pneumonia.

When the disease is complicated with tuberculosis it is necessarily of a serious character. I would not despair of a cure, however, unless the phthisis is far advanced, or the pneumonia is secondary upon some puerperal affection, as well as upon the tuberculosis. We must not forget that there are cases in which, while pregnancy has apparently arrested or suspended the development of tubercles, the pu-

erperal condition may have an opposite effect. With some women this fatal acceleration of phthisis is very marked.

If this form of pneumonia is complicated with pleurisy, and more especially with pleuritic effusion, the risks are increased by the tendency of the contained serum to degenerate into pus, and to form an abscess. These cases recover very slowly.

Metastatic abscess in the lung, like the case of mammary abscess which I have shown you this morning, may be salutary. They sometimes afford a means of escape and diversion for poisonous matters, a species of safety-valve for the organism, and are not of necessity fatal. In some cases there is a tendency in these abscesses to revert to their original site; and in others to locate themselves in the larger joints, and even in the pelvic articulations. Exceptionally, a secondary abscess in the ankle or elsewhere, in the course of a primary pneumonia, may be a good sign; but usually, as with our patient, it is not so.

Grisolle's idea that the pneumonia of pregnancy is a very serious affection is undoubtedly correct; but there are some cases of broncho-pneumonia of a catarrhal nature which come over from the pregnant to the puerperal state, that are curable. So that the prognosis is not always unfavorable. It is said to be a bad sign when the odor of the breath distinctly resembles that of the lochial discharges.

When puerperal pneumonia is complicated with very grave general conditions, or when it is hypostatic, we should be chary of promising to cure it. Occasionally, no doubt, the pulmonary lesion affords a diversion which, although it is beset with danger, may be salutary and curable. Usually, however, as in other puerperal diseases, the prognosis varies not only with

the septic or the pyæmic vitiation of the blood, and of the secretions, but also with the more or less serious nature of the intercurrent affections.

Exposure of the patient to cold and wet, and to injurious atmospheric influences, when it has caused pneumonia during the lying-in, sometimes appears to stamp it with an almost necessarily fatal character. It was for this reason, among others, that I felt extremely anxious in regard to our patient at my first visit. You cannot have forgotten my remarks upon this subject.

This drawing on the blackboard will give you the morning and evening record of the pulse, and of the temperature in the case under review. The blue line indicates the pulse, the red one the temperature. The figures are already in your case-books, but this chart is more graphic and suggestive.

Observe that, in this instance, the septic period was extended until the close of the thirteenth day. This is somewhat unusual, and is referable to two causes: (1) to the total suppression of the lochia, and (2) to the fact that at first the pneumonia was circumscribed, and of very limited extent. For the space of eight days, with two brief exceptions, the temperature did not fall below 102°, and then it only reached 101°. While this state of things indicated exemption from immediate danger, in so far as the lungs were concerned, it could not continue. The local lesion must declare itself, by a lowering of the temperature, and by a disclosure of the physical signs which should and did unmask the pneumonia.

When this septic period had passed, and the pneumonia had become lobar, the descent in the scale indicated the drift toward suppuration. A falling temperature, in cases like this, always foretells one of two things, *id est*, either

suppuration or convalescence. If the decline is gradual, and the general and local symptoms improve accordingly, the prognosis is favorable. But, if the local symptoms become more extended and manifest, and a typhoid condition sets in, the very approach of the temperature to the normal standard implies the risk of abscesses, and is full of danger. It is under such circumstances that one may be gratified and encouraged, as we were on the eighteenth day, by a rise of the temperature; but, if it drops again suddenly, as it did on that day, and more especially at evening, our hopes will be blasted.

So that, in similar cases, it will not always be safe to conclude that, because the temperature has become more nearly normal, therefore our treatment has been most fitly chosen, or that our patient is getting well. Invaluable and indispensable as is the clinical thermometer in the diagnosis, prognosis and treatment of all kinds of puerperal affections, it nevertheless may be insufficient to meet all the requirements of the case. We must not rely upon it exclusively.

In the study of puerperal pathology there is nothing more tricky than the pulse. But, in this case, the record of the pulse had a certain significance, which this blue curve-line will keep in your minds. Observe that from the thirteenth day the relative position of these two lines is changed. Until that time (excepting for about twenty-four hours, beginning on the evening of the second day), the heat-line was invariably the highest. But from the evening of the thirteenth day forward, this order was exactly reversed. The inference to be drawn from this clinical fact (which is absolute and not fanciful), is that an exclusive reliance upon either of those two methods of examination would certainly have misled us. To have judged by the pulse alone in the first half of the period, you would have said that the patient was doing well; and

to have depended upon the thermometer exclusively in the last half of it, you would have decided that there was no danger.

There are cases like this in which the contrast and comparison of these two curves is worth a hundred times more than either of them alone. This is one reason why I have had them arranged for you on the blackboard. They should always be studied together and compared with each other, for their conjoined use will enable us the more accurately to perceive the real constitutional condition of the patient, and therefore to make a better prognosis and a better prescription.

Here is the morbid specimen which illustrates our case. Three-fourths of the upper lobe of the right lung is involved in this abscess. You can see its outline, and when I turn it inside out the whole suppurating surface is exposed.

The pus is thick, and of a greenish-yellow color, and we find, by cutting, that it had pushed its way into the right bronchus. If this discharge had overflowed into the larger tubes, the patient must have died from suffocation. For, in her weak state, it would have been impossible for her to have expectorated so large a quantity at one time.

Whether this lesion began with the embolic infarction of one or more of the small pulmonary vessels, we cannot say. According to Virchow, if the abscess had been metastatic, it must have originated in that manner. It is very probable that the abscess at the ankle was due to the plugging up of some of the little vessels in that vicinity. But in this case the pneumonia must have followed the usual course in its local development, always remembering its lobular character. There was, probably, engorgement, then effusion, fibrinous coagulation, extension of the disease, and a gradual coming on of the suppurative process.

When the stage of red hepatization is reached, in puerperal pneumonia especially, there is a fearful tendency toward purulent infiltration. Hence the simplest and most circumscribed attack of primary pneumonia in a lying-in woman may develop into an abscess, as this has done, and quite independently of pulmonary infarction. In secondary puerperal pneumonia this termination is the rule and not the exception.

I take pleasure in showing you the uterus and its appendages. You will be struck with the thickness and firmness of the uterine walls. As we cut through them there is no evidence of phlebitis, and the lining membrane of the cavity appears healthy. The ovaries and other appendages are normal. You can examine the heart-clot and this section of the ulcerated intestine at your leisure.

These convergent facts are worthy of your notice and study, not only because they will be likely to repeat themselves in your own professional experience, but also because, at present, there is almost nothing in our literature on the subject of puerperal pneumonia.

LECTURE XXVII.

SUMMARY.—Rheumatism, continued (see Lectures III, IV, V and IX). *Case* of rheumatism with endocarditis. Aortic insufficiency. Two sounds in the crural artery. How to distinguish the systolic from the diastolic murmur. Theory and practice. Science and art. Theory of the two arterial murmurs in insufficiency. Mono-articular rheumatism. Good effects of *china*. Articular rheumatism. Contraction of the mitral orifice. Hemoptysis, *case*. *Millefolium*. Certain rare complications of articular rheumatism. Hematuria, *case*. *Hamamelis* and *Spigelia*. Spinal rheumatism, *case*. Acute parenchymatous myelitis of the anterior gray columns of the cord. *Plumbum*. Locomotor ataxia, *cases*.

Rheumatism.

GENTLEMEN: Unlike nosography, clinical teaching is not compelled to follow a fixed order from which there is no departure; and, although we have already spoken to you of rheumatism, and of its cardiac complications, we think it well to return to this subject, and to call your attention to the patient who occupies No. 4 in the men's ward. The occupant of No. 5 will furnish the occasion to speak to you of mono-articular rheumatism. And several other rheumatic patients will illustrate the clinical history of some rare complications of this disease, especially of rheumatic paraplegia and hematuria.

CASE LXX.—*Acute articular rheumatism, endocarditis, aortic insufficiency, double murmur in the crural artery.*

Joseph R——, aged twenty-eight, domestic, admitted to No. 4, men's ward, on the 22d of December; discharged on the 23d of January.

Except the small-pox, with which he was attacked six years ago, this man, whose constitution is vigorous, enjoyed good health until the month of May, 1875. He says that during the

war he suffered very much, and that for eight months he was exposed to the inclemency of the weather.

In the month of May last he began to have acute pains in both knees. These pains were brought on by motion, and disappeared with rest and at night. There was no change in his general health, and he continued his occupation of footman until December.

On the 18th of December he had chills, and at the same time the pains, which he had for seven months in a slight and not very severe form, became so intense that he was forced to take to his bed. The leg and the left foot, however, were first seized. The next day the joints of the right leg became in turn the seat of a painful swelling. In the onset there was no sign of cardiac complication.

He entered the hospital on the 22d, with the following symptoms:

The fever, which he had at the onset, has subsided; in the morning the temperature was normal, but in the evening it reached 100.9°; the upper extremities have escaped, but the joints of the left leg are still somewhat swollen and painful; respiration is slightly oppressed, and the qualities of the pulse are such as to draw our attention to the heart. The pulse is strong, vibrating and receding.

By listening to the heart-sounds we find at its base a bruit de souffle, which can be heard from the vessels of the neck to the femoral artery. Over this latter vessel we distinguish the double sound which corresponds to the systole and the diastole of the heart. The first of these is the stronger; the second, which can only be heard by means of the stethoscope, is the weaker one. *Aconite*, 3d dil., was prescribed.

December 25. The patient suffers much less with the left knee and with the joints of the left foot; in the morning the

apyrexia was complete, but in the evening the temp. was 101.12°, and the pulse 88. The same prescription.

December 28. So far as the articulations are concerned, he is doing well; but during the day, and more especially during the night, he has had some palpitation of the heart. *Colchicum*, 3d dil.

December 31. The souffle has diminished a little in its intensity; there is always a slight evening exacerbation of the fever; the appetite is better. The same remedy.

January 3. The swelling in the joints has disappeared, and they are no longer painful. *Aconite*, 3d dil.

January 8. The evening temperature is always 100.4°; the palpitation is less frequent, and the patient is more quiet during the night. The same remedy.

January 11. The fever is entirely broken, but he complains of pretty severe pains in the joints of the left leg. *Chininum sulph.*, 3d trit., twenty centigrammes.

January 13. The pains in the joints are less severe, but the palpitation has returned and is worse than ever. Nevertheless, the same remedy was continued.

January 15. He passed a pretty good day yesterday; today auscultation shows that the souffle at the base of the heart has returned, but that it is decidedly softened in its tone. The same remedy.

January 19. The pains have slightly increased since yesterday. *Chininum sulph.*, 1st trit.

January 20. He complains very much of his heart. During the night he had a great deal of palpitation, and for two days the pulse has had an intermittent beat. *Spigelia*, 3d dil.

January 22. No improvement in the rhythmic movements of the heart. *Spigelia* in the mother tincture, three drops.

January 24. Yesterday there was a slight aggravation of the symptoms. *Spigelia*, 30th dil.

January 26. He is more calm, and the intermittent beating of the heart is less frequent. *Cactus*, 12th dil.

This patient left us to try another kind of treatment. After a few months he went home to the country with confirmed heart disease. Then he applied for readmission to the hospi-

tal, but the condition of his health did not permit him to make the journey.

Here is, therefore, a rheumatic patient who, from the beginning of his illness, has had a tendency toward chronic disease. For seven months preceding it he had had occasional pains in the joints, but without fever. Then followed an attack which was not very severe, and which yielded to remedies, but which returned three or four times within a month with diminishing intensity.

The endocarditis, which began with his admission to the hospital, was not accompanied by a violent febrile reaction; but the lesion increased whenever the trouble with the joints disappeared. This endocarditis persisted, in spite of homœopathic and allopathic treatment, until a cardiac cachexia was developed.

The intensity of the heart affection, and the absence, or at least the mildness of the febrile reaction, incline us to believe that it was not of very recent date. And yet the physician who had charge of him previously insisted that, in the outset, his heart was not at all implicated.

Therapeutically considered, this case is one of very little interest, for the patient left before the principal remedies for the cardiac lesion could be used. Following the indications of Petroz in rheumatic endocarditis, we gave *colchicum*. But it was insufficient; and so also were *aconite* and *spigelia;* and he determined to leave just as we had begun with the *cactus*.

The interest of the case centers in the diagnosis of aortic insufficiency, and in the clinical value of the signs that pertain to this lesion. We shall insist for a moment upon this particular point.

A diastolic *bruit de souffle* having its greatest intensity at the base of the heart, and extending along the peripheric

arteries, in which vessels we may recognize the double murmur, and a pulse that recedes and rebounds, are unmistakable symptoms of an insufficiency of the sigmoid valves of the aorta.

Theoretically speaking, nothing is easier than the diagnosis of this aortic lesion; but if you cannot distinguish clearly between a diastolic and a systolic murmur; if you do not know how to seek and to find the double murmur in distant arterial trunks,—in the femoral artery, for example; if you do not detect the evidence afforded by Corrigan's pulse (which rebounds and recedes), you will blunder in the practice, for medicine is both a science and an art*—a science, when it treats of those principles upon which it rests, and also when it describes morbid phenomena; and an art, when its knowledge is made use of for the benefit of the sick. Here the most extensive and the most positive learning is not sufficient; for the application of the senses is necessary, and upon their education and their delicacy will the success of the physician depend; and the special work and use of the clinic is to educate the senses and to teach you to perceive clearly the most delicate symptoms.

In this case you will recognize, when your ear has become familiar with the heart-sounds and with the interval between them, that the bruit de souffle coincides with the cardiac diastole. The systole causes a dull noise, which is followed by a very brief silence, after which comes the diastole with its clear and brief click, which is followed by an interval of silence of a much longer duration than that which succeeds the systolic murmur. Therefore, a dull murmur, a very brief silence, a dry sound and an interval which is relatively long, make a cardiac revolution.

If your ear was accustomed to seize upon these shades of expression, it would be easy for you to observe in this case

*See my work on General Pathology.

the bruit de souffle following the brief interval and preceding the other, and that, consequently, it takes the place of the dry diastolic murmur, which murmur exists no longer, from which you would conclude that the pathological murmur is really diastolic belonging to the second beat; and, as it is located at the base of the heart, it is to be taken as a certain sign of aortic insufficiency.

In using the microscope it often happens that those who know the least of what is really in the field of the instrument see the most, and say the most of what they think they have seen. In the practice of auscultation the ear needs to be trained to exclude what it does not hear, as well as to catch and to keep what it does hear; and unless we are able to interpret these sounds, the mere hearing of them will convey no more information than if we listen to one who reads to us in a language that we do not know. Our author certainly does not confuse his ideas with words, but, on the contrary, is very plain and practical. With such an aid, a little study will make this whole subject clear and available.—L.

There is another and a more common method of determining whether the bruit de souffle is systolic or diastolic. It consists in taking the pulse at the same time that we practice auscultation. Since the cardiac systole corresponds sensibly with the arterial diastole, and the cardiac diastole with the arterial systole, this method answers very well. By it, a bruit de souffle, which is heard the moment that the pulse strikes the finger, will be a systolic murmur, while, on the contrary, the diastolic murmur occurs during the interval between the pulse-beats; but if the heart beats rapidly, the application of this method will be difficult, and will necessitate a delicacy of touch and of hearing of which every doctor is not possessed.

Here, then, are two means of knowing if a bruit de souffle is diastolic or systolic. You can use them conjointly; but when there is a diastolic murmur in the aorta with insufficiency of the semi-lunar valves, you will confirm the diagnosis by detecting the two sounds in the remote arteries.

The femoral artery, by its volume, by its superficial position in Scarpa's triangle, and by the ease of its exploration with the stethoscope (for in this case the stethoscope is indispensable), is the one in which you should seek the double bruit de souffle which confirms the existence of insufficiency of the aorta. By applying the stethoscope very carefully to the femoral artery, you will readily hear a dull murmur which corresponds to the arterial diastole, and consequently to the systole of the heart. But if, without removing the instrument, you press it firmly against that vessel, you will hear a second sound, which is more feeble and more clear, and which corresponds with the arterial systole and the cardiac diastole.

The first of these sounds is due to the volume and force of the column of blood, and to the compression of the vessel by the stethoscope; but the second murmur, or that which corresponds to the arterial systole, is due to the falling back of the column of blood that results from the aortic insufficiency. This reverse flow affects the whole arterial system, gives the rebounding character to the pulse, and to the sphygmographic trace its dicrotic peculiarity. This sign, if carefully observed, is, therefore, a positive sign of aortic insufficiency.

Since this second murmur is coincident with that of the cardiac diastole, the attempt has been made to explain its occurrence, by supposing it to be an echo of the latter. But the retreat of the column of blood, which certainly takes place, gives the only admissible explanation of this second murmur.

This very practical discussion of the physical signs of the case under review is exceedingly suggestive and satisfactory. Those readers of this work who are interested in the matter of physical diagnosis—and every general practitioner should be—will do well to procure a copy of Dr. H. C. Clapp's *Tabular Hand-book of Auscultation and Percussion*, Boston, 1879. It is exceedingly concise and practical, and really deserves a wide circulation.—L.

I hope that with these two signs you will be able to distinguish with certainty an insufficiency from a narrowing of

the aorta; for, in the latter lesion, the bruit de souffle is systolic; there are no abnormal murmurs in distant arteries, and the pulse is small and often unequal. Besides, the sphygmograph will settle the question. You will recall the tracing which belongs to aortic insufficiency, and which is so characteristic that it cannot be confounded with any other. (See Trace No. 2, page 20.)

Here is a case of *mono-articular rheumatism* which was speedily relieved and cured by *china:*

Case LXXI.—*Acute mono-articular rheumatism. China. Cured.* M. Joseph N——, aged twenty-six, was admitted to the men's ward, No. 5, on the 26th of December, and discharged on the 16th of January. He applied for relief from an acute affection of the right knee-joint.

His symptoms were as follows: The right leg is in a state of demiflexion, and cannot be straightened without difficulty; the knee is swollen, and the skin red and somewhat tense; the joint is not sensitive to pressure, excepting over the posterior ligament. With both hands applied in front of the joint the sense of fluctuation is easily recognized. The etiology of this case of mono-articular arthritis is somewhat obscure.

The patient has never had rheumatism, and tells us that it is only four days since he began to suffer with the right knee. He has not been dissipating of late, and, moreover, declares that he has never had the gonorrhœa.

With this exception his general condition is good. There is no fever, but the pains in that joint are very severe. The prescription was *rest* and *apis mellifica*, 3d trit., twenty centigrammes.

December 28. The swelling of the knee has not diminished; the pains are even a little worse than at the onset. *China*, 3d trit., twenty centigrammes.

January 2. The condition of the knee is greatly improved; it is not so swollen, and the effusion within the joint is decidedly less than before. The same remedy.

January 6. He continues to improve. The movement of

the joint is almost painless. *China*, 2d trit., twenty centigrammes.

January 12. The right knee is reduced to the size of its fellow, but to-day he has some pains in the left knee which resemble those of the first attack. *Sulph.*, 6th dil.

January 15. The pains in the left knee did not return. The patient complains only of the old stiffness in the right knee. *China*, 3d trit., twenty centigrammes.

