When a case presents clear cut indications for a remedy, it is certainly the best to prescribe on these symptoms, without any prejudice to the miasmatic factor. Faced with a paucity of symptoms, however, the understanding of the miasmatic factor may provide the missing link in the scanty evidence upon which we have to base our prescription.

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RHEUMATISM

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Rheumatic diseases are the most common and crippling ailments of our time. They constitute a serious economic and social problem. A few figures may illustrate this statement. An American statistic covering the years 1935-1936 discloses the fact that 5% of the population suffer from some form of rheumatism. There were two cases of rheumatism to every one of heart disease, 7 cases to every one of cancer and 10 cases to every one of tuberculosis.

Dr. Kemsley's statistic for the year 1927 shows that of 1,000 insured people, unfit for work over a period of more than three months, over 14% were rheumatic cases. Moreover, 16% of all rheumatic patients are gradually developing diseases of the heart.

The annual death rate of heart diseases in England and Wales is 95,000, of which 40% are due to rheumatic fever.

Further statistics of Davidson and Duthrie prove that every year at least 300,000 new cases of rheumatic diseases in Scotland require medical treatment. 75% of these patients are suffering from rheumatic fibrositis, i.e. rheumatism of the muscles, nerves and tendons.

Impressed by such figures, showing the gravity of the problem which rheumatic diseases represent, Dr. Davidson

quite rightly calls Rheumatism *"Public Health Enemy No. 1."*

It was for these reasons that the governments of nearly all civilised countries have set up special committees to investigate the causes and nature of rheumatism in order to find the best way of dealing with the problem.

Many attempts have been made to classify the various rheumatic ailments according to their ætiology, pathology or clinical symptoms. All these classifications are, however, of no practical use, especially for the *homœopathic physician,* who always considers the rheumatic patient as a single problem, in spite of the many different clinical symptoms. I, therefore, restrict myself to mention the classification advocated by the English Rheumatism Committee, which differentiates between the following 9 groups: (1) Rheumatic fever or acute rheumatism. (2) Subacute rheumatism. (3) Muscular rheumatism. (4) Lumbago. (5) Sciatica. (6) Rheumatic arthritis. (7) Osteo-arthritis. (8) Gout. (9) Various chronic joint changes.

In the limited space of my article I am dealing with rheumatic fever (acute rheumatism of the joints) only, and even here I must restrict myself to a few of the more important points.

Rheumatic fever (acute rheumatism) is an inflammatory process, which starts primarily in the synovial membrane. It is a constitutional disease, characterized by progressive and *symmetrical* changes in the joint. It is a disease, which on the whole, is more frequent among anæmic, undernourished, asthenic patients.

Acute attacks of rheumatic arthritis start *suddenly* with swelling, redness, heat and pain in the afflicted joints. Sometimes the pain is so severe that the patient is afraid to move. He shrinks from being touched and even dreads the shaking of his bed or the slamming of the door. When several joints are affected, the patient lies with his hips slightly flexed and turned outwards, the knees and elbows bent, the fingers spread and extended. The acute rheu-

matism often moves from one joint to another, a characteristic feature which was responsible for the name "rheumatism," which is derived from the Greek word *"Rhéo"* meaning running. The *simultaneous* affection of the *corresponding* joints distinguishes the *rheumatic* arthritis from other cases of acute arthritis.

I am referring to the many cases of acute arthritis associated with other infectious diseases, such as typhoid fever, pneumonia, bloodpoisoning, also cases of acute arthritis secondary to diseases of the central nervous system, such as locomotor ataxy.

All these and many other cases, although they may represent the same clinical symptoms, have nothing to do with rheumatic diseases. They are never symmetrical.

Rheumatic arthritis, which always starts in the synovial membrane, should be differentiated from *osteo-arthritis*, which is a more chronic degenerative process, more frequent among well-nourished obese people during or after middle age. It is characterized by progressive deterioration and erosion of the *cartilaginous* surfaces of joints and affections of the bones.

Both types of arthritis are progressive.

With the advance of the disease the surrounding tissues become involved as well.

Excessive amount of fluid may or may not be present in the joint. When the amount of fluid is excessive the capsule and ligaments of the joint with the overlying muscles become stretched and weakened.

There is always atrophy (wasting) of the muscles, which is a common symptom of all kinds of rheumatism.

All rheumatic or arthritis patients, regardless of the great variety of their clinical symptoms have, according to Dr. Rabe, the following symptoms in common:

(1) The *character* of the pains: they are always *drawing* and *tearing*.

(2) The pains are located in all parts where there are joints, ligaments or stronger nerves.

(3) The clinical symptoms are rapidly moving; they afflict in a rather periodic way the various painful parts of the organism.
(4) The patients are very sensitive to wind and weather.
(5) The afflicted joints and limbs are extremely stiff and painful.
(6) All rheumatic patients suffer from disorders of perspiration. It might be increased or diminished.
(7) All symptoms are improved by dry heat.

They are, on the whole, aggravated at night.

It is by these symptoms, that we can differentiate between *rheumatic* and *gouty* patients. The rheumatic patient feels always better with dry heat, whilst the gouty patient feels easier in cold weather and by applying cold compresses. Needless to underline the paramount importance of a correct diagnosis, which can only be arrived at by a thorough examination, appropriate tests and by