This patient was discharged cured. The effect of the china was very remarkable. The improvement began with the first days of its administration, and continued constantly until, in a fortnight, the joint had returned to its natural size. You are already aware of my preference for china and for chininum sulph. in gouty and rheumatic arthritis. My experience has often confirmed the value of these remedies, and I insist that nothing is more certain than the effect of china in rheumatic arthritis, although the excellent Manual of Dr. Richard Hughes is almost silent upon this subject.

Case LXXII.—*Acute articular rheumatism; mitral constriction; hemoptysis.* M. Eugène C——, admitted on the 12th of December, discharged on the 17th of December. (Men's ward, No. 2.)

This patient, aged twenty-eight, followed a very severe occupation, that of a machinist. Two months ago, after working harder than usual, he had some spitting of blood. Nevertheless, he continued to labor as usual until two days ago, when he quit work entirely.

He had not enjoyed perfect health prior to this illness. At the age of eighteen he had a first attack of articular rheumatism, which was general, and which continued for three months. Four years later he was again seized with rheumatism, and the illness was of much longer duration. In fact, he says that he kept his bed for eight months, and that his convalescence dragged along for three months.

His health was, however, pretty well established finally. The heart was not implicated until three or four years later,

and the cardiac symptoms were very mild at first. Palpitation from time to time, breathlessness while walking, and a slight œdema about the malleoli at evening, are the symptoms of which he has now complained for some years. But during the last two months his disease has taken a much more acute form.

When this man entered our wards he was still expectorating blood in considerable quantity. That blood was of a bright red color, and mixed with air and a little mucus. He took *millefolium*, 3d dil., and was put upon the milk diet.

December 14. He raised a little more blood yesterday, but feels a great deal better to-day. Physical examination of the lungs revealed nothing abnormal. We found by auscultation of the heart that, at its apex, there was a bruit de souffle, which was not intense, that preceded the first sound of the heart — the pre-systolic murmur. At the base of the organ the sounds were normal.

The pulse had no very decided peculiarities; it was slow and strong, with a feeling of resistance to the finger. The same treatment.

December 16. The patient gains strength; no more cough nor bloody sputa; respiration is free, and the palpitation occurs very rarely. He wants to go to work again. Discharged.

A month later he had had a slight relapse; but the sanguineous expectoration was arrested in two days by the same remedy that he had previously taken.

Two successive attacks of rheumatism, and a cardiac affection following the last of these attacks, several years later; a contraction of the mitral orifice, with a pre-systolic murmur at the apex of the heart; then a pulmonary congestion and hemorrhage, which was the almost fatal consequence of the obstruction of the blood in the left auricle, were the obvious morbid symptoms of this case. For the relief of the cardiac hemoptysis, *millefolium* has been quite as useful as we have often found it to be in the hemoptysis that is incident to pulmonary tuberculosis.

I will now call your attention to a more complicated case, and one in which the symptoms are much more difficult of interpretation.

Case LXXIII.—*Acute articular rheumatism; rheumatic endocarditis; hematuria.* Maria B——, aged twenty-six, a cook, was admitted to ward 3, No. 3, on the 12th of December, and discharged on the 6th of February.

After having enjoyed good health until her twenty-first year (1871), this patient experienced her first attack of articular rheumatism. Its course was protracted, for it kept her in bed six weeks. This attack left no perceptible sequelæ, for, having quite recovered, she resumed her usual occupation. For about three years there was no trouble, either with the joints or with the heart.

In 1873 she began to have palpitation and difficulty of breathing whenever she walked, and especially when she was forced to move rapidly. Sometimes, at evening, there was a little œdema about the ankles.

Nevertheless, she continued at her work until the end of November last, at which time she was seized with pains in the joints, and chiefly in those of the inferior extremities. These joints become slightly swollen. When she entered the hospital she had only a few signs of this recent attack.

The fever also is broken, but the pulse is quite frequent, and is characteristically strong and vibrating. The joints are but slightly painful, but she complains the most of the excessive violence of the palpitation, which persists for hours, forcing her to sit up in her bed, and which is followed by great agitation, that continues long after the palpitation has subsided. The fits of palpitation recur several times during the day.

The symptoms disclosed by auscultation of the heart are a soft bruit de souffle, with the first sound at the apex of the heart; and also the same kind of a murmur with the second sound, at the base of the heart. *Aconite*, 3d dil.

December 14. Slight improvement. As she has not had her menses for two months, *Pulsatilla*, 3d dil., was prescribed.

December 18. She has been taken with pains in both knees again, but is less agitated than before. *Bryonia*, 3d dil.

December 24. The pains have disappeared, but for two days she has complained of frequent palpitation. *Cactus*, 3d dil.

December 27. No improvement, and the palpitation is accompanied by precordial anxiety. *Spigelia*, 6th dil.

December 30. She is a little better to-day. *Aconite*, 3d dil.

January 4. *Spigelia*, 3d dil., was resumed. The menses have appeared.

January 7. She continues to be agitated, and complains of a very severe pain at the apex of the heart. *Spigelia*, in the mother tincture, three drops during the day.

January 11. She passes blood with the urine. *Hamamelis*, 3d dil.

January 13. The hemorrhage continues, but in smaller quantity. It is worthy of note that the blood is found in the urine only in the evening; that which is passed during the night and in the morning is quite limpid. *Hamamelis*, 1st dil.

January 15. No more blood in the urine; she still suffers greatly with her heart. *Aconite*, 1st dil.

January 17. Same. *Spigelia*, as before.

January 21. She is more calm; the fits of palpitation come very rarely. The same treatment.

January 22. The blood has reappeared in the urine. *Hamamelis*, 1st dil.

January 24. The hematuria has ceased. *Spigelia* again.

January 29. Under the last remedy the patient continues to improve.

February 2. Although she had her menses at the beginning of last month, they have not reappeared. *Pulsatilla*, 3d dil.

February 4. The menses came yesterday, and to-day she feels pretty well.

February 6. She is so much improved that she wants to go to work again. The *spigelia* was continued for some days.

In this case, as with the former one, it was some years after the first attack of rheumatism that the patient began to complain of cardiac symptoms. In Case LXXII four years, and in Case LXXIII three years, elapsed between

the onset of rheumatism and the appearance of endocarditis. Moreover, in these two cases, we remark that the endocarditis was without fever from the beginning, and that its course was decidedly chronic. The palpitation, the dyspnœa, the precordial pain, and the œdema of the ankles, were the only signs of the trouble with the heart. These facts are far from being rare; and, as you will often meet with them in practice, I have called your attention to them in order that you may not be surprised by this *latent* form of rheumatic endocarditis. For, when a patient has survived an attack of acute articular rheumatism, and escaped without any implication of the heart, you should not be quite certain that the cardiac affection will not develop itself some years later, even though there is no new affection of the joints.

Our patient presented one symptom which is very rare in acute articular rheumatism — I mean the *hematuria*.

It might be asked if the hemorrhage in this case was connected with a local rheumatism of the kidneys; with the trouble of the circulation on account of the cardiac disease; or with the chlorosis of which this girl shows the most positive symptoms. Thus, the palpitation that she had was out of proportion with the valvular lesions; on the contrary, it had all the qualities of chlorotic palpitation; the delay and suppression of the menses leave no doubt of the existence of a chlorosis which, in this particular case, complicated the articular rheumatism and its incidental affections.

We think that this patient's hematuria was due to the condition of the blood, *aglobulie*, or a diminution in the ratio of the red corpuscles, which characterizes both the chlorosis and the articular rheumatism; and that it was induced by the delay and the scantiness of the menses; that, in a word, it should be regarded as a case of supplementary

hemorrhage, or, as some prefer to style it, a case of vicarious hemorrhage.

Whatever it may be, the fact remains, as with all facts which are exceptional, the pathological significance of this hemorrhage is doubtful.

We should speak of the rapid action of the *hamamelis.* This remedy, which you have already observed to be so efficacious in bleeding hemorrhoids (see page 196), arrested and cured the hematuria in this case,—the first time in four days, and the second in two days. The first dilution acted more promptly in this instance than the third.

Spigelia is the remedy which has afforded our patient the most complete and the most durable relief for her frightful palpitation. It was indicated by the severe pain at the apex of the heart, and by the extreme anxiety of the patient. We evidently had the best effect from the mother tincture. It is worthy of remark, and of recollection, also, that, while *aconite* seemed to be indicated by the rheumatic nature of the affection, it failed completely.

The next case is interesting, both because of its rarity and because of the clearly defined nature of its symptoms.

Case LXXIV.—*Articular rheumatism; the acute parenchymatous tephro-myelitis of Dr. Charcot* (*acute fascicular myelitis of the anterior cornua*). Miss N——, aged twenty-six, admitted on the 19th of February, and discharged on the 19th of March. (Ward 3, No. 1.)

This patient's health was pretty good until 1873. During her infancy, however, she had had a scrofulous affection. In December of that year, being seized with acute articular rheumatism which affected the various joints, she kept her bed for two months. After this first attack her health was pretty well restored, and she was able to resume her duties.

At the beginning of January, 1875, she was taken with a

second attack of rheumatism, accompanied by fever and violent pains in almost all the articulations. For this she received the ordinary treatment for rheumatism.

Her present symptoms are as follows: Several of the joints are still somewhat painful, but they are neither red nor swollen; there is complete paralysis, which has already involved the muscles of the neck and those of deglutition; the patient, who is helpless when she is lying upon the back, cannot move the extremities in the slightest degree; when the assistants seat her upon the bed her head falls upon her breast, and she cannot lift it up again; it is exceedingly difficult for her to swallow, and she must be fed with the greatest care; the sensibility is intact, and when the parts are moved they are even painful; she is naturally and equally sensitive to the application of cold and heat; the electric contractility is almost abolished, and while Faradization is very painful, it is necessary to apply a very strong current in order to produce contractions of the muscles of the fore-arms and of the legs.

This general paralysis appears insensibly to have followed the immobility which was caused by the rheumatism of the joints.

The respiration is very much oppressed, but this oppression is due to a cardiac affection. There is, indeed, a bruit de souffle with the first sound of the heart, heard at its apex, which is the sign of a mitral insufficiency of rheumatic origin.

The patient has some appetite, but no fever; obstinate constipation, but no signs of paralysis of the bladder.

Plumbum, 30th dil., four globules in 200 grammes of water, three teaspoonfuls daily. The diet to consist of porridge.

February 24. Positive improvement; she swallows better, holds up her head, and lifts the right arm a little. The same treatment.

February 27. The improvement continues; the voluntary movements have returned, but in a limited degree, to the upper and lower extremities. *Plumbum*, 30th dil.

February 28. The power to move increases, and the patient can swallow solid food without difficulty. *Plumbum*, 30th dil.

March 10. Under the influence of *plumbum* all the natural movements are entirely restored. The patient complains of

the eyes, which are red and inflamed. *Apis mellifica* cured this rheumatic ophthalmia, and some days later she was discharged, being completely cured of her paralysis, but still having the mitral insufficiency.

Spinal rheumatism is an affection which is rare, and which is still imperfectly understood. For anatomical reasons, the physician generally locates this disease in the meninges, where the arachnoid offers an analogy of structure with the synovial membranes and the endocardium, and which seems to favor the localization of rheumatism upon this membrane. The case just cited does not confirm this prevalent idea, for the totality of the symptoms proves that it is a case of myelitis of the *anterior gray matter of the cord*, or of *acute parenchymatous anterior tephro-myelitis* of Charcot.

In assuming the paraplegic form, the paralysis developed itself very rapidly. In a few days it reached its maximum of extent and of intensity. It involved the muscles of deglutition, which is a certain sign that the lesion had passed the limits of the marrow and had attacked the bulb. Overcome with inertia, the muscles had almost entirely lost their reflex and electrical excitability. However, the sensibility was intact, and the patient complained bitterly of the electrical investigations that we thought best to practice upon her Finally, there was neither a paralysis of the bladder nor ot the rectum.

In this case the posterior gray fasciculi were intact, for the general sensibility was perfectly preserved; the lateral fasciculi had also escaped, for there was neither contraction nor convulsion, and, under the influence of volition the bladder and the rectum performed their functions,regularly. Consequently, the only lesion was one of the anterior or central gray substance of the cord, for the affection consisted in the

almost complete loss of the voluntary and electrical contractility. This part of the cord was undoubtedly involved throughout its whole extent, for all the muscles except those of respiration were paralyzed. There is no doubt that if this disorder had persisted, *muscular atrophy* would have developed very rapidly, for the gray cells of the anterior columns exert an undoubted action on the nutrition of the muscles.

In closing this lecture, gentlemen, I must insist upon the heroic action of *plumbum* in this form of paraplegia. On the fifth day of the administration of the remedy we already observed a decided improvement; the patient swallowed better, held up her head, and lifted the right arm a little. Three days later the voluntary movements, although still feeble and limited, returned to all the extremities; the next day she began to swallow solid food, and in two days more, *id est*, in less than twenty days, the paralysis had entirely disappeared.

You will also observe that the remedy was given in globules of the thirtieth dilution.

Plumbum is perfectly homœopathic to muscular paralysis with a loss of electrical contractility, and with consecutive atrophy. This fact is placed beyond a doubt by the complete history which we have in our day of lead paralysis; but the *plumbum* is as applicable to the lesion as it is to the paralysis itself. In fact, Vulpian caused an acute myelitis by poisoning a dog with lead; and Hallopeau has observed the same fact in a man who had been poisoned by it.

Plumbum is, therefore, homœopathic to acute and chronic inflammation of the gray matter of the anterior columns of the cord. Consequently, it is indicated in the treatment of *acute* or *chronic anterior tephro-myelitis;* in other words, in

the *confirmed paralysis of infants*, in *acute spinal paralysis* and in *progressive muscular atrophy*, the lesion of which consists in an acute or chronic inflammation of the substance of the anterior cornua. Dr. Richard Hughes very properly recommends plumbum in the treatment of progressive muscular atrophy, which, as we have just said, is only a chronic myelitis affecting the anterior horns of the gray matter.

Progressive Locomotor Ataxia.

As germane to the last case given by Dr. Jousset, we think best to insert a few interesting reports upon this peculiar and very troublesome disease. The first of these is from our friend, Dr. N. A. Pennoyer, of Kenosha, Wis., and is designed to illustrate the virtues of the *argentum nitricum* in this form of spinal affection.—L.

Case I.—The first case was that of a lady sixty years of age, who had been under the care of physicians in the east, where she resided, and where she was treated for rheumatism, neuralgia, etc. She suffered greatly from chilliness during the previous winter, and required her room so very warm that it was unbearable for her friends to remain in it. She suffered from dimness of vision, attacks of vertigo that were worse in the dark or when closing the eyes, neuralgic pains in hands and feet, followed by numbness and awkwardness in gait when walking. The sensation in the feet was of a prickling like needles, followed by a velvety feel of what she touched. She had difficulty in going up and down stairs and in moving one foot first. The pulse was frequent. She had a sighing respiration, and was considerably depressed in spirits. *Argentum nit.*, 2d decimal dil., in spring water, was given four times daily.

The improvement was very satisfactory. Her eyes regained their customary strength, the anæsthesia of the extremities disappeared, so that she could walk as usual, going up and down stairs with each foot in turn advancing.

In seven weeks she returned home, and I was informed that no relapse occurred, she being able to attend to her usual household duties.

A year and a-half or two years following, a sister had a long illness with paralysis, which proved fatal, my patient being with her continually, and doing much toward administering to her comfort. A few months ago I learned that she also had died, but with general dropsy, nearly three years since she was under my care.

Case II.—The next case was that of a bachelor, forty-two years old, a saloon-keeper by occupation, who had led rather a dissolute life. He had vertigo when the eyes were closed, and in a dark room he could not stand; the staggering, but jerking step of this disease; sleeplessness at night, and much neuralgia in the extremities, which was worse at night. The pulse was frequent and irregular; sighing respiration; an enormous and ungovernable appetite; the bowels were constipated; he had some cough and considerable emaciation.

The case was an unpromising one, it having been developing for years; but we prescribed the *argentum nit.*, as for the former case. The improvement was soon noticeable. The vertigo was lessened; the constipation was materially relieved; he walked easier, and could go up and down stairs so much better that it was especially noted by the other house-patients.

He remained only four or five weeks under treatment, asking to go home on business, and did not return. I have since heard that he was drifting into a worse condition, but the effects of the argentum nit. were unmistakable while under its influence. The case had advanced too far to reasonably expect anything more than a stay in the progress of the disease.

Case III.—I had one other patient who had an asthmatic affection that was causing him considerable difficulty, and in which the symptoms of locomotor ataxia were present. The asthma came on at night, as soon as he went into the house, and it was worse in the room, so that it obliged him to seek the open air. He also had a slight cough, and thought that a cold was the cause of the difficulty. He used tobacco excessively.

On close inquiry, I found that he had vertigo, which was worse when closing the eyes, and he had difficulty in keeping to the sidewalk when he was out at night. The bowels were

irregular, there being alternate costiveness and diarrhœa. He had neuralgic pains in the extremities, and a sensation of numbness in them.

This patient had been under my care several times before for neuralgia. The symptoms indicated *argentum nit.*, and it was given him in the second dilution. In one week he was entirely relieved of the asthma, the vertigo, and of all the symptoms just enumerated. I do not regard this as a case of locomotor ataxia; but might it not have led to that disease if it had been improperly treated?

The symptoms of *argentum nitricum* point to it as a remedy for loss of sensation rather than for a loss of motion. I have had several cases of numbness of the lower extremities, with coldness, that have been relieved by its use. One patient with cerebro-spinal hyperæmia had numbness of the limbs; they felt when rubbed "as if boards encompassed them, and these were being rubbed."

A mental symptom which I have not noticed in any of the books, and which I have many times relieved with this remedy, is "a feeling as if a cloud hung over him, with great depression." This is usually attended by a sighing respiration. I never see a patient with sighing respiration that I do not think of *argentum nit.* It is not the yawn that indicates hyoscyamus, but an occasional sigh, which may even be unnoticed by the patient. This symptom is aggravated in a close room, and may require going to the window or to the open air for relief.

One case of this sighing that was caused by a suppressed eruption (the itch) I cured with *sulphur*, 200th dil. I should give the sulphur for the relief of this symptom if it had been caused in this way; but if it came from other causes, the *argentum nit.* answers a better purpose. The stomach symptoms of argentum nit. are valuable: Frequent or constant empty eructations, great flatulency, and a weak digestion. The empty eructations seem, in many cases at least, to come

from spasm of the diaphragm, the stomach literally pumping up the wind. The bowels are constipated and torpid, or there is diarrhœa alternating with constipation. We have many times verified all of these symptoms, and find they may attend locomotor ataxia.

I have used the *argentum nit.* in multiple sclerosis, but without any special indications for it, and my patient derived no benefit. I do not think it useful in antero-spinal paralysis; whereas *plumbum*, both by its pathogenetic symptoms and from pathological indications, is eminently so.

The next selection is a case furnished by A. C. CLIFTON, M.R.C.S.E., to the *British Journal of Homœopathy*, Vol. XXXIV, page 127. In many respects this is one of the most remarkable cures on record.—L.

A Case of Duchenne's Pseudo-Hypertrophic Paralysis.—M. J——, aged eighteen, has been ill more than a year. She states that about a year ago she noticed purple spots, about the size of a shilling, on her legs, and felt very weak. She bathed her legs with cold water for several days, which did them good, but at the next catamenial period she was unwell merely for a few hours, and had only a slight and pale discharge. She continued to feel weak, lost her appetite, suffered with headache and palpitation of the heart, and was unable to retain her situation as general servant. Whilst in this condition she went as in-patient to the Northampton Homœopathic Dispensary in the following condition:

It is with great difficulty that she can walk a few yards; when she does so it is with her shoulders thrown backward, the abdomen prominently forward, the legs separated, walking in a waddling side-to-side manner, and it is with difficulty that she can even stand, as her legs feel as if they will give way, except when widely separated. She cannot rise from a chair without assistance; complains of numbness, and pins-and-needles sensations in the lower extremities; in the upper extremities no pain or numbness is felt, but some amount of stiffness. She can grasp an object with her hand for a few minutes, but cannot retain the grasp longer than that time. Her face is pale

and anæmic in appearance; appetite is poor; suffers some pain in the left side; bowels act every third or fourth day; the catamenia are irregular, only occurring every six, seven or eight weeks, very little, and pale in color; the urine is normal; there is no vertigo, headache or defective vision; there is some tenderness of the lower dorsal vertebræ. When standing, there is a deep anterior curve of the lumbar vertebræ, which, however, is much diminished when in the prone position. The glutei muscles are firm and hard, and somewhat enlarged; so, also, are the oblique abdominal muscles; the muscles of the upper arm are enlarged, hard, and firm; the right arm, across middle of the biceps, when the arm is extended, measures, in circumference, nine and three-quarter inches, and the left arm, in the same place, measures nine and a-half inches; the forearms are apparently normal. The muscles of the thighs and legs are much larger and harder than normal; the circumference of the middle of the right thigh is nineteen and three-quarter inches, and of the left, nineteen and a-half inches; right calf measures fourteen and a-half inches, the left fourteen and one-fourth inches.

This being her condition when admitted, the question of diagnosis was important. I was at the time treating a similar case in a little girl about six years of age, by treating merely symtomatically, not having seen the disease before. Dr. D. Dyce Brown, then of Aberdeen, was staying with me for a day on his way to London; he saw both cases, and diagnosed them as the "pseudo-hypertrophic paralysis" described by Duchenne, a case of which he had recently had under his care, and an account of which he had published. Dr. Brown, however, gave me but little encouragement in the way of treatment, saying that there never had been a case known to be cured except when treated before the pseudo-hypertrophy had commenced and when only in the first stage of weakness, and that the only hope was in electricity. This I could not let the patient have, living, as she did, some miles from here, and as I had no institution for in-patients. I resolved, however, to give the patient a chance of recovery by drugs. She was advised to return home, receiving a placebo until time could be given for studying her case and getting any more leading symptoms of it previous to her present condition.

On examination I found that, as a child, she had been subject to frequent violent attacks of epistaxis, frequent diarrhœa, or rather lienteria, sometimes profuse flow of urine for several days together, and that her growth from twelve to fifteen was very rapid, causing weakness and fainting. These were the only additional symptoms which could be obtained. Notes were made of several medicines, which appeared more or less indicated, such as *natr. mur.*, *pulsatilla*, *phos. acid*, *ferrum* and *zincum*, but *phosphorus* was decided on as most likely to do good. Three weeks after her first visit, *phosphorus*, 3d dil., two drops three times a day, was prescribed, and sufficient medicine was given to last her a month. At the end of this time she was rather better, felt stronger, appetite was improved, face was of better color, there was less stiffness in her arms, and less weakness in her legs. The medicine was, therefore, repeated.

I need not relate her report from time to time, as it was always improved in some respect or other, and, therefore, the same medicine was continued for a period of fourteen months, with the exception of one month, when she had *ferrum phosphoricum*, 1st trit., two grains three times a day, and that because the catamenia, though increasing in quantity, were still very pale. It was an error, however, to give it, as she did not improve by its administration.

At the end of the fourteenth month from commencing *phosphorus* she walked a distance of two miles to Northampton and two miles home, though when she first came she could only walk a few yards. She is now able to do household work, her appetite is good, the catamenia are regular and of good color, and her complexion, though rather pale, is otherwise healthy. The muscles of her arms and legs are much smaller and much less hard; but on walking, her shoulders are thrown somewhat backward, owing to the anterior curve in the lumbar region. For this she wears a spinal support, which I should not have recommended could I have taken her into an institution and given her appropriate treatment by friction, movements, etc. She, however, considers herself well. The course which her improvement took was the reverse of that of the development of her disease: the arms were the first to be relieved, then the

numbness and pins-and-needles sensations in her legs, then the weakness of her legs, next the walking powers, followed by diminution of the enlargement and hardness of her muscles, and finally her general health and strength.

As this subject is not within the range of our special study and experience, we have referred the foregoing cases to our colleague, Prof. Fellows, who is an expert in the treatment of diseases of the nervous system, and who has been kind enough to send us the following communication:

CHICAGO, Ill., Sept. 4, 1879.

DEAR DOCTOR: The proofs of the cases of Jousset, Pennoyer and Clifton, which you were kind enough to show me, are very instructive. The use of *argentum nitricum* in diseases of the central nervous system, where sclerosis is the pathological change, is becoming more and more approved. Dr. Pennoyer's cases illustrate the action of this drug very well.

The history of a case of cerebral sclerosis in a young man was given me orally by the late Dr. G. D. Beebe, where the argentum nitricum cured the case. The diagnosis was confirmed by Dr. Wm. A. Hammond, of New York.

Some years ago I pointed out, in some remarks made before one of our medical societies, that this drug was homœopathic to such diseases of the nervous system as terminated in sclerosis; while *plumbum* would be useful where there was a primary destruction of the nerve-cells, either by softening or atrophy. Dr. Jousset's case fully confirms this action of plumbum. Any sclerosis about the roots of the nerves in this class of diseases is undoubtedly secondary, and a consequence of the primary atrophy of the cells in the anterior cornua.

Allopathic writers say, "the well-known fact that *phosphorus* produces fatty degeneration, should contra-indicate its use" in pseudo-hypertrophic paralysis. Dr. Clifton has shown that it may be the curative remedy when used in safe doses.

A notable symptom in locomotor ataxia may be mentioned, because the teaching of Westphal and Erb must be somewhat modified. They say that the tendon reflex is always abolished in this disease whenever the lumbar cord becomes involved. While this is true in general, exceptions are to be made to the rule. Prof. Berger, of Breslau, found in eighty-two cases that it was absent in two of them. The absence of the patellar reflex has also been observed in diphtheritic ataxia. Should this symptom, however, come on in any given case after atrophy of the optic nerve, after a very early symptom of the disease had made its appearance, it would be very suggestive of tissue change. It should, therefore, be sought for early and repeatedly, and, should the reflex disappear, it would probably mark an extension of the disease.

Very respectfully, etc.

H. B. FELLOWS.

LECTURE XXVIII.

SUMMARY.—Scrofulous keratitis, *case*. *Apis mellifica* and *apium virus*. Acute articular rheumatism terminating in white swelling, *case; sal croisici*.

Scrofulous Keratitis.

GENTLEMEN: We have already spoken (see page 261) of the unreliability of the lower triturations of the *apis mellifica* that have been made from the entire bee, and also of the superior efficacy of the preparation which contains only the poison of the insect, the *apium virus*. Here is a case that confirms our opinion, while at the same time it demonstrates with what rapidity a well-chosen remedy may overcome this most rebellious disease.

We are inclined to think that the failure of *apis mellifica* to relieve in many cases is due to the inefficient manner of its preparation. Some years ago we had much trouble with failures to cure. After experimenting with such preparations as we had, we drove into the country and captured a number of healthy bees, and with our own hands made at once a fresh trituration of them. This trituration was afterward repeatedly used with the most gratifying results in every case.—V.

We also have made some observations of a similar kind. Thus, in our *Lectures on Diseases of Women*, page 459, we have said:

"Concerning the use of the apis mel., which is an invaluable remedy at this stage of the complaint (pelvic cellulitis), I am of the opinion that many physicians have failed with it because the preparation which they have given has not been trustworthy. In 1868, my friend, Dr. J. D. Craig, of Niles, Michigan, sent me a trituration of the remedy which he had prepared and prescribed with excellent effect. His method was to extract the sting of the honey-bee, and its poison-bag, also, with a pair of tweezers, and then to triturate these with the saccharum lactis, in the proportion of two grains of the sugar to one sting. This he called the first trituration, from which others could be made in the usual manner. I have prescribed this preparation in the second stage of cellulitis, and in dropsical disease, with good effect, and can, therefore, recommend it to you."—L.

Case LXXV.—*Scrofulous Kerato-Conjunctivitis.*—Miss Mary T——, aged eighteen, governess, was admitted on the 4th of January, and discharged on the 16th of January. (Ward 3, No. 3.)

This young girl does not appear to be scrofulous, although several members of her family have had strumous affections, and she herself, at the age of three and a-half years, had sore eyes for the first time, which continued for a whole year. Her physician said that she had an attack of scrofulous keratitis.

From that time until about the 15th of last December her health has been very good. Then she was seized with pains in the eye, accompanied by a bright redness of the conjunctiva. She continued to work; but, suffering more and more, and finding no relief from homœopathic treatment outside of the hospital, she determined to enter this institution on the 4th of January.

At the time of admission her symptoms were as follows: The left eye is almost entirely well. There is nothing upon the cornea, and only a very slight injection of the vessels of the conjunctiva. On the right side there is an active inflammation with tension and pain in the orbital region. The conjunctiva presents a vascular plexus that is extremely developed; and there are several pustules upon the cornea, but fortunately none of them are centrally located. The patient suffers very much with this eye. There is a continual lachrymation and photophobia. *Ipecac.*, 1st decimal trit.

January 6. There is a slight improvement, which is limited to the conjunctiva; the keratitis with the tearfulness and photophobia persist. *Apium virus*, 3d trit.

January 9. To-day there is a very marked improvement; the suffusion and the vascular injection are decidedly lessened. The same treatment.

January 12. The photophobia has entirely disappeared; the pustules on the cornea have shrunken, and the patient who, when she was admitted, saw absolutely nothing with that eye, begins to discern objects at a certain distance. The same treatment.

January 15. She thinks herself cured, and wants permission to leave the hospital; the inflammation has entirely ceased;

the vision of the right eye is satisfactory, but there are still two or three little patches on the cornea. The same treatment.

We saw this patient again at the hospital dispensary, and for a month the cure seemed to be perfect; but at the beginning of March she suffered a relapse, and the physician on duty at the time gave her *hepar sulph.*, 3d trit., and also *apis mellifica*, 3d trit. The woman, however, followed us to the dispensary in the *rue de Verneuil*, and the *apium virus* quickly cured her keratitis. Some months later I examined her, and the cure seemed permanent.

This case affords an excellent illustration of the necessity of affiliating our remedies properly, and also of the importance of using them in the most reliable form for the cure of the sick. Here is a serious case of scrofulous keratitis, with ulceration of the cornea, which was treated twice, but without success, by homœopathic remedies; the first time, at the onset of the disease, by one of our pupils, and the second time by one of our colleagues. In the former instance I attribute the failure to the omission of *ipecac.* as a remedy for combating the conjunctivitis; in the latter, to the premature employment of *hepar sulph.*, and in both cases to the unreliability of the *apis mel.* in the form in which it was given. For in twenty-four or, at the most, in forty-eight hours after the *apium virus* had been prescribed the improvement began, and it afterward continued without interruption until the cure was complete.

Hepar sulphur is not indicated, we think, unless pus has formed, or there is immediate danger of it. When such is the case it is one of the most valuable remedies that we have.—V.

Therefore, gentlemen, I would have you remember this precept: In the treatment of scrofulous keratitis, when the keratitis is accompanied by an intense conjunctivitis, always begin with *ipecac.* Then, when the improvement which follows

the use of this remedy has ceased, follow it with the *apium virus*, and continue its employment so long as it is necessary; for you know that in chronic diseases it is only by persevering with the proper remedy that we can arrive at a cure.

The specific use of ipecacuanha in scrofulous conjunctivitis has never before been so authoritatively laid down. We allude to it more fully under Lecture XIX, page 250.—V.

When the keratitis has existed for years, and has caused films and infiltrations and interstitial abscesses of the cornea; iritis; and all the lesions which characterize scrofulous affections of the eye, in their chronic stage, even the *apium virus* may fail. You have seen an example of this kind in Case LVIII. In such rebellious cases you will find the needed resource in *hepar sulph.*, *aurum muriaticum*, *opium*, *arsenicum alb.*, *euphrasia*, *belladonna*, and other remedies that are indicated in inflammation of the eyes.

Always, when iritis complicates or threatens, and when it does not, if the corneal inflammation or ciliary pain is great, a local solution of neutral *atropia sulphate* is strongly indicated. This solution may be of from two to four grains to the ounce of distilled water, and instilled at intervals of hours or days, as the urgency of the case demands; for in iritic complications, so liable in this group of eye troubles, the physician who depends on internal treatment alone does not secure the greatest benefit to his patient, and will have a large percentage of cases left uncured, and many seemingly cured but temporarily quieted with lesions of great damage.—V.

The warm water which specialists so frequently use in scrofulous keratitis may also be applied as adjuvants in the worst cases. In our own experience, excepting in interstitial abscesses between the layers of the cornea, we have rarely been obliged to have recourse to them.

Properly and intelligently used, we think warm water compresses of the greatest value.—V.

Acute Articular Rheumatism.

Case LXXVI.—M. Xavier M——, aged twenty-seven, a baker, was admitted on the 1st of December, and discharged on the 28th of February. (Men's ward, No. 2.)

This patient, who is apparently of a vigorous constitution, had some scrofulous disorders during his infancy. On two separate occasions he had trouble with the eyes, which continued for several months, but from the twelfth year he seems to have had no further manifestation of the strumous habit.

The disease for which he enters the hospital had its origin in a general attack of articular rheumatism, which began six weeks ago. At present most of the joints are free, and are not painful when they are moved. The wrist and the ankle joints of the left side, as well as the corresponding radio-carpal and the tibio-tarsal articulations, are considerably swollen and painful on pressure. The muscles of the left arm are slightly atrophied, and so, also, are those of the shoulder; indeed, the infra-spinatus muscle has almost entirely disappeared.

The patient's general condition is tolerably good, the temperature is normal, and the digestive functions are in good order. China, 3d dil.

December 4. There is no observable improvement. *Vipera torv.*, 3d trit.

December 18. The swelling about the foot seems to diminish; the power of motion in the affected part is returning; the swelling of the wrist continues, however, and when one tries to flex the fingers, it causes severe pain. The same remedy.

December 22. He complains of severe pains in the wrist, but it is neither red, nor is the heat of the part increased. *China*, 3d trit., twenty centigrammes.

January 2. The swelling of the ankle joints continues to diminish very sensibly; concerning the wrist, there is no

change either in its size or its mobility without pain. *Sal croisici*, 3d trit., twenty centigrammes. At the same time an application of dry heat was made to the latter joint.

January 8. The wrist appears to have diminished a little in its size, but on its dorsal surface we find a little soft projection which imparts the sense of fluctuation. Dry heat and *sal croisici*, 3d trit.

January 30. This treatment has brought about a decided improvement; the little fluctuating tumor on the back of the wrist has disappeared; the proper movements of the ankle joint have returned, and the patient can walk a little without suffering very severely.

The extremities of the wrist bones, which were badly swollen, are decidedly better; and on motion the radio-carpal joint is not very painful. The same treatment was continued.

February 15. The patient grows better and better. The swelling lessens daily, and pressure upon the wrist joint is scarcely felt.

The same treatment was continued until February 28, when he quit the hospital that he might convalesce in the country. The left tibio-tarsal articulation had nearly the same mobility and volume as its fellow; and although the left wrist was still a little stiff in its motion, and there was also a slight swelling that remained, still the patient could use it pretty well.

This case shows how very decidedly different diseases may influence each other. This man was scrofulous, his rheumatism was scrofulous, and the rheumatic arthritis was the *common* symptom that resulted in the development of the white swelling.

The common symptom (*l'accident commun*) in pathology is an affection which is proper to two diseases. Thus, bronchitis is common to rubeola and to phthisis, and it is this disorder which serves as a bridge between them. A catarrhal ophthalmia, in a scrofulous subject, develops a scrofulous keratitis, and the inflammation of the conjunctiva is the common affection. In persons of a scrofulous diathesis, arthritis may

be the common affection which shall carry the case to the production of a white swelling, whether the arthritis itself is rheumatic, traumatic or gonorrhœal. The physician should never lose sight of this law in general pathology. A surgeon in one of the Paris hospitals has just re-discovered this law which had been propounded thirty years ago by Dr. J.-P. Tessier, in his lectures at *l'Ecole pratique* and at the Hotel Dieu.

You have remarked that the principal remedy prescribed for this patient was the *sal croisici*, in the third trituration. The name designates the salt derived from the sea-water of Croisic. This water contains the bromide of sodium chiefly. Bathing in this sea-water is certainly the most decided remedy for scrofula; and since every one cannot go to the sea-side for this treatment, I have had a trituration made of this salt, and have given it internally.

During the last year I have frequently prescribed this preparation for scrofula, and also in the treatment of uterine affections which were characterized by copious and too prolonged menstruation. My observations are still too limited and imperfect to permit me to give the precise indications for its internal use. But they are, however, so satisfactory as to prompt me to recommend my confrères to try the efficacy of the *sal croisici* in all those cases for which they usually advise sea-bathing.

Uterine affections are so often engrafted upon the scrofulous constitution that any remedy which promises to be of service in both these classes of disorders, or, in other words, to relieve the symptoms which they have in common, is worthy of trial. The great value of the preparations of calcarea carb., calcarea phos., calcarea sulph., ammonium mur., kali carb., and other remedies of a similar kind, lies in the fact that their curative sphere includes a relation to these compound disorders. There is no doubt, in our own mind, at least, that the good effects of mineral waters and of sea-bathing in chronic uterine complaints, comes from the taking of these and various other salts that have been prepared and attenuated in the great laboratory of Nature. It is not unlikely that the *sal croisici* recommended by Dr. Jousset will yet prove of exceeding value in this class of cases. We shall see.—L.

LECTURE XXIX.

SUMMARY.—Hydrarthrosis, *case*. *Jodium*. Diagnosis of hydrarthrosis. Hydrarthrosis acutus, *case*. *Apium virus*. Periodical hydrarthrosis, two *cases*. Sea-bathing. Asthma with epileptiform vertigo, *case*. *Arsenicum*. Hemoptysis in asthma, *case*. *Arsenicum* and *nux vomica*.

Hydrarthrosis.

GENTLEMEN: I shall speak to you at this time of a disease which is extremely rebellious, especially when it has passed its first stage. That disease is *hydrarthrosis*. Here is a case of *chronic hydrarthrosis* taken from our wards:

CASE LXXVII.—Miss G——, twenty-five years of age, was admitted on the 5th of December, and discharged on the 28th of January. (Ward 1, No. 3.)

During the preceding winter this patient had been treated for two months for a chronic hydrarthrosis of the right knee, which she had had for at least ten years. She says that almost every winter her knee was so swollen that she was obliged to keep quiet for some time.

On her admission the following record was made of her case: The knee is deformed, enlarged, and somewhat sensitive; by palpation an effusion within the joint is easily recognized; it is excessively painful for her to walk, and she can scarcely stand upon the right leg. The general health is tolerably good. The prescription was: absolute rest, and *jodium*, 6th dil., two drops during the day.

December 11. The swelling of the knee is perceptibly diminished, and the joint is not painful to pressure. *Jodium*, 3d dil., in the same manner.

December 21. The effusion is almost entirely re-absorbed.

The joint can be flexed without much difficulty. *Jodium*, 12th dil.

December 28. We cannot detect the fluid in the joint. The patient has been allowed to rise, and can walk without difficulty. She can, however, flex the knee only imperfectly. *Jodium*, 2d dil.

January 13. The same remedy has been continued. She is doing well; but when she begins to move the knee or to walk, the joint is a little stiff. The ligaments remain congested. *Apis mellifica*, 3d trit., and dry heat to be applied about the joint.

January 17. A new application of the heat over the articulation. *Apis mel.*, 3d trit.

January 20. The local condition of the joint is changed; the tissues that surround it are more supple, and motion is much more easy. Dry heat, and the same remedy.

January 28. The patient left, in a very satisfactory condition.

It is very important not to confound *hydrarthrosis* with *white swelling*. The first of these two affections is almost painless, and can only become painful by the extreme and rapid distention of the joint. Moreover, the effusion is more copious and more liquid than it is in the white swelling. To feel the fluctuation, we must extend the limb so as to relax the ligament of the patella, surround the patella above and below with both hands firmly applied, and grasp the joint tightly; then, with the index finger of the right hand, press perpendicularly and quickly upon the patella. This bone will sink in the water, which is below it, and strike upon the condyles of the femur. When there is considerable effusion, the patient carries the limb in a demiflexed position, because in this position the capsular ligament is not so fully distended.

Jodium was the chief remedy in this case, and it had the effect to stimulate the absorption of the effused liquid. *Apis mellifica* and the dry heat were necessary on account of the congestion of the ligaments and the tendons.

But, in acute hydrarthrosis, the *apium virus* is the principal remedy, as you will see in our next case.

Case LXXVIII.—*Of Acute Hydrarthrosis.*—Mrs. C——, aged thirty-two, is a somewhat delicate woman. Her courses having been habitually too free, she has a consequent anæmia; but, otherwise, her general health is usually good. Early in December she was taken with a painful impediment in the left knee, with a very rapid swelling of the joint. I saw her on the third day from the beginning of her trouble, and noted the following symptoms: Enormous tumefaction of the knee, which is round like a globe; very evident fluctuation; constant demiflexion of the limb; pain from the distention; neither heat nor redness of the part; loss of appetite and of sleep, but no increased frequency of the pulse. She was ordered to remain in bed or upon an extended chair, and to take of the *apium virus*, 3d dil., three drops in 200 grammes of water, one teaspoonful every three hours.

Fifth day. There is undoubted improvement; the knee is still large, but the tension is decidedly less, and the sleep and appetite have returned. The same treatment.

Seventh day. She is still improving; the joint is not so swollen, and the leg can be extended without pain. The same treatment.

Ninth day. The natural outline of the joint is readily made out, but there is still some fluctuation; the patient keeps the sitting posture one-half of the day. The same treatment.

Twelfth day. The effusion has disappeared; the patient begins to walk a little, but the joint is still stiff. The same treatment.

Some days later she began to go out of doors, and then gradually resumed her old habits.

In this case the medicine acted promptly, and the improvement was so constant that it was not necessary to make any change in the treatment.

À propos of this subject, I will report two cases of a variety of hydrarthrosis which is very rare,—I mean the *periodical hydrarthrosis*, which, in this instance, occurred in a scrofulous subject.

Case LXXIX.—Mrs. G——, aged forty-six years, still menstruates regularly, but is slightly anæmic. The cervical glands are swollen, although they were once very much relieved by the waters of Saline. Last year she had hydrarthrosis of the right knee, which has been quite cured. During the summer of 1873 she spent a month at Croisic, for the sake of the waters, which helped the glandular swellings very much, but brought no sensible relief to a slight and periodical hydrarthrosis which dated from the previous winter.

January, 1874. The dropsy of the joint continues for from four to six days; then, after six or eight days, in which it seems to have passed away, it returns again. The duration of the disease is not always the same, but its reappearance occurs, in the same location, with great regularity every twelve days. There is no pain, but a simple stiffness; the knee is tumefied, of a globular form, and fluctuation is evident.

Pulsatilla, 3d dil., had no effect; *sulphur*, 30th dil., produced only a slight improvement; but sea-bathing and the baths in the Croisic water, taken during the month of July, effected a cure which lasted until the next spring. *Chininum sulph.*, 3d trit., and *china*, 3d trit., afterward kept this affection at bay for some months, but did not cure it, for the dropsy came again with its old periodicity. The patient was obliged to remove to Pau, and I do not know what has become of her.

Here is a case of periodical hydrarthrosis in a woman with menorrhagia and consequent anæmia:

Case LXXX.—Mrs. de Saint-G——, aged forty, the mother of several children, has been subject for some years to very copious menstruation, and also to an abundant leucorrhœa. She is very anæmic, feeble and short of breath.

For fifteen months she has been afflicted with a periodical hydrarthrosis seated in the left knee. This affection returns about once in twelve days, and continues four or five days. The knee is swollen, stiff, non-painful and fluctuating. Two years ago she had the same trouble in the right knee, which, after four months' duration, was cured by the waters of Saint Honoré. The interval of health between the two attacks was six months. Last year she passed a season at the waters of Canterêts, but these powerful thermal springs had no effect in breaking up the periodicity of the hydrarthrosis.

Chininum sulph., 3d trit., was prescribed in February, 1876, but it produced only a slight and insignificant change in the symptoms. In the month of March I gave her of the *sal croisici*, 3d trit., sixty grains divided into twenty-four powders, one to be taken in two parcels daily. In April the menses were not so abundant. The same remedy was continued, with the addition of hydrotherapia. Under their combined influence the flow diminished, and became almost normal, but the paroxysms of the hydrarthrosis were scarcely changed at all; but a season of sea-bathing at Croisic disposed of the articular affection completely, and restored the catamenia to their normal condition. The patient regained her strength and her appetite, and seemed to be entirely cured.

I have cited these last two cases more as a pathological curiosity than as an argument in favor of homœopathic medication, since the sea-baths at Croisic have played the chief rôle in the improvement of the first case and in the cure of the second.

Asthma with Hemoptysis.

I have often had occasion to speak to you of asthma, and of its treatment. Of late we have had two patients in our wards who furnish us a reason for returning to this subject. The first of these is remarkable for the paroxysms of epileptiform vertigo which accompany the fits of coughing, and also for the occurrence of hemoptysis at the onset of the

disease. The second one, who was attacked with bronchitis during the course of his asthma, had likewise experienced slight returns of hemoptysis during the first years of his illness.

Case LXXXI.—Albert G——, thirty-three years of age, was admitted on the 21st of December, and discharged on the 30th of December.

This man, endowed with a good strong constitution, came hither because of paroxysms of dyspnœa, which began a long time since, but which of late have assumed such an acute form that he has been forced to quit his very painful occupation as a butcher's boy. He is not a hemorrhoidal subject, and has had no herpetic affection. But he has had some symptoms of the gout.

His emphysema began ten years ago, when he had an attack of hemoptysis, which continued for ten days, and which was the first symptom of his ill-health.

He takes cold every winter, and then coughs for three or four weeks. At these times his dyspnœa is decidedly aggravated, and he is forced to abstain entirely from work. Then he also has severe fits of asthma, which come especially at night, but sometimes also during the day, after eating. His respiration is slightly oppressed during the summer season, but at that time he does not suffer very much, and can continue his employment.

We must not forget to state that our patient has a deposit of red sand in his urine; but nevertheless he has never had pains in the joints, nor nephritic colic. The appetite is good, but the digestion is slow, and accompanied by a determination of blood to the head, with a tendency to sleep; in a word, he is dyspeptic.

To-day his condition is as follows: The cough is quite frequent, loud and resounding, but rarely followed by expectora-

tion. The sputa are slight, mucous, and a little ropy. The soft parts being very thick over the thorax, percussion reveals nothing. On auscultation we detect sibilant and snoring ronchi, and prolonged expiration. *Arsenicum*, 3d trit., twenty centigrammes during the day.

December 24. The patient feels no better; the expectoration is still scanty and very difficult. *Arsenicum*, 2d trit.

December 25. He complains of vertigo, which comes with the fits of coughing. This vertigo is so violent that, for a little while, he loses consciousness. *Cuprum*, 12th dil.

December 26. He was more quiet yesterday. The dyspnœa has subsided very much, but the vertigo persists. *Arsenicum*, 3d trit.

December 27. In so far as the chest is concerned, our patient is improving; but he suffers to-day from a stitch in the left side. The expectoration is easier and a little more free; the paroxysms of vertigo have disappeared. *Nux vomica*, 3d trit.

December 29. The cough and the stitch in the side have almost ceased. The patient feels so well that he begs for his discharge. He was given *arsenicum*, 3d trit., to take after he had left the hospital.

This case presents two peculiarities to which I desire to call your attention; the first is the occurrence of an hemoptysis at the onset of the disease, and the second, the returning fits of vertigo simultaneously with the paroxysms of coughing.

It is very rarely that hemoptysis occurs during the course of asthma, and this complication always awakens in the mind of the doctor, as well as in that of the patient, a fear of phthisis pulmonalis. It is necessary, therefore, that you should be forewarned of the possibility of hemoptysis, even in a violent form, in the case of those who have the asthma, but without any tubercular or cardiac complication.

The elder Gabalda, in a memoir upon asthma, published in the *Journal de la Société Gallicane*, has spoken in the following

terms of the existence of hemoptysis occurring in the course of ordinary asthma:

"The hemoptysis of asthmatic patients has some peculiarities which are not always the same. Sometimes the matter that is expectorated is mixed with a greater or less quantity of blood, so long as the exacerbation of the other symptoms of the disease continues; at other times a large quantity of pure blood is expectorated in a few moments, as happens in phthisis." (Page 559.)

It was a copious hemorrhage from the lungs that our patient had ten years ago, and yet you see that not only has he failed to have phthisis, but he is still of a vigorous constitution. The capital fact which you should remember, and which is very important in a prognostic point of view, is, that asthmatics may have even an abundant hemoptysis without being threatened with tuberculosis.

As a clinical rule in these cases, the greater the degree of a decided asthma, or of periodical suffocation in connection with attacks of hemoptysis, the less the probability of a tuberculous complication. If a patient who is subject to distinct and repeated fits of asthma is seized with hemoptysis, the probabilities are that he is not suffering from and will not have phthisis.—L.

The second point concerns the vertigo, with loss of consciousness during the coughing fit in the case of asthmatics. We have already had occasion to refer to this peculiar complication in the case of a woman whose clinical history you will remember (see page 137). That woman had a general tonic convulsion, with a cyanotic hue of the face and entire loss of consciousness. *Arsenicum* will cure this condition. The man of whom we have been speaking had neither a convulsion nor cyanosis, but vertigo with insensibility.

Within the present year the occurrence of *epileptiform vertigo* during the fits of coughing to which asthmatics are subject has attracted the attention of clinical teachers. M. Charcot is disposed to admit a vertigo, the origin of which

he refers to the larynx (like that of Ménière, which began in the labyrinth of the ear), as an explanation of the sudden fall of these patients, as if struck by lightning, at the close of a fit of coughing. He has observed this form of vertigo in gouty and asthmatic persons.

À propos of M. Charcot's report to the Biological Society, M. Gellé presented, in the name of M. Collin, of Vangirard, the following case of

Apoplectic Spasm of the Larynx.—M. Collin was seated at the table opposite M. G——, one of his friends, aged sixty-eight, who was slightly emphysematous, but actually very well. While the dessert was being served, M. G—— laughed at a joke and was suddenly seized with a fit, which at first was very light, but then grew worse, and had no remission. His face became red and congested, the eyes were injected, and it seemed as if he was being strangled by a cough. Then he leaned his head forward and stopped coughing, and remained for some seconds in that position, immovable, with his nose in his napkin. From the moment in which he became conscious he was giddy, and knew very little of what had passed. There was also a slight stupor. Although the fit lasted only a few minutes, it seemed like hours to his friends. M. G—— had several paroxysms of this kind during the last three years of his life.

He died, at the age of seventy-one, of tracheo-pneumonia. For fifty years he had suffered from chronic hypertrophic pharyngitis, with slight deafness.

Here is a clinical fact that may throw some light on the subject of *laryngeal* vertigo:

Fibroma of the Larynx as a cause of Epilepsy.—The author knows of the case of a man, fifty-four years of age, who had a tumor seated upon the vocal cord of the left side, which

had caused a hoarseness that had continued for several years. The year after the hoarseness began to increase it became complicated with dyspnœa; and, moreover, the patient was seized with epileptiform paroxysms, which usually came during the night. One of these fits was followed by a slight paralysis of the extremities on the left side of the body, and also of the muscles supplied by the facial nerve on the same side. The paralysis disappeared little by little. The means used to prevent the epileptiform attacks having failed of effect, they became more frequent and severe, and it was supposed that the presence of the tumor in the larynx had something to do with their occurrence. It is worthy of note that fifteen years before the patient had had a few epileptiform fits, of which he was cured by the incision of a cutaneous cicatrix located on the back of his hand. With the aid of a bistoury, Sommerbrodt removed the tumor, which proved to be a fibroma. * * * * The hoarseness of the voice and the dyspnœa disappeared at once, and, five months after the operation, the epileptiform fits had not returned a single time. (*Berliner Klin., Wochens*, No. 39, 1876.)

We do not wish, at this time, to attempt any physiological explanation of this new form of vertigo; but let us not forget that, in the two cases which you have seen in our clinic, *arsenicum* has promptly caused it to disappear.

Here is another case of asthma, in which we also find there have been slight attacks of *hemoptysis*, not only at the onset, but likewise during the course of the disease:

Case LXXXII.—M. Charles L——, aged forty, was admitted on the 1st of February, and discharged on the 18th of February. (Men's ward, No. 4.)

This patient, who has asthma, with pulmonary emphysema, has never had any herpetic or hemorrhoidal troubles.

His health was very good until the age of thirty, when it

became somewhat broken by paroxysms of asthma, for the relief of which he sought our advice, now ten years ago. From that time he has taken cold every winter, and then has coughed for two or three months.

His general condition, despite the expectoration of a slight quantity of blood, which almost always accompanies his yearly attacks of bronchitis, is satisfactory. The dyspnœa, which is the principal difficulty, disappears almost entirely in the summer, but returns in a very severe form in the winter.

He is now in the acute stage, and has coughed for a week. This cough is dry and extremely painful. The expectoration, which is slight, is of whitish, aerated sputa, which does not adhere to the bottom of the vessel.

His breathing has been very much oppressed for some days, and during the night he is seized with violent fits of asthma, which prevent him from sleeping.

A physical examination of the thorax reveals the ordinary signs of pulmonary emphysema. His chest, which is very much protruded in front, gives, on percussion, both before and behind, an exaggerated resonance.

By auscultation we perceive on the two sides of the thorax a great many sibilant and sonorous râles; at the base and posteriorly, there are mucous râles on inspiration. The expiration is very much prolonged. *Ipecac.*, 12th dil., and *bryonia*, 12th dil., to be taken alternately.

February 3. The patient still coughs; the dyspnœa is very bad, and worse at evening. *Cuprum*, 12th dil.

February 4. No improvement. *Arsenicum*, 3d trit.

February 8. He is a little better to-day; the expectoration is easier, and the suffocation less painful. *Arsenicum*, 3d trit.

February 11. For two days he has not been quite so well; the cough is a little more frequent. *Arsenicum*, 3d trit., in the morning, and *nux vomica*, 3d dil., at evening.

February 15. There is a considerable improvement in his condition; he coughs no more, excepting at very long intervals, but he complains of a pain in the left side; the dyspnœa is scarcely observable. *Bryonia*, 3d dil.

February 18. There is no more pain in the side, and the respiration is easy. He wants to go to work again.

LECTURE XXX.

SUMMARY.—Vaginismus, *case*. Causes and treatment. The French surgeons and Dr. J. Marion Sims. Note; *case*. Hemorrhagic variola. Influence of vaccination upon the suppurative stage, and the therapeutic fallacies which spring from it, *case*. The *hemorrhagic rash* and the *scarlatinal rash*. *Phosphorus*. Hemorrhagic variola without increased frequency of the pulse; death; *case*. The *malignancy* of disease.

Vaginismus.

GENTLEMEN: Here is an illustration of a disease from which no one has ever died, but which has very often caused the poor women who suffer from it to wish that they could die. Accompanied by a painful spasm of the sphincter vaginæ, as a fissure of the anus is accompanied by a like spasm of the sphincter ani, vaginismus may or may not be complicated with excoriations and fissures of the vulva; but in this affection, as in the disease of the anus (which has been so well described by Boyer), the lesion of the mucous membrane plays only a secondary part, for the painful spasm of the sphincter is the principal, and, sometimes, the only, difficulty.

We are indebted to a French surgeon for the first work on vaginismus. In his inaugural thesis, published in 1834, Huguier detailed a case of vaginismus, and in this connection gave its pathological history and treatment. He very properly compared it to a fissure of the anus, and proposed to treat it by incision of the sphincter. It is, therefore, proof of the ignorance of the American surgeon, Sims, who, when he met with his first case of vaginismus, in 1857, avowed that "the books threw no light" on the subject of its

treatment. He bethought himself of a surgical operation, but adds: "*However, I declined to do anything, on the ground that an untried process was not justifiable on one in her position in society* (the patient being in high life), *the hospital being the legitimate field for experimental observation.*" (*Clinical Notes on Uterine Surgery*, 1866, page 323.)

If Dr. Sims had known the French surgeons he would not have ignored the operation made by Huguier in 1831; that practiced by Pinel-Grandechamp, and reported in *Dupuytren's Clinic* (2d edition, 1839); or the operation of Michon in 1851. He might also learn from our surgeons that the rank of the patient constitutes neither an indication nor a contra-indication for an operation, and that those unfortunates who are obliged to go to an hospital, far from being mere subjects for experimentation, are so much the more respectable because they have nothing to care for but their misery and their disease.

Vaginismus is most frequently developed at the first sexual act, which, under the circumstances, is rendered impossible. At other times it follows excessive coitus (as in the case cited by Huguier, and the XIXth of Visca's memoir); or it may happen after child-birth, and even where there is a rupture of the perineum; and sometimes it is due to eczema, to pruritus of the vulva, or to a blenorrhagia. Certain cases seem to depend upon the different uterine affections, and upon the leucorrhœa that accompanies them; upon fissures and ulceration at the entrance of the vagina, of the labia minora, but especially of the caruncles or of the hymen. Polypi within the meatus urinarius are often the point of departure for a painful spasm of the vaginal sphincter. In the case of hysterical subjects the affection is sometimes periodical, accidental, and of temporary duration, when it is not associated with some other lesion.

In some cases in which this painful affection is linked with hysteria, resulting in periodical headaches, incipient and temporary insanity, spasms, convulsions, and even hemi-anesthesia, the trouble really originates in the ovary. And in milder cases, where the disorder has existed for a long time in the unmarried, and in those women who, by reason of circumstances beyond anybody's control, are forced to live apart from their husbands for weeks or months at a time, the same is true. It is a little strange that most writers in gynæcology have overlooked this important clinical fact.

So, also, there are cases of vaginismus which are the indirect result of spinal irritation, of concussion of the spine, of nervous shock, of uterine flexures, and of uterine engorgement.—L.

It is an important question whether an habitual and permanent vaginismus, like an anal fissure, is always connected with a hemorrhoidal difficulty. We cannot decide that it is so.

A forced continence which is more or less absolute is the usual result of this disease. The history of the young woman who is now in our wards is but a repetition of that which is common in such cases, *id est*, her separation from her husband and her determination to return home and live with her mother.

In his Principles and Practice of Gynæcology, page 601, Emmet says: "There is a certain condition which is almost always accompanied by a moderate cellulitis in one of the broad ligaments, rendering the female devoid of all sexual desire. For a time, woman-like, she will submit to marital approaches through a sense of duty, but after a while, by degrees, their suggestion even excites a feeling of disgust. If she continues to submit to what she supposes she is obliged to do, this hyperæsthesia and spasm become finally developed as an earnest of the disgust, in the same manner as the gullet closes spontaneously against, and rejects, a nauseous draught. If the necessary treatment can be administered by degrees, this condition will disappear without an operation, and the woman will return to her duties as a wife with very different feelings."

Other causes of this painful affection are linear ulcers about the meatus urinarius and the neck of the bladder, granular vaginitis, herpes of the vulva, vulvar folliculitis, vaginal neuromata, spasmodic dysmenorrhœa, pelvic cellulitis, and the contact of an acrid leucorrhœal discharge.—L.

This particular case will serve to acquaint you with the usual symptoms of vaginismus, and, at the same time, will show you the close analogy between it and painful spasms of the other sphincters. It will also demonstrate that dilation is not an infallible means of curing this disease, since the de-

livery, although it was premature, has had no effect in modifying the painful spasm of the vulva.

Case LXXXIII.—Marie M., aged seventeen, was admitted on the 13th of January, and discharged on the 25th of February. (Ward 2, No. 2.)

This woman, of a good constitution, was married in her sixteenth year. She says that her sexual relations were always exceedingly painful; however, she became pregnant, and afterward suffered an abortion in the fourth month. She soon recovered from this mishap; but the vaginismus, instead of being mitigated by her delivery, was so much worse that she renounced her married life altogether. At the same time she began to suffer from hemorrhoids, and with vesical irritation. Three weeks from the invasion of these new symptoms she came to the hospital, and the following is her record:

There is a hemorrhoidal discharge, with tenesmus, and for some hours after a stool she has the excessive pains which are characteristic of fissure of the anus; there is also an extremely painful tenesmus of the bladder, painful urination and hematuria; the spasm of the vagina is so severe that it is extremely difficult to practice the "touch"; the attempt to pass the finger makes her scream, and the pain caused by it persists for several hours. There is neither a fissure, an excoriation, nor a blenorrhagia.

The patient believes that this painful condition has been greatly aggravated by her accouchement. Independently of the spasms which are caused by urination, defecation or the "touch," there is a constant pain that is very much increased by walking.

Phosphorus, 6th dil., *aloes*, 3d trit., *nux vomica*, 3d dil., and *capsicum*, 3d dil., have entirely cured the hematuria and the hemorrhoidal discharge; and *sedum acre*, 3d dil., has allayed the painful spasms of the sphincter ani; but these remedies have been of no avail for the relief of the vaginismus.

Plumbum, 6th dil., internally, aided by the application of bits of charpie dipped in lead-water, brought no improvement. We also tried the effect of bathing the parts with a solution of the hydrate of chloral, but the extreme pain caused by the in-

troduction of the charpie caused us to desist from its use, and we have advised the patient to consult a surgeon.

In this case the extreme youth of the woman at the time of her marriage and a decidedly hemorrhoidal tendency, may be considered as having caused the vaginismus. The dilatation of the vulvar orifice by a premature delivery, far from having the favorable result that one would reasonably expect, really made matters worse and aggravated the difficulty. But this is not a novel result. Depaul has reported a case of vaginismus which was caused by a wound resulting from the passage of the fœtal head during labor; and Bernutz has seen a woman in whom vaginismus was caused by an abortion. In his clinic, Guneau de Mussy cites the case of a lady in whom vaginismus had persisted, and was really increased after four deliveries at term.

In common with ourselves, Scanzoni has observed instances in which the vulvar spasm existed conjointly with spasms of the sphincters of the rectum and of the urethra. And in these cases he has remarked that walking will often increase the suffering, as it did with our patient.

As in the treatment for fissure of the anus, relief is best obtained by surgical means. In the Old School, belladonna and the bromide of potassium have not had the success which the nature of the disease and the properties of the remedies would seem to warrant. In our own school, we are still without any clinical records upon the medical treatment of this affection. The indications which are given by Jahr for *ferrum*, *kreosotum* and *berberis* for pain during coitus correspond only to a sensation of smarting, and not to a contraction of the vagina.

In his treatise on the Diseases of Women, this author (Jahr) enumerates several remedies which he declares have been very effectual in the treatment of this disease. But if you try to verify the symptoms of belladonna, nux vomica, ignatia, pla-

tina, etc., in the Materia Medica, you will find that the pathogenesy of these remedies does not contain a single symptom that belongs to vaginismus. Besides, the description which Jahr gives of this affection proves that he did not understand it, and destroys all confidence in his declarations.

As the author puts it, this criticism is just; for Jahr evidently wrote from the pathogenetic side of this question only. It is very doubtful if he ever saw a case of vaginismus. The medical treatment of this affection affords another instance in which clinical experience has outrun the provings. We certainly have several times cured the milder forms of this disease, when it was secondary upon ovaritis, with belladonna, platina, gelseminum, caulophyllin, and kindred remedies.

In these cases the vaginismus was symptomatic, and disappeared when the lesion upon which it depended for its existence was cured.—L.

According to Dr. Richard Hughes, *plumbum* should produce vaginismus; but you have seen that it did no good in the case under review. Possibly its use was not continued for a sufficient length of time, or the dose may not have been strong enough. This question is, therefore, an unsettled one.

Gradual dilatation; rapid dilatation, as for anal fissure; the incision of the sphincter; the incision of the border of the hymen, and of the vaginal mucous membrane; either, separately or combined, have produced a large number of radical cures. The painful points must be removed, and the dilatation resulting from the operation, maintained by a kind of tampon that is anointed with belladonna.

Several different operations have been proposed and practiced for the cure of vaginismus. Dr. Burns first recommended a division of the pudic nerve. Dr. Sims' plan is to make deep incisions to the right and left of the mesian line of the vagina, passing across the sphincter vaginæ for about half an inch, but not through it. He then inserts a conical glass or rubber dilator, which is to be worn while the parts heal. Dr. Tilt recommends the forcible dilatation of the constrictor muscles of the vagina by introducing the two thumbs with their backs toward each other into the vaginal orifice, and forcibly stretching the orifice by their separation for some minutes. Scanzoni treated one hundred cases mainly by dilatation, and cured them all without having recourse to the knife.

The following case is copied from our work on the "Diseases of Women," page 467:

Case.—March, 1862.—Mrs. —— consulted me for the relief of an irritable and sensitive condition of the vagina, which, during her three years of married life, had caused her untold suffering, and interfered most positively with sexual congress. She was a most intelligent person, frank and candid in her manner, and extremely anxious that something should be done for her relief, more especially lest her husband should become disaffected, and her family and friends continue to ridicule her for not having become a mother.

On physical examination there was nothing abnormal about the external generative organs except the hyperæsthesia of the vulva and of the vaginal outlet. The slightest and most delicate touch with the finger caused the vaginal spasm immediately, and she was thrown into the same state of suffering which she said she had always experienced in the conjugal act. I placed her under the influence of sulphuric ether by inhalation, and these symptoms disappeared. The dilatation with bougies, anointed with belladonna, was begun, and repeated every two days for a fortnight, then every day for another week, and the barrier to intercourse was removed. She soon conceived, and now has a son, a beautiful boy, nine years old. I gave her no medicine.—L.

Hemorrhagic Variola.

Some days ago you saw, in a private room of the hospital, a young girl who had all the symptoms of *hemorrhagic variola*. You observed that we were very anxious concerning the issue of the case, and you also witnessed the slow but certain influence of vaccination over its progress. Indeed, at the sixth day, the morbid process was decidedly modified, and the patient has recovered, after having been dangerously ill during the first two periods of the disease, and finally passed through the stage of suppuration, which is usually the most perilous, in a comparatively easy manner. You should always remem-

ber this fact, gentlemen, in order that you may not blunder in the prognosis of variola, and also that you may not become the victims of a therapeutical illusion.

Variola is more or less modified by vaccination. Between the case in which it prevents the small-pox altogether and that in which the patient dies in spite of it there are many degrees of influence which are not always appreciated. Very often the effect of an old vaccination is shown in the suppurative stage of variola, which is so modified that, as in the *varioloid* disease, there is no suppuration. You will often see cases, like the one before us, where the variola sets in and continues during the eruptive stage with the most alarming symptoms, but in which the danger disappears, as if by magic, on the seventh or the eighth day, and the patients pass directly into a state of convalescence.

You will understand that this very remarkable effect is a fertile source of therapeutical error. The doctor is always inclined to attribute these happy results,—which really depend upon a former vaccination,—to the remedy or remedies that he has given. It is this kind of a fallacy which has made no little reputation for the *saracennia* and other boasted specifics for small-pox.

In order that a remedy may be absolutely beneficial in variola occurring in those who have been vaccinated, it is not necessary that the suppurative stage should be suddenly arrested, but that, while it follows its proper course, it should be decidedly mitigated and modified thereby. And it is also necessary that this result should be equally pronounced in the case of those who have never been vaccinated.

If vaccination did no more than to mitigate and modify the small-pox, or to abort its suppurative stage, it would still remain an incalculable blessing to the race.

The cases that follow are of exceeding interest, their only defect consisting in the fact that we are not informed if either of the patients were of the hemor-

rhagic diathesis; for cases of eruptive fevers engrafted upon this constitution are, in our experience, always of a serious character, and, what is more, should be treated with especial reference to that diathesis.—L.

CASE LXXXIV.—*Hemorrhagic variola; phosphorus; cure.* Augustine P——, twenty years of age, a washerwoman, was admitted to a private apartment in the woman's ward on the 19th of December, 1876. She had never had an eruptive fever. She had been vaccinated when very young, but could not give the date thereof. She had not been exposed to the small-pox.

December 16. In the evening, having been in perfect health, she was seized with severe pains in the loins; chills, headache, nausea, bilious vomiting, inability to sleep, loss of appetite, and a violent epistaxis.

The same symptoms continued for several days.

Fourth day. She entered the hospital on the 19th of December. At the morning visit there was upon the front of the neck and upon the upper and anterior part of the thorax a very decided *hemorrhagic rash*. The same eruption was also observed upon the abdomen. This rash appeared upon the neck on the 17th, or the second day of the disease, and upon the abdomen on the 18th, or the third day of the disease. There was some redness of the face, but no visible eruption. The nose-bleed, the vomiting and the constipation continue, and there is also some sore-throat. The axillary temperature reached 104°. In the course of the day the eruption appeared, the pustules being small and slightly confluent; between them the skin is reddish-looking. They also appear upon the hands, are less numerous on the arms and the breast, and there are very few of them upon the abdomen.

The morning prescription was *phosphorus*, 6th dil., which appears to have arrested the epistaxis; the evening temperature was 104.9°.

Fifth day, or the second day of the eruption, she had a bad night, with delirium, vomiting, and constipation. There is no nose-bleed, but the menses have appeared five days too soon. Morning temp. 104.72°. The eruption continues. The same treatment.

Sixth day. Another bad night with delirium. This morn-

ing she is a little more calm, with less heat and vomiting; no epistaxis; the sore throat is more pronounced, with defervescence; the temperature being 99.68°. At the evening visit the face is slightly swollen, but the hands are not so; the eyes are red and tearful; the temperature is 100.76°. The same remedy.

Seventh day. Mild but continual and wandering delirium, with nausea; the temperature is normal. *Tartar emetic*, 6th dil., during the day, and *belladonna*, 6th dil., for the night.

Eighth day. The wandering continues, but there is no vomiting; the face is decidedly swollen, but the hands are very little so; the pustules are surrounded by an ecchymotic aureola; the temperature is normal.

Ninth day. More delirium, very little nausea; but some of the points are suppurating, while others are drying up without having suppurated.

Tenth day. The patient is convalescent.

What has the *phosphorus* accomplished in this case? We shall not commit the blunder of which we have just spoken; but we may remark that it would not have answered so good a purpose in the rash of scarlatina, where the prognosis is not usually so grave, as it did in this hemorrhagic rash, which was characterized by many little spots of ecchymosis that run into larger patches, some of which are red and others black, with intermediate tints.

You will not forget that this rash included a large part of the cutaneous surface; that it was accompanied by repeated attacks of nose-bleed; then by premature menstruation or a real uterine epistaxis; and that, finally, the disease was not arrested on the sixth day, but the delirium and other serious symptoms continued until the ninth day, while some of the vesicles suppurated. From this we conclude that, in a similar case we might depend with confidence upon the use of phosphorus.

A most remarkable cure of hemorrhage by phosphorus was reported in a medical clinic, given in April, 1878, in the Hahnemann Hospital of this city, by

Prof. Hawkes. The case was one of hematuria. We extract the more important facts from the lecture as it was published in the *United States Medical Investigator*, Vol. VII, page 370.—L.

The history of the case is as follows: The patient is a young man of about twenty-six years of age, tall, well-built, and of nervo-sanguine temperament. About the 8th of February last he fell while descending the steps of his residence, striking his left side on one of the steps. The blow left but little mark, and was followed, for a short time, by a feeling of faintness. This soon passed off, however, and he went about his affairs as usual. Three days afterward he observed an unusual appearance of the urine, which led him to consult a prominent allopathic physician, who, on examining the urine, advised him to go home, and promised to call and see him. Some pain was experienced in the region of the right kidney at this time. The patient did as directed, and the physician called, as he had promised, the same day. There seemed to be some doubt in the physician's mind as to the source of the large quantities of blood which were found in the urine, he at one time thinking it came from the kidney, and at another from the bladder. The patient was obliged to keep his bed after the first day. The quantity of blood discharged from the bladder steadily increased in spite of the most "heroic" means employed by the attending physician, and a second prominent practitioner was called in consultation with the first, and the already aggravating doses of irritating drugs were doubled with the advice.

Turpentine, in combination with various other substances, was given in nauseating doses, until the stomach heaved at even the thought or sight of it, and had become so irritable and sensitive that it could retain nothing whatever. The kidneys, bladder and whole urinary tract were being inflamed by the drugs in addition to the already existing serious lesion. While the turpentine, in reasonable doses, might have been beneficial and curative, as it often is in such cases, and in accordance with the law of cure, here it was largely adding to the trouble. All sorts of absurd and torturing expedients were blindly resorted to by the physicians in charge, in their great extremity; such as cramming ice up the rectum while they diagnosed the difficulty to be in the kidneys, and injecting

a solution of *nitrate of silver* and other irritating astringents into the bladder, when they thought the lesion was in that organ!

I found the patient, on the 26th of February, in a truly deplorable condition. He was passing half a chamber-vessel full of bright red arterial blood three times a day; his lips were the color of his cheeks, and his cheeks were the color of the sheets upon which he lay. His stomach was so sensitive and irritable as to be unable to retain even the simplest nourishment. After repeated trials it had been able to retain a spoonful of alkathrepta. His pulse was feeble and thready, the heart beating 120 to 130 times per minute. He was nervous and sleepless. What passed from the bladder seemed like pure blood, and, as I said before, half filled an ordinary chamber-vessel three times in a day. A microscopic examination showed nothing but red blood corpuscles.

There was some pain in the region of the right kidney, and frequent spasmodic pains from that locality, along the course of the corresponding ureter to the bladder. These pains, together with the elongated clots in the vessel, settled the question of the locality of the lesion, to my mind. I fully realized the gravity of the case before me, and diagnosed a severe, protracted and aggravated case of hematuria, with the kidney as the seat of the lesion and the source of the vast quantities of blood discharged.

The next problem which presented itself to my mind, and to me and to the patient the most important and vital question of all, was, what shall be the remedy which will most speedily, radically and effectually stop this terrible, and if not soon checked, necessarily fatal, waste of the vital fluid.

On glancing mentally back over the provings and symptoms of *phosphorus*, I found that it produces hemorrhages from the kidneys. I found that *arsenicum*, *carbonate of ammonia* and *phosphorus* are mentioned by even the old-school authorities (*Ziemssen*) as producing hemorrhage from the kidneys. This being the case, and *phosphorus* being so completely indicated constitutionally, and independent of this particular occasion, there was no other proper or scientific course for me to pursue but to give this patient *phosphorus*. This I consequently did.

Phosphorus, 6th trit. and 30th dil., in water, a dose every hour for a few hours, and later every two hours, was prescribed, with a discontinuation of all external, useless and annoying applications. This was about 11 A.M.

In the evening I fancied there was even then a little improvement in the patient's appearance and in the pulse. I anticipated a sleepless night, and advised his friends and himself that such would probably be the case, as he had been under the influence of morphia the previous night. I explained to them why I expected it, and why it was better to have him wakeful and restless than to stupefy him with morphia, and thus retard his final recovery, and eventually increase his restlessness.

February 27, 10 A.M. Found the patient had passed a sleepless night, but was no worse. In fact, he was able to retain quite a little alkathrepta on his stomach. In the evening I found him certainly better. Pulse steadier and below 120, and the stomach much less irritable. The contents of the vessel showed little if any change, with the probabilities favorable. Continued the *phosphorus*.

February 28, 10 A.M. Patient had passed another sleepless night. Had been at times delirious, gazing and speaking wildly at and to the nurse, raising himself up on his elbow and calling them to take a great weight off his chest and shoulders, saying some one was sitting on his shoulders and chest. The pulse, however, had still further steadied and decreased in frequency. He asked for food. The contents of the vessel were more brown, and less like pure blood. He was stronger; there was present, however, a troublesome hiccough, or half belch and half hiccough, which was so severe as to shake his whole body, and was painful to hear. This was, in a measure, relieved by taking a teaspoonful of warm fluid — milk and water or alkathrepta — whenever the trouble would appear. In the evening he seemed decidedly better. Continued the remedy.

March 1. Had slept fifteen minutes to half an hour at a time, though in a nervous, starting manner; pulse 108 and stronger; quite an appetite, and stomach less irritable; the vomiting has ceased altogether. Urine is visible in the vessel after standing awhile, showing a less proportion of blood.

Better in every way; hiccough still annoying. In the evening he seemed better, but begged for something to make him sleep. Left three powders of *coffea*, 30th trit., to be given one every hour from 10 o'clock. *Phosphorus*, 30th dil., continued.

March 2, 10 A.M. Patient had had but little sleep, although some more than he had had the previous night. Found in the vessel quite a number of fibrous-looking particles of various sizes, together with clots of dark blood. We were all very much alarmed, although the patient was better in all other respects. We much feared that the fibrous-looking particles were portions of the substance of the kidney. However, examination under the microscope showed no well defined tube-casts, and a careful examination convinced me that the alarming substances were shreds from either the lining membrane of the pelvis of the kidney, ureters or bladder, and such they proved to be. The quantity of urine had hopefully increased, and the quantity of blood proportionately decreased in the vessel. Food was relished and comfortably retained on the stomach, and the belching or hiccough was much less severe. Continued the *phosphorus*, and ordered an injection into the bladder of two teaspoonfuls of *hamamelis* in one pint of water after each urination, or three times a day. Gave three powders of *belladonna*, 30th dil., in the evening, to relieve a certain wakefulness, characterized by starting wide awake immediately after falling asleep.

The improvement was steady and satisfactory from this time on. The hemorrhage became steadily less and less, until it had altogether ceased, and only mucus appeared in the field of the microscope, with an occasional mucous tube-cast, and now and then a group of pus cells, and quite a number of crystals of the triple phosphates, which latter, and the mucus in greater or less quantity, remained for several days.

In less than three weeks from the time I first saw him he was up and dressed, and in less than four weeks he walked out. There seems at the present time no sign whatever of the trouble, or of serious consequences. The patient attends to his business as usual, walks long distances daily, experiences no pain, and has almost fully regained his former strength.

The symptoms upon which the remedy was selected, and

which are characteristic of *phosphorus*, were: the hemorrhagic diathesis, the disposition to bleed much from small wounds, the spongy, easily bleeding gums. *Phosphorus* has also, in a marked degree, relieved that annoying belching of wind which distressed this patient so much.

Possibly, if we had given phosphorus in the following case, which I borrow from my private records, we should not have had to regret the death of the patient; but I confess that the absence of fever, or at least of the frequency of the pulse, during the first days of the disease, deceived me completely.

Case LXXXV.—*Hemorrhagic variola; painful and incessant vomiting, without increased frequency of the pulse; repeated hemorrhages; death on the sixth day, from collapse with asphyxia.* Madame de S——, aged forty-five, vaccinated in her infancy, but not revaccinated, is a stout, fresh-looking woman. For some months she has lived in the country where the small-pox was prevalent, and she visited and nursed those who were ill with it.

Second day. I found this patient greatly excited; she had bilious vomiting every hour, frightful pains in the loins, an intense headache, a cool skin, and a pulse at 72; the vomiting had resisted Seltzer-water and ice. Ipecac., nux vomica, opium and belladonna were prescribed successively during that day and the following days, but almost without effect.

Third day. She has not slept; the excitement is great; she sits down, lies down and moves about continually; vomits almost constantly, but still thinks herself hungry; she has taken some broth, which increased the vomiting; the face is highly colored; the eyes are injected with hemorrhagic patches which are beneath the conjunctiva upon the globe of the eye, and the other symptoms are unchanged; the pulse is always 72.

Fourth day. In the morning she vomits less, but every quarter of an hour she is seized with violent and painful retching; she complains of a severe pain in the heart; has had no sleep during the night; the agitation increases; the face is red

and puffy; there is a true hemorrhagic chemosis of the eye, and papules of a dark red color are seen on the neck; the pulse is still 72.

In the evening the eruption had spread, the papules touched each other, and appeared upon the arms and the palms of the hands; some patches of purpura are mixed with the eruption on the neck. *Aconite* in the mother tincture and *vaccinium*, 3d trit.

Fifth day. She had a horrible night. Excitement and anguish, fear of death; many of the pimples are vesicular; hemorrhage from the bowels and with the urine; the pulse varies from 72 to 80; the skin is not warm to the touch (the patient refused to have the thermometer placed in the axilla); the face is more and more bloated; the vomiting has ceased, and she has taken some broth and some jelly. *Arsenicum*, 3d trit., every hour.

Sixth day. The agitation and anguish are constantly increasing; she changes her place several times in a minute; the hemorrhages continue; there is a good deal of the purpura, and she expectorates a bloody mucus. The morning pulse had increased to 96; she is quite rational, but believes that her death is very near. At about three o'clock a mucous râle began to be observed in the chest; the pulse increased to 120; the anguish and agitation increased until she had a frightful sense of suffocation. She died at 10 P.M., having retained her consciousness and her unrest until 9.45; then she fell into an asphyxiated collapse, and sank away in half an hour.

Every earnest physician who reads this work will be thankful to the author for his frankness and candor in publishing this case. It is good and wholesome for the truthful mind to meet with such an honest confession of inability to cope with everything in the shape of disease. Such a statement will do us infinitely more credit than a thousand reports from those doctors who protest that they have never, under any circumstances, lost a patient.—L.

We sincerely regret not having taken the temperature of our patient. The pulse continued normal until the fifth day, and in spite of the terrible condition, which terminated fatally on the sixth day. What was the temperature of this frightful case of variola? The patient's whims prevented me from

taking it, and the skin did not show any elevation of temperature when the hand was applied to it.

I have found the same condition of the pulse with several patients whose clinical history is given by Dufresne, *à propos* of an epidemic of hemorrhagic variola at Geneva, but in these reports, also, the temperature is not given.

In the cases of hemorrhagic variola, observed by Huchard (*On Death from Variola*, in the *Archives de Médecine*, 1871), the pulse was frequent, and the temperature above 102.2°. But we remark that in Case VII, on the evening of the sixth day, the pulse being at 72, the temperature had reached 104.72°. The pulse may therefore be normal, and yet the temperature ascend to, and perhaps exceed, 104°. This is because of the lack of coördination, or of relation between the usual symptoms and the malignancy of the attack.

In order to obtain the most trustworthy data from the pulse and from the patient's temperature, we must study them together, and not separately. No better illustration of this fact could be found than in the cases quoted. So wide a discrepancy between the pulse and the temperature, more especially if the latter remains very high, is almost always a bad sign. Exceptionally, however, in the puerperal state, this disparity is met with in very nervous and hysterical women, where, from some unknown cause, the hyper-thermic condition continues, or recurs, for some days without being necessarily dangerous.—L.

The Malignancy of Disease.

In what, therefore, does this *malignancy* consist?

Pathologists have agreed to drop this word from their nosography, because the existence of this state does not rest upon a precise definition, and because the word *malignancy* belongs to medical tradition as a sort of metaphor that serves to indicate what is very grave but very indefinite. *The dog that bites without barking* is, evidently, not a faultless character, and in the science of observation we should only be satisfied with rigid definitions; but since, in spite of us, this *malignancy* is too real and too frequent in the course of disease,

in our clinical teaching we must retain the word and make use of it almost daily. Let us see if, by the observation of facts, it will not be possible to give it a more precise and positive meaning.

The type of the malignancy is illustrated in the pernicious fevers. But what are the symptoms that are proper and common to the pernicious fevers? Or, in other words, what is the peculiar something that makes them pernicious?

The first peculiarity is, the danger of a very early death; for, whoever is attacked with a pernicious fever, no matter what its form, may die in a few hours.

The second peculiarity is, that this death is not caused by the mechanical process that belongs to other diseases, as in cerebral hemorrhage, croupal diphtheria, or an endocarditis, which kill by arresting the functions of one of those organs that are essential to life — the brain, the lungs, the heart — and the cessation of which functions is explained by the organic lesions that characterize each of these disorders. In these pernicious affections the heart ceases to beat, and the lungs to carry on the proper oxydation of the blood without any appreciable lesion that might account for the result.

A third peculiarity of this malignancy pertains likewise to the mode of death in such cases. This peculiarity consists in the fact that it is quite as difficult to foretell the time of death as it is to explain it; and that the fatal result is very often unexpected.

The ancients held that in consequence of this malignancy there might be a complete derangement of the vital functions, (Galen classed the respiration and the circulation as vital functions,) and that this condition, which is always so serious, and which often causes death in a few hours, may furnish another

quality of this malignancy, *id est*, the discrepancy among the symptoms. For example, a normal pulse and a temperature that exceeds 104°, as in hemorrhagic variola; and a complete absence of the pulse, although the physical strength remains, as in the Asiatic cholera, in which disease the patients may get up and go around for some hours after they have become pulseless. This blow which is aimed at the vital functions, explains the anguish, the agitation, the præcordial oppression, the coldness of the extremities, the lividity, and the tendency to syncope, which permit the experienced practitioner to recognize the malignancy of the attack and to prognosticate its issue.

Finally, its fifth and last feature is, that it is accompanied by symptoms of a benign character which, by reason of their preserving the animal functions intact, may serve to deceive the patient and all concerned.

Now, therefore, we are prepared to define this *malignancy* as an insidious condition, that is characterized by a disaccord among the symptoms, the overthrow of the vital functions, and by the danger of imminent death from syncope, or by the arrest of the chemical process of respiration.

Let me add, in conclusion, that this condition of malignancy sometimes takes the form of a pernicious paroxysm, as in intermittent fever, and in all febrile diseases, like pneumonia, the typhoid and eruptive fevers, etc.; and again it assumes the continuous type and identifies itself with this or that disease, of which it constitutes a particular form, as in the malignant pyrexiæ, and in those grave disorders which belong to an intermediate class, including diphtheria, erysipelas, dysentery, etc.

LECTURE XXXI.

SUMMARY.—Putrid diphtheria. Premature paralysis. The spasmodic element of croup denied by Bretonneau and his followers, *case*. Death by syncope can only be explained by the diphtheritic paralysis of the heart. *Cyanuret of Mercury*, indications for. Is there a preventive treatment for the syncope? Alimentation and its difficulties. The poisons: *lachesis*, *vipera* and *apis*, *camphora*, *agaricus muscarius*, *belladonna* and *arsenicum*. *Pneumonia* and *pleurisy* from diphtheritic paralysis of the nerves, which preside over the nutrition of the lungs and of the pleura.

The Putrid Form of Diphtheria.

GENTLEMEN: The child that was seized with the putrid type of diphtheria, and which you saw in one of the private rooms, succumbed very rapidly after the entire disappearance of the false membranes, and an improvement in the symptoms, which caused us to hope that she would recover. This is not a rare circumstance in the history of diphtheria, and I wish to take advantage of the case to consider the terrible consequences that may result from such a sudden and unexpected death when the doctor and the family may have anticipated a speedy cure.

The special therapeutics of diphtheria would be much more satisfactory and useful if those who have reported the results of their experience had been careful to give the full facts of the case; for there is a mild type of the disease that will get well of itself, and there is a malignant form of it that nobody has cured. Between these two extremes there is every possible shade of difference, not only in degree, but also in the kind and quality of its symptoms.

So that, when we come to consider the question of remedies, if these qualifying conditions are not given, we have no clinical data upon which we may depend. We must know the type and form of the disease, its peculiar complications, its epidemic mildness or malignancy, the patient's temperament and diathesis, and all the modifying circumstances that attend upon its course, before we can determine that any plan of treatment whatever has really been successful. A clinical report is worse than useless if it does not contain the

internal evidence of a careful discrimination on the part of the physician who has prepared and presented it, and of his desire not to mislead his brethren nor to misjudge the value of his remedies.—L.

You will hear it said that the death in these unfortunate cases is due to diphtheritic poisoning; but I warn you to free your minds from the mania for hypothetical explanations which has been such an injury to Medicine, and, instead of being satisfied with a mere figure of speech that will mislead you in the matter of treatment, analyze the facts, and you will become convinced that such fatal terminations are always due to a *premature diphtheritic paralysis.* In this way we confront a tangible reality in therapeutics instead of an empty metaphor, and are not left to look for an antidote which is as uncertain as the existence of the diphtheritic poison itself.

Before entering upon the history of the case which is the special subject of this lecture, let me recall a fact which I observed in 1859, and which has given me the true meaning of certain mortal conditions that may occur in diphtheria and croup.

A child of five years, which was seized with ordinary croup, had been the subject of tracheotomy after a fit of suffocation with increasing violence. An absolute calm succeeded the operation, and for twenty-four hours there was hope of a cure; but in a moment, and without any pulmonary complication, the fits of suffocation returned. The canula was replaced by another which dilated the wound to its full extent, and which would not permit its obstruction by the false membranes, that could not be seen elsewhere. However, the paroxysms became more frequent and severe. They were accompanied by a characteristic symptom, which is a temporary paralysis of the upper lid of the right eye, and a cough, with retraction of the diaphragm during

inspiration. The child died on the third day, and, in the absence of pulmonary lesions, as well as of obstruction of the trachea, a premature paralysis of the diaphragm afforded the only possible explanation of the fits of suffocation. We might very properly say that the paralysis of the right upper eye-lid was the sign of the paralytic nature of the difficulty.

At that time those whose minds were dominated by Bretonneau considered the suffocation of croup as entirely due to the mechanical obstacle resulting from the presence of the false membranes. Indeed, this was neither the single nor the least serious of the errors of a leader who to undoubted professional gifts added the most detestable defects. Bretonneau wished to bring the operation of tracheotomy into favor again, and he founded the argument for its necessity upon the suffocation that is due to the presence of the pseudo-membrane. With him, as with Trousseau, all the other causes of death and of dyspnœa signified nothing, and the treatment of diphtheria was embodied in a single precept — to practice tracheotomy as soon as the diagnosis is certain.

We are far from endorsing this idea, for more modern researches have ascribed to the spasms of the muscles of the glottis their rightful importance in the production of the fits of suffocation in laryngeal diphtheria. This *rôle* had already been assigned them by physicians before the time of the school of Tours.

We are of opinion that, besides the mechanical obstacle from the presence of the membranes and the spasm of the glottis, there is still another factor of the dyspnœa and of the suffocation in croup. That element is the premature or the untimely *paralysis* of the muscles of the glottis and of the diaphragm. We have already elaborated this question in our journal (*L'Art Médical*), and shall not further insist upon it now. In this

lecture we shall limit ourselves to the study of the premature *cardiac paralysis of diphtheria.*

The details of the case upon which this lecture is founded are as follows:

Case LXXXVI.—M——, a little girl of five years of age, had lost a little sister who died in four or five days after being attacked with diphtheria. She fell sick herself on Friday, the 2d of February, 1877, some days after the death of her sister. She had fever, headache, and a sore throat. Before resorting to the homœopathic treatment, her throat had been cauterized with the nitrate of silver.

Third day. She came into the hospital at evening. She complains very much, and is greatly excited; the sub-maxillary glands are greatly swollen and painful; the throat, the veil of the palate, the uvula and the tonsils are covered with a grayish membrane, but there is nothing of it in the nostrils; the respiration is nearly normal, but the breath is fœtid. The child takes its food pretty readily. Prescription: *cyanuret of mercury*, 2d trit., twenty centigrammes in 200 grammes of water, a teaspoonful every half-hour.

Fourth day. The night has been a restless one; the glands are more swollen, having increased to the size of a turkey's egg; the false membranes are growing thicker; there is constipation, and the flow of urine is arrested; it is very difficult to get her to take her food. *Cyanuret of mercury*, 2d trit., and *apis mel.*, 2d dil., every half hour, alternately; with milk, broth and wine.

Fifth day. The same state of aggravation; mucous râles, a thick cough; the nasal discharge consists of false membranes mixed with blood; there is extreme agitation and anguish; the face is pale and puffy, with a livid hue of the lips, and there is considerable dyspnœa, but without any fits of suffocation; however, I requested Dr. Tessier to be ready to perform tracheotomy. *Cyanuret of mercury* and *arsenicum*, 2d trit., every half hour, alternately. We also insisted that she should be forced to take the milk, soup and wine.

Sixth day. During the day she had some diarrhœic stools;

the flow of urine returned; a patch of false membrane was expelled; the swelling of the glands diminished; the expression is better, the agitation less, and the improvement is manifest; she has taken some white wine, broth and milk. The same prescription.

Seventh day. The patient wants some food; the urine, on being analyzed for the first time, shows the presence of albumen very decidedly. In the evening the voice and the cough are hoarse, and there is some, but not a very marked, laryngo-tracheal whistling; from time to time she raises herself quickly, but she does not have any decided paroxysms of suffocation. The same prescription.

Eighth day. The symptoms improve; a patch of the membrane as big as a dollar has been cast off. The same remedies.

Ninth day. The false membranes have entirely disappeared; the glands have returned to their normal size; the mucous membrane of the throat is very red; deglutition is painful, and fluids return by the nose. She calls for her mother incessantly. The pupils are slightly dilated. She takes very little nourishment because of the pain and the paralysis of the veil of the palate. The urine is still albuminous. The same remedies.

Tenth day. The general appearance is not bad. In the morning, however, the pulse was very feeble, and it was very difficult to feed her. Nutritive enemata, thick cream; *phosphorus*, 3d dil., and *china*, 3d dil., in alternation.

During the day the patient grew weaker very decidedly, and died at 4 P.M. without any shock or asphyxia.

During the time she was in the hospital she had taken broths containing eggs, milk, wine and biscuit, and she had been nourished as well as possible.

In this case death occurred without asphyxia, and without any violent fever. Although the nutrition was difficult, yet it certainly was sufficient to sustain life.

Would it be possible to explain this unfortunate result on the theory of an unknown poison, the sources of which had been exhausted for more than forty-eight hours, because all traces of the false membranes had disappeared two days before

death? To my mind, it is more rational to hold firmly to the idea that the heart, which had become gradually enfeebled, stopped on the tenth day of the disease. The cardiac paralysis was evidently of the same nature and origin as the paralysis of the pharyngeal muscles. In order to explain this *symptom*, there is no need of a theory of morbid poisons, especially since careful dissections have disclosed the existence of degeneration of the motor nerves in muscles that have been paralyzed.

But here is a case of *putrid diphtheria*, in which death by syncope was still more evident :

Case LXXXVII.—H. L——, a little girl of eight years, who had enjoyed good health, and who was of a strong constitution, was taken with headache and malaise on the 17th of March. On the 18th she had some fever and complained of a sore throat, but it was some days before a pseudo-membranous patch was found upon the left tonsil.

Being under the professional care of a distinguished physician, she was first treated by applications of lemon-juice, then, the diphtheria having invaded the pharynx and the nasal fossæ, by injections of lime-water. I was assured that no medicine whatever had been given internally.

I was called to this child on the 22d of March, which was the fifth day of the disease. She then had the following symptoms: dorsal decubitus, somnolence, the eyes were half-open, the face was puffed, shining and very slightly livid, the respiration was somewhat accelerated and noisy, and the mouth was open. Both nostrils discharged a grayish liquid, which contained some flocculi, from the false membrane. The movements of respiration made this liquid foamy; the upper lip and alæ nasi are red and sore; the pharynx is covered by a large milky looking, thick, and very adherent, false membrane.

This membrane, which is most developed on the left side, covers the whole isthmus of the fauces and the uvula. There is no decided odor to the breath; the left sub-maxillary gland is enlarged, is as hard as wood, and painful. On the right side the sub-maxillary gland is much smaller.

The fever is intense; the pulse 116; the urine is pale, thick, scanty, and contains albumen.

The child, deprived of its sleep, has a strong voice, which is not hoarse, and she does not cough, which shows that the larynx is not involved; she has a great repugnance to taking her food. I prescribed the *cyanuret of mercury*, 3d trit., twenty centigrammes in 200 grammes of water, a teaspoonful to be taken every hour. I also insisted that she should take the broth, the milk and the wine.

May 23, sixth day. She had a pretty good night, and otherwise is about the same. There is a remission of the fever; the morning pulse was 90, and the evening pulse 112. The false membrane has not extended any farther. She has been forced to take the nourishment ordered. The same treatment.

May 24, seventh day. The night was restless; the fever has increased very decidedly and seriously; the false membranes exhale a sweetish odor; the urine is pale, thick and albuminous; and the facial expression is bad. Hourly alternations of the *cyanuret of mercury* with the mother tincture of *china* in water.

May 25, eighth day. The night was more calm; the patient looks better; the false membrane is the same; the child had been nourished as thoroughly as possible. The same treatment.

May 26, ninth day. The improvement is slight, but unmistakable; the face is less swollen; the false membrane appears to me to be thinner; its borders are pared down; the night has been comparatively good; the urine is the same as before.

May 27, tenth day. She is better; the general condition is much improved; the sleep is good; the child eats with some disrelish, but still she does take her food; the false membrane melts away, little by little, like a piece of ice; the discharge from the nasal fossæ is less free, and is no longer foamy; two diarrhœic stools. The same treatment.

May 28, eleventh day. The improvement continues; the mucous membrane of the pharynx and of the uvula can be seen again; it is so sensitive that deglutition is more painful than ever; diarrhœa and some vomiting of food; the pulse remains at 100 morning and evening. I continued the *cyanuret*

in alternation with *arsenicum*, because of the diarrhœa and the albuminuria.

May 29, twelfth day. She is still better; there is almost no trace of the false membranes; the child sits up in its bed; its expression is natural, but it sometimes vomits its food. The same treatment.

May 30, thirteenth day. Improving; the false membranes are gone; the child arose at five o'clock; she has eaten two oysters and some beef-steak, and she has no more fever; there is paralysis of the veil of the palate; the voice is nasal, and liquids are returned by the nose; diarrhœa; the urine is still albuminous. The same treatment.

May 31, fourteenth day. The child has passed a good night; this morning she complained of being a little chilly; she sat up in her bed to wash her hands; she called the nurse and cried because she could not see her any longer; the hands were moved convulsively; she fell back upon the pillow frightfully pale, and was dead.

One of the first cases of this disease that we treated, in 1862, was that of a bright, beautiful boy of eight years, who, with a moderately severe attack, had reached the ninth day, and was apparently doing well. The throat was almost clean, and all of his symptoms were favorable. An hour after our visit he asked to be carried to the window that he might look at the snow which was falling. He was lifted very carefully to a seat in his mother's lap by the window. He looked a moment, then asked her to wipe off the pane so that he could see more distinctly. She took her handkerchief to do as he wished, and in a moment he was dead.—L.

In a prognostic point of view, let us remember the diarrhœa and the vomiting of food from the date of convalescence, the paralysis of the veil of the palate, and the persistence of the albuminuria.

The mother of this child was seized on the twelfth day of her little daughter's illness with a comparatively mild attack of diphtheria, which, however, was accompanied with albuminuria. And a little brother of five years, who was kept away from his sister, and who, on the second day of her disease, was taken to Epernay, was nevertheless attacked fifteen days later

with a diphtheria that was limited to the right nostril. Dr. Couillaud recognized a thick, gray, false membrane therein, which did not disappear until after eight days' duration. The child was but slightly ill, and had no albuminuria. The treatment resorted to by Dr. Couillaud was the internal use of a solution of *bromine*, and nasal irrigations containing Labarraque's solution.

I have said that we cannot explain the rapid death of the child whose case you have studied in our ward, nor the sudden death of the one whose history I have just given you, except by the cardiac paralysis.

With one of them the fever had disappeared, and with the other it had greatly diminished; and we cannot, therefore, ascribe the fatal result to the violence of the fever. Whilst, on account of the paralysis of the pharynx, the alimentation was imperfect, nevertheless it was more than sufficient to support life; and death did not, therefore, result from inanition.

To claim that these patients succumbed to the malignancy of the disease, or to a diphtheritic poisoning, is to be satisfied with a figure of speech, instead of seeking for the true course and nature of the conditions that have resulted in death. Such a course would make us renounce a positive therapeutics for the sake of employing those antidotes which are as fanciful as they are lacking in efficacy.

The argument that diphtheria depends upon a blood-poison is founded upon its infectiousness; the possibility of its being conveyed by fomites; its inoculability; its having a period of incubation, like the eruptive fevers; its prevalence along with and in complication with other zymotic diseases, as scarlatina, rubeola, variola and erysipelas; the fact that a whole family or community may have it; its being traceable, in many instances, to defective drainage, bad sewage, bad ventilation, the use of impure water, and to the exhalations from the patient; the tenacity with which its contagion, whatever it may be, clings to certain houses, and even to certain rooms, in which there have been one or more cases of this disease, just as in puerperal septicæmia, malignant scarlatina and the small-pox; the possibility of auto-infection during the attack; the fact that it is most frequent among children, and that it has a train of secondary affections or sequelæ which are as characteristic as those of any other zymotic disease.—L.

The most recent researches in pathological anatomy show that, in diphtheritic paralysis of the veil of the palate, there is not only an alteration of the nervous filaments which are supplied to the muscle, but also of the muscular fibres themselves.

A similar lesion also accounts for the condition of fainting, and the fatal syncope in diphtheria. In this disease, as in typhoid fever, when the lesion is very pronounced, the muscular fibres undergo a fatty degeneration, and become incapable of the proper cardiac contractions.

Whether the cardiac nerves are subject to changes similar to those which occur in the motor nerves of the veil of the palate, is still an open question.

The *cyanuret of mercury* was the principal remedy in these two cases, and its efficacy in the early stage of the disease will not be denied. The analysis of the symptoms in these cases will show you where the remedy which has been so highly recommended by Beck, of St. Petersburg, is indicated, *id est*, for false membranes which are thick and putrid, and which occupy the whole throat, and extend into the nasal fossæ; for enormous and painful glandular swellings; for palor and shining tumefaction of the face, with very decided adynamia. These symptoms, which characterize the most fatal form of diphtheria, were present in both of our cases, and they yielded rapidly to the action of the cyanuret of mercury.

In an article on the clinical application of this remedy in diphtheria, published in the *American Homœopathist* for January, 1878, my friend, Dr. W. H. Burt, has analyzed the toxical symptoms of this drug very carefully. Quite a number of these symptoms are almost identical with those of diphtheria. He also poisoned a large dog with the cyanuret, by injecting the crude drug beneath the skin, and the autopsy showed such laryngeal and cardiac lesions as bore a strong resemblance to those of diphtheria.

Dr. Burt says: "Usually the pseudo-membrane is of a dark-gray color, which I believe to be the true color indicating this drug. I have often seen this dark-gray colored pseudo-membrane not only covering the tonsils but the whole of the soft palate, uvula and fauces, extending up into the nares, completely occluding the nostrils. I have also had a number of cases in which the deposit was wholly confined to both nostrils,—two very recently,—one in a young girl

and one in a young lady, in which cases, for several days, the air could not be drawn through the nose; and, through the influence of this drug, both of them recovered.

"I have also attended a few cases of the so-called croupal diphtheria. In one marked case, in a lady forty years of age, the voice was lost for six weeks, but she finally recovered. I gave her up to die, and prepared her husband for it, but the cyanuret of mercury as it were snatched her from the grave.

"Another case of croupal diphtheria was that of a little girl of seven years. The pseudo-membrane extended from the tonsils into the larynx, producing complete aphonia, which lasted for two weeks. One nostril was occluded in this case also, but she made a good recovery."

Dr. Burt adds: "In several of my cases that have been treated with the cyanuret, during the first two days, in order to subdue the fever, I have given *baptisia* in alternation with it, and I believe it to be a good plan. I should advise the cyanuret of mercury in from the third to the thirtieth attenuation, but probably the sixth attenuation will be just what we want."—L.

But you will observe, gentlemen, *that the improvement did not begin until the fourth day of the treatment*, which was the sixth day of the disease in the first case; and on the eighth day of the disease, being the fourth day of the treatment in the second case. I had been called to this case on the fifth day of the disease, after the physician in attendance had declared the case to be hopeless.

In these very grave cases we must insist upon the value of the cyanuret of mercury, at least during these four days; and you will recall the precept which I have already given you so often, that it is by persevering with the same remedy that you will obtain the best results. If other indications spring up, and are very decided, try to meet them with whatever else is indicated, but continue the principal remedy, *the* remedy, which, in putrid diphtheria, is the cyanuret of mercury.

There is a great variety of opinions on this question of perseverance in the use of remedies in diphtheria. Some writers, who describe the disease from their inner consciousness, insist that unless the patient improves at once we must change the remedy, while others would have us cover the case as nearly as possible with the remedy, and persevere with it to the end.

In a thesis on diphtheria, presented to the Hahnemann Medical College, of this city, in 1873, by Dr. George Bollen, of South Australia, and published in the *United States Medical and Surgical Journal*, Vol. VIII, page 261, we find the following paragraph:

"Any disease like the one we are discussing, which vitiates the blood, all other things being equal, requires the *lowest dilutions*, and these I have generally used. I believe, also, that in all acute diseases which have no regular period to run, we may not only expect, but must look for, curative action *at once;* and in this class, which includes diphtheria, we need a *frequent repetition* of the dose. I also believe that when a constitutional disease sets up local lesions, as diphtheria does, that it is quite right to meet it at both ends by the *alternation of remedies.* I have also found, *by experience*, that a remedy which benefits the case for a day or two seems often to lose its effect. The disease will first come to a standstill, and then return, and that remedy is of no further service in that case. Without pausing to explain this, suffice it to say that I have adopted a rule which has worked admirably with me for a long time, and that is, in diphtheria, *never to use a remedy, however much good it may be doing, over forty-eight hours consecutively, and in urgent cases over twenty-four hours, without changing; and then after using other remedies for twenty-four or forty-eight hours, to change back again*, and so on."—L.

But how shall we avert those fatal terminations which are as terrible as they are unexpected? How shall we prevent the snycope that is incident to convalescence? Without doubt the tonic and nourishing regimen which is prescribed by all schools of medical belief, is indicated and should certainly have its effect to reduce the proportion of the cases of death by syncope in diphtheria; but every experienced physician knows how difficult it is to nourish this class of patients.

It is in just this variety of cases that we encounter such an invincible aversion to food, and such a marked difficulty of swallowing, on account of the paralysis of the veil of the palate, that we may be obliged to nourish the patient through a tube in the œsophagus, in order to prevent death by starvation; and it is a very serious question to decide how we shall overcome this condition and keep our patients well-nourished.

When our patients are old enough, we insist upon their taking a swallow or two of milk every half hour or so, nominally for the throat, but really for their nutrition, also. When the vitality of the mucous membranes is so low, and their secretions are so decidedly changed, it is possible that beef-tea might increase the sepsis by its own decomposition. Ice cream is always grateful in these cases, and might be given freely in the form advised at page 371.—L.

The Materia Medica furnishes a certain number of remedies that cause fainting and syncope. The most important of them are the animal poisons, for serpent wounds induce a condition of fainting, and even death, by syncope. *Lachesis*, *crotalus*, *naja*, *vipera*, and *apis mellifica*, may, therefore, be indicated.

Besides these poisons, *camphor* is one of the medicines that is most certain to cause a fainting condition. *Agaricus muscarius*, and its active principle, *muscarine*, may cause an arrest of the heart's action and death by syncope. (*Atropine* is the best remedy for arousing the action of the cardiac muscle in the case of animals that have been poisoned by muscarine.)

There are remedies, such as *phosphorus* and *arsenicum*, that cause a degeneration of the muscular tissue of the heart, and thereby occasion fainting and syncope.

The Materia Medica is therefore rich, I should say too rich, in the number of its remedies for syncope; but before clinical observation has taught us which of these is the most reliable in diphtheritic syncope, I fear that we shall lose many more cases from this cause.

It is a question whether we should ascribe the pneumonia and the pleurisy, which are always symmetrical, which occur without any accidental cause, and which give rise to an insignificant reaction, to the paralysis that follows diphtheria.

You are aware that, *in a certain proportion of cases*, a section of the pneumogastric nerve will cause a congestion and even a hepatization of the lung; that it is impossible to explain these facts by the return of food and of gastric liquids in the windpipe, since it happens with animals whose trachea has been tied upon a tube; and that the explanation given by Claude Bernard, who held that the congestion in this case must result from the embarrassment of the circulation, is a mere assertion.

And we must not forget that, in certain cases, also, the removal of the last cervical ganglion of the great sympathetic gives rise to a violent pleurisy with effusion.

These facts confirm our belief that when diphtheritic paralysis attacks the great sympathetic, or the pneumogastric, nerves, it may in the first case be the cause of a pleurisy which is not referable to taking cold during the convalescence from diphtheria, and in the second case it may give rise to a pneumonia which is developed under the same circumstances.

In putrid diphtheria much relief may sometimes be given by throwing a spray of lime-water, or of a solution of the chloride of lime, directly into the throat. The air of the apartment may also be disinfected in the same way. An ingenious method of getting rid of the deposit is to throw a spray of lactopepsin into the fauces, so as to digest and dissolve the membrane.—L.

LECTURE XXXII.

SUMMARY.—Slight albuminuria. Consecutive Bright's disease. Serious albuminous nephritis in typhoid fever, *case*. Prolonged typhoid fever, serious albuminuria; inflammation of the parotid gland. *Terebinthina;* cure; *case*. Prolonged typhoid fever; albuminuria with hematuria, *phosphoric acid;* symptoms of spinal meningitis, *sulphate of strychnine*, remission of the fever which is rebellious to the sulphate of quinine; cure. Relapsing typhoid, *case*. Its character is not that of a relapsing typhus. The pernicious paroxysms, and their peculiarities in typhoid fever. Typhoid fever without fever.

Albuminuria in Typhoid Fever and in Relapsing Typhoid.

GENTLEMEN: The patient who occupies No. 4 in the men's ward has furnished an illustration of serious albuminuria in typhoid fever; and this complication will be the subject of our lecture.

A slight and temporary albuminuria is very often met with during the course of typhoid fever. This change of the urine, which arises from a congested state of the kidneys, has not the slightest signification, either in diagnosis or prognosis, and affords no therapeutical indication whatever. It is not of this common form of albuminuria, which is incident to most of the acute diseases, that I mean to speak. I shall also put aside, for the present, the history of the parenchymatous nephritis, which sometimes develops during the convalescence from typhoid fever, and which constitutes one of the sources of Bright's disease. Our subject will be more limited: we shall study to-day the albuminuria and the hematuria which belong to a parenchymatous nephritis occurring in the course of the typhoid fever. This is a rare but a serious complication; for in a memoir which has been recently published

(*Archives de Médecine*, December, 1876,) MM. Le Groux and Hannot have had five deaths in the case of five patients attacked with typhoid fever complicated with albuminous nephritis. We have only had two cases of this kind, and, under the influence of the homœopathic treatment, both of them were cured.

I will first call your attention to the history of a private patient in whom, from the first, the albuminuria was so marked that, for several days, there was some hesitation concerning the diagnosis. At the beginning I thought that it was a case of acute nephritis, and, during the course of the disease, the symptoms of the nephritis, instead of being concealed, or, so to speak, veiled, by those of the typhoid fever, continued as they were at the beginning; so that with the fever, the stupor, the tympanitis, the diarrhœa and the stomatitis of the typhoid, we had the urine and œdema of albuminous nephritis.

Case LXXXVIII. — *Typhoid fever; albuminuria from the outset; albuminous anasarca; intestinal hemorrhage; inflammation of the parotid; cure.* Mrs. D——, aged twenty-five years, widow, with feeble health from misfortune and from chronic catarrhal metritis, was taken ill on the 19th of December, 1876. The attack set in with a decided paroxysm of fever, chill, heat and sweat, and the fever assumed the tertian type. But after the third paroxysm, which occurred on the 23d of May, the fever became continuous.

December 24, fifth day. The morning temperature was 103.10°, and the evening temperature 104°. The patient has been tormented with thirst, and by a continual desire to vomit; she is already very feeble. *Ipecac.*, 3d trit., in 200 grammes of water, a teaspoonful to be taken every two hours.

Until the tenth day, the 28th of December, her condition was very nearly the same, the morning temperature being 103.10°, and the evening temperature 104.5°. Thirst, nausea, and a painful dryness of the tongue; the diarrhœa set in; the

typhoid spots were abundant on the abdomen; but, what was still more characteristic was that, from the fifth day, the urine was bloody and contained a very large quantity of albumen. This symptom was so marked that I was led to consider the case as one of acute nephritis. I prescribed *belladonna*, 3d dil., which very decidedly allayed the thirst and the nausea; and *cantharis*, 3d dil., which was continued for twenty-four hours only, because, while it had no effect upon the urine, it brought back the distressing nausea. Broth and milk, and a little wine and water.

On the eleventh day the temperature dropped a little in the morning, 102.56°, but it rose again at evening to 104.50°. The nausea has disappeared, but the diarrhœa and the bloating of the abdomen are very much increased. The urine still contains blood and albumen.

The temperature continued at 103.28° in the morning, and 104.50° in the evening. The patient was agitated, anxious and depressed. She took *arsenicum*, 3d trit., twenty centigrammes in 200 grammes of water, a teaspoonful every two hours.

The febrile heat being very distressing to her, I ordered cold lotions with *l'eau vinaigrée*, once in three hours. She felt very much relieved; but the temperature remained the same until the fifteenth day, when it suddenly fell to 100.40°. This change was due to a pretty severe intestinal hemorrhage, that continued for three days. *Phosphoric acid*, 3d dil., and afterward in the 1st dil., checked the flow. During this hemorrhage the temperature varied from 99.5° to 102.20°, the cold lotions being discontinued meanwhile. She had considerable stomatitis, and gargled her throat incessantly; the tongue was dry, cracked and bleeding, and the folds and veil of the palate were covered with a pultaceous coating.

About the time that the hemorrhage ceased, the abdomen became so distended as very decidedly to interfere with respiration; and, at the same time, the diarrhœa stopped. I then gave *colocynth* in alternation with the *phosphoric acid*, and these remedies had the effect to relieve the tympanitis and to bring on the stools.

On the twentieth day, the temperature having returned to 103.10°, I prescribed one gramme of the sulphate of quinine,

but without any very decided effect. The temperature continued at 101.48° in the morning and at 103.10° in the evening. The same dose of the quinine being given on the twenty-second day, brought both the morning and the evening temperature to 100.40°.

During all this time the urine continued to be highly albuminous, and, on the twenty-fourth day, the temperature suddenly mounted to 103.10°, then to 104°, and an inflammation of the left parotid gland followed. At the same time we also observed a considerable œdema about the loins, in the face, the eyelids, and beneath the conjunctiva of the globe of the eye. *Apium virus* and *cantharis*, 3d dil., had no effect upon this latter condition. The swelling of the parotid increased rapidly, the skin being purple and threatening to become gangrenous. A surgeon, who was called in consultation, could find no fluctuation, and thought best not to interfere with it.

Twenty-ninth day. The patient presents the following condition: incessant, and sometimes involuntary, diarrhœa; excessive abdominal tympanitis; increasing œdema; the urine is bloody and albuminous; the pulse small and frequent, and the temperature varies from 104° to 104.5°.

For this serious condition we prescribed *terebinthina*, 1st decimal dil., three drops in 125 grammes of water, one teaspoonful to be taken every hour.

Under the influence of this remedy the improvement was very rapid; the tympanitis subsided; the urine ceased to contain blood, although it continued albuminous; the œdema disappeared; the temperature did not exceed 101.30°, morning or evening, and the swelling of the parotid *seemed* to diminish.

Thirty-fourth day. For the first time the morning temperature fell to 99.86°, but it reacted to 102.20° in the evening; and from this moment the patient improved gradually each day. The temperature dropped to 96.80° in the morning, and came up again at evening to 100.40°.

From the thirty-sixth day the parotid became slowly softened, and it was lanced on the forty-third day of the disease. The albumen diminished progressively, and finally disappeared about the 20th of February, *id est*, the seventieth day of the disease. *Arsenicum*, 3d and 2d trit., was continued until that

time. It is hardly necessary to state that, from the thirty-fourth day, and especially from the time that the abscess of the parotid was opened, the appetite, the sleep and the strength improved progressively.

You observe, therefore, gentlemen, that parenchymatous nephritis, like pulmonary hepatization and local encephalitis, may exist as a complication of typhoid fever. And you will remember, also, the excellent effect of the terebinthina in this case as a remedy for the hematuria, the involuntary diarrhœa, and the excessive tympanitis of the abdomen.

Here is the clinical history of the patient occupying No. 4 of the men's ward:

Case LXXXIX.—*Typhoid fever of the tedious type; albuminuria; and spinal congestion.* M. P——, aged eighteen years, a saddler, was admitted on the 21st of December, 1876, and discharged on the 24th of March, 1877.

After four or five days of malaise, he was seized, on the 10th of December, 1876, with chills, headache, pains in the abdomen and epistaxis, complete anorexia and diarrhœa, on account of which he was compelled to take to his bed.

Some days later, he does not know exactly when, he began to cough, became quite deaf, and was a little delirious.

He entered the hospital on the twelfth day of the disease, and until that time had taken nothing but teas. At the evening visit the temperature was 104°, the pulse 120; great prostration; anorexia; a very dry and sooty tongue, with angina; pain upon pressure in the right iliac fossa; slight gurgling; some rose-colored spots on the abdomen; deafness; less headache than before; frequent cough, and bronchitis.

December 22, thirteenth day. The same condition. *Ipecac.*, 6th dil., and *bryonia*, 6th dil. These medicines were continued for four days.

December 24, fifteenth day. The expression is a little better; the evening temperature has fallen to 102.56°.

December 26, seventeenth day. Last evening the temperature was 104°. Prescription: *arsenicum*, 3d trit.

December 27, eighteenth day. The diarrhœa is very bad; the general condition is always the same. Prescription: *muriatic acid*, 3d dil.

December 29, twentieth day. No change. Prescription: *arsenicum*, 3d trit., and *bryonia*, 3d dil. (These remedies were continued for six days.)

December 30, twenty-first day. The fever, which has been continuous until now, had a slight remission this morning (101.48°); the patient takes a little interest in what is passing about him; the evening temperature, however, rose to 104°.

December 31, twenty-second day. Another remission this morning; temp. 101.48°; evening temp. 102.56°.

January 5, twenty-seventh day. The morning remission, which began with the twentieth day, is still more pronounced; the range of the temperature has increased; the patient is still prostrated, and inclined to dream; the gums bleed; the cough is frequent; the hoarseness, which amounts almost to aphonia, and which has continued since he entered the hospital, still persists, with some soreness of the throat. Prescription: fifty centigrammes of the *sulphate of quinine*, and to rest for four days.

January 10, thirty-second day. The same condition; *phosphorus*, 12th dil., on account of the aphonia and the cough, for three days. The deafness seems to have diminished somewhat.

January 13, thirty-fifth day. Since yesterday the range of temperature from morning to evening has been very marked — from 98.60° to 102.20°. Prescription: *sulphate of quinine*, seventy-five centigrammes during two days; then the next day one gramme, and to rest until the thirty-ninth day.

January 18, fortieth day. The same condition; the quinine, given in such large doses, not having changed the febrile movement, we returned to *phosphorus*, 12th dil.

January 19, forty-first day. The same. *Chininum sulph.*, 3d trit., for two days.

January 21, forty-third day. The voice is a little stronger, the deafness is not so bad; the gums are cleaning; the appetite improves.

January 22, forty-fourth day. The general condition is better; he could raise himself in the bed during the day; but he

has had slight epistaxis. *China*, 3d trit., to continue for three days.

January 26, forty-eighth day. The patient complains of pains which prevent him from sleeping; these pains are seated in the spinal cord, and follow the distribution of the spinal nerves; the intermittent type of the fever continues (98.60° in the morning and 102.20° in the evening). Prescription: *colocynth*, 1st dil.

January 27, forty-ninth day. Prescription: *belladonna*, 3d dil.

January 28, fiftieth day. The same.

January 29, fifty-first day. The spinal pains are chiefly located in the lumbar region; they are very much increased by pressure. *Sulphate of strych.*, 2d trit., to be given for two days.

January 31, fifty-third day. For two or three days the urine, which from the beginning has contained albumen, has a great deal of blood in it; at the same time the epistaxis increases, and the gums begin to bleed. Prescription: *terebinthina*, 1st trit., for two days.

February 3, fifty-sixth day. The same. *Phosphorus*, 6th dil., to be continued for two days.

February 6, fifty-ninth day. *Phosphorus*, 3d dil.

February 9, sixty-second day. The spinal pains continue; the urine contains albumen and blood; the fever has ceased. *Arsenicum*, 3d trit., for two days.

February 12, sixty-fifth day. No marked change. *Phosphoric acid*, 1st dil., ten drops.

February 14, sixty-seventh day. The urine is less highly colored with blood, and contains less albumen. The same prescription, to be continued for four days.

February 19, seventy-second day. There is no more blood, and but little albumen, in the urine. *China*, 3d dil.

February 20, seventy-third day. No hematuria, and very little albumen, in the urine; but there is a relapse of the spinal suffering. *Sulph. of strychnia*, 2d trit., to be continued for six days.

February 27, eightieth day. The albumen has disappeared; the spinal pains are very much diminished, but there are some

rheumatic pains in several of the joints, as the hip, the shoulder, etc. *Chininum sulph.*, 1st trit., continued for four days.

March 3, eighty-fourth day. The rheumatic pains continue. *Rhus tox.*, 3d trit., and *arsenicum*, 3d dil., were given while he continued in the hospital. The pains diminished gradually, and he was discharged on the 24th of March, completely cured.

Let us recapitulate briefly the course, and the rather unusual symptoms which have marked the last part of this prolonged attack, for the fever continued for more than ten weeks.

After a decided diminution of the fever (99.5°) following the thirty-fourth day, it assumed an intermittent form of the most pronounced quotidian type (98.60°, and even 97.70° in the morning, and 102.20° to 103.10° in the evening); but the quinine failed to have any lasting effect in changing its character.

On the forty-eighth day the patient began to complain of pains, which did not leave him until the eightieth day of his disease. The fifty-first day he had a copious hematuria, with epistaxis and diarrhœa, which put his life in danger, and which continued until the seventy-second day.

Suppose we consider the character of the pains from which he suffered, and also the hematuria. The pains were *spinal*, *id est*, they were located along the vertebral column, following the course of the intercostal nerves, and a little later, the track of the nerves of the arms and of the thighs. Sometimes they predominated in the dorsal region, again in the cervical region, and again in the lumbar region. Their radiations extended to the walls of the thorax, to the abdomen and to the extremities. Pressure upon the spinous processes of the vertebræ greatly aggravated these pains. Touching the skin near the spine, where the congestion was located, with the end of the finger, would extort cries from the patient; while, on the contrary, a broad and firm pressure upon these same parts lessened the suffering.

These pains were continuous, but they were redoubled at night, so as to make the patient cry aloud. Indeed, his complaints so troubled the other patients in the ward that we were obliged to threaten him with an extreme diet if he did not desist.

The urine voided by our patient contained albumen from the time of his admission into our wards, but from the fifty-first day there was a decided hematuria. The *terebinthina*, of which you could appreciate the value in the former case, had only a slight effect in this one. *Phosphorus*, 6th dil., then 3d dil., and *arsenicum*, 3d trit., were without effect. The diarrhœa that was added to the other symptoms, suggested *phosphoric acid*, 1st dil., on the sixty-fifth day. The next day the symptoms had improved, and, eight days later, the hematuria had entirely disappeared; but the spinal pain, in all its varieties, grew much worse. It was, however, sensibly relieved by the *sulphate of strychnia*, 2d trit., continued for six days. Then, these spinal pains were followed by rheumatism of the principal joints. *China*, 1st trit., and afterward *rhus tox.*, 3d dil., and *arsenicum*, 3d trit., disposed of the rheumatism.

You will observe that the febrile movement, after having descended gradually to 99.68°, on the morning of the thirty-fourth day, rose abruptly to 104° on the same evening; and that it presented a remittent type (102.20° and 103.10° in the evening, with 97.88° and 98.60° in the morning), until the sixtieth day, when it suddenly ceased. We must add that, whatever the dose in which it was given, the sulphate of quinine failed to break up the fever.

In this case the symptoms of nephritis were less marked than in the preceding one; but the hematuria was much worse, for the patient lost a great deal of blood; and *phosphoric acid* proved to be the proper remedy for it.

This patient also afforded us a very rare example of intense

congestion of the spinal meninges. For the relief of this complication the sulphate of strychnia was very effectual. The intermittent type of the fever persisted throughout the later weeks of the illness. This was also true in the first of these cases ; and it has been observed very often during this year in the prolonged or more tedious form of typhoid fever.

Relapsing Typhoid.

I will now direct your attention to a case of *relapsing typhoid*, which will give you some practical hints. During the first part of her illness this patient was under the professional care of our friend and colleague, Dr. Gonnard, and we borrow our notes from his record.

Case XC.—*Relapsing typhoid fever; the second paroxysm is an exact copy of the first; pernicious complications during both these attacks.* Marie H——, aged twenty-six, a domestic, was admitted on the 18th of October, or the seventh day of the disease. The diarrhœa, the prostration, the eruption, the fever (104.72°), told what the disease was. The tongue was broad and moist. Typhomania, subsultus, a pinched expression and a complaint of violent and constant headache were symptoms also. Besides, in order to get a clear and definite answer from her, it was necessary to repeat the questions several times.

October 19, eighth day. I prescribed *belladonna*, 6th dil., and *muriatic acid*, 6th dil., alternately. The heat of the skin being of a burning character, she was ordered to be sponged with an aqueous solution of aromatic vinegar.

October 20, ninth day. The temperature fell during the night from 104°, last evening, to 103.10° this morning; the pulse is 98, full and non-dicrotic; the tongue is dry at the tip, and there is some perspiration. The same treatment.

October 21, tenth day. Last evening the temperature exceeded 104°; this morning the patient is delirious, the head is tossed about, the limbs tremble, and she tries to get up and go away; the skin is cold, the respiration panting, and the pulse not discernible; this paroxysm began about midnight.

Prescription: one gramme of quinine to be taken as soon as there is a remission. This period having arrived at noon, the medicine was given. The next day the paroxysm was less severe, but she is still cold and delirious. The same prescription.

October 23, twelfth day. There is less agitation; the pulse is 120; she makes some sensible replies during her wanderings, and always complains of a violent headache; the head is moved to and fro regularly. The same prescription. During this crisis of three days, a paralysis of the bladder made it necessary that the catheter should be used.

October 25, fourteenth day. The head is not tossed about any longer, and the facial expression is more calm; the heat has fallen to 101.12°; the pulse is firm at 112; headache and constipation; contraction of the pupils, and profuse sweats. *Opium*, 6th dil.

October 26, fifteenth day. There were large stools during the night; the evening was calm and quiet, but the morning has been an excited one, and the hands are cold. *Quinine.*

October 27, sixteenth day. There is the same contrast between the restful state in the evening and the disquiet of the morning, which condition should be reversed. The same treatment.

October 30, nineteenth day. Although the headache persists, the mind is much more clear; for three days the regular tossing of the head has been going on again; the general appearance is improved; the temp. 102.20°. *Arsenicum*, 3d trit., which was continued without interruption for two weeks.

November 2, twenty-second day. The balancing of the head has stopped, and the bladder has relieved itself of an abundant flow; the patient wants milk, which is given her mixed with water. The evening temperature is still high, 104.72°.

November 4, twenty-fourth day. The heat is 102.20°, the pulse 108; the headache is less severe, and the sleep has returned; at her own request she had some broth instead of milk.

In proportion with the decline of the fever, and the ability to sleep, and with due consideration for the caprices of the appetite, she was nourished with increasing liberality.

On the thirty-first day of the disease the temperature dropped suddenly from 101.84° to 98.60°. *China*, 3d trit.

November 13, thirty-eighth day. The patient, who has grown very thin, is fully convalescent, without eschars or abscesses.

Being without fever, and able to eat well, she was up and about the ward for nearly a week, when, without any appreciable cause, the disease returned. And here follows the history of the second attack:

November 25, 1876. The patient being too weary on account of walking in the ward, or possibly from having eaten improperly, the fever returned, and the temperature reached 104.18° in the evening; the pulse was 120. *Arsenicum*, 3d trit., and *bryonia*, 3d dil., to be continued for five days.

For that period the temperature continued to be high, and without any morning remission.

November 30, the sixth day of the relapse, the morning temperature dropped to 101.84°, and the evening temperature to 103.64°.

December 1, seventh day. The same remission. *Belladonna*, 3d dil., and *arsenicum*, 3d trit.

December 2, eighth day. The same. *Hyoscyamus*, 3d dil., for three days.

December 3, ninth day. The evening temperature, 104.36°; in the morning, chilly; in the evening, delirious.

December 4, tenth day. The temperature the same as yesterday; the face is bluish, and the delirium is very violent.

December 5, eleventh day. For three days past there has been a paroxysm, the pernicious character of which is marked not only by a difference of about 3.5° between the morning and evening temperature, but also by a coldness of the extremities, a cold sweat, an asphyxiated hue of the countenance, and a violent delirium at night. For this condition we did not hesitate to prescribe the sulphate of quinine at our morning visit. After taking this remedy the delirium subsided, and the temperature was raised only a few tenths of a degree. The quinine was continued during four days.

December 9, fourteenth day. The delirium has almost entirely ceased; the tongue is more moist, and the patient perspires freely. *China*, 3d trit., for two days.

December 11, seventeenth day. Nothing new to record, excepting that the evening temperature is 103.10°. *Carbo-vegetabilis*, 12th dil., for two days.

December 14, twentieth day. She is becoming excoriated, and there is an eschar. *Lachesis*, 3d trit., for three days.

December 17, twenty-third day. She is much better, and there is no more fever. *Lachesis*, 12th dil., to be continued for a fortnight.

After a month's convalescence in the wards the patient was discharged, January 22. She took *china*, 3d dil., and then the 6th dil.

This case is full of instruction: first, it is a good example of a relapsing typhoid, which is a form of the fever that physicians have frequently encountered in the epidemic of 1876–77, and upon which we published some observations in *L'Art Médical* in September, 1863, under the title: "*Of relapses during the convalescence of typhoid fever.*"

The next point of interest in this case is the advent of the pernicious paroxysm at the beginning of the second week. These paroxysms had already been present in the first edition of the fever, if we may use such an expression. Let us examine these two points a little.

The relapsing typhoid is a rare form of the disease. Although Thierfelder has reported eight cases of this kind, we believe that we were the first to describe it clearly and particularly in 1863, when we published two cases in support of our views. In the epidemic of that year the examples were more frequent, and we could describe its clinical history more perfectly, which we did in our first publication. The febrile movement recommences with the same symptoms as it had at first; the relapse is very analogous in every respect to the first attack, for there are the same complications and the same contingencies. A glance at the facts just given will convince you of the truth of this remark. The rose-colored spots are

habitually reproduced, and the autopsies made in the hospitals have shown that the intestinal lesion reappears and runs its course over again.

The second attack is habitually shorter than the first, and usually terminates in recovery. However, these patients, exhausted by a second assault, do sometimes succumb. Finally, a few very rare cases have been observed in which a third attack, similar to both the others, has occurred. This fact has given rise to the theory of a typhus with relapses; but the idea should be discarded altogether, because the symptoms and the lesions of the latter disease are entirely different from those of typhoid fever.

I wish to call your attention to the pernicious paroxysms that may occur in typhoid fever. Observe, firstly, that they are not characterized uniformly by a difference of temperature, whether great or small, between the morning and the evening. Thus the patient mentioned in Case LXXXIX had a fever which was decidedly intermittent. For almost thirty days the temperature rose at evening to 102.02°, and dropped in the morning to 98.60°; and yet, despite the gravity of the prognosis, based upon the signs of an intense nephritis and of spinal congestion, we had no thought of a pernicious state. You remember very clearly, no doubt, that the strongest doses of the sulphate of quinine had no effect upon that condition.

What is it, therefore, which characterizes the pernicious paroxysm, when it occurs in the course of disease in general, and of typhoid fever in particular? It is the return, under a type which is almost regular, of the signs of *malignancy*. For example, with our patient, the fits were not only marked by a great difference of temperature between morning and evening, but by a coldness of the extremities, with cold sweats, discoloration of the face, asphyxia and violent delirium. At the same time, the pulse was extremely small and frequent,

the debility excessive, and the patient was evidently almost moribund from embarrassment of respiration and of the heart's action.

In this condition the sulphate of quinine is the remedy which is indicated above all others; but we must not, as in the mild remittants which so often occur at the end of a typhoid fever, prescribe it in small doses. No; for this is the kind of a case that requires strong doses, and one gramme, at least, should be given to an adult. You will repeat this dose daily, for several days in succession, and see to it that the patient takes it during the remission. In the particular case which we have cited this remedy acted heroically, and, as a result, the pernicious contingencies were immediately arrested and did not return.

Still another remark, which, *à propos* of this case of relapsing typhoid, is, that it was at the tenth day of the first attack that the pernicious paroxysms began, and at the ninth day they showed themselves in the second attack; or, in other words, in both cases they began during the second week. These pernicious paroxysms had similar symptoms in both cases, and in both, also, they yielded rapidly to the quinine; but in the relapse they were decidedly less violent. We were, therefore, correct in saying that, as a rule, the repetition is milder than the first attack.

To complete my reference to the epidemic of typhoid fever of 1876 and 1877, I must call your attention to the existence of a form in which the disease may be said to be defaced (*forme fruste*), as Trousseau has named it, and in which I have proved, by the aid of the thermometer, the complete absence of fever. I have observed this in my private practice.

It may be thought that we should not apply the name of typhoid fever to a pathological condition in which the

fever is lacking. But every physician has observed cases of measles and of scarlatina without fever. And why may not typhoid fever present itself under a similar form?

These pathological departures, happening during an epidemic of typhoid fever, have been characterized by malaise, extreme lassitude, loss of appetite, a furred tongue, sometimes by a diarrhœa or a cough, by insomnia, by headache and a duration of at least two weeks.

I do not hesitate to consider these patients as suffering from typhoid fever of a very mild type.

As in all good clinics, the incidental instruction given in these lectures is of great value. We are quite confident that the author's experience in the relapsing typhoid, and in the spurious or imperfect form of the disease in which the fever is lacking, will be confirmed by physicians in America, more especially in the west and south.—L.

TABLE

OF

FRENCH AND ENGLISH WEIGHTS AND MEASURES

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1 Milligramme	=	.015 grs.
1 Centigramme	=	.15 grs.
1 Decigramme	=	1.54 grs.
1 Gramme	=	15.43 grs.

1 Millimetre	=	.039 inches.
1 Centimetre	=	.39 inches.
1 Decimetre	=	3.93 inches.
1 Metre	=	39.37 inches, or 1 yd. 3.7 in.

1 Litre	=	1 pt. 15 oz. 2 drs. 111 m.

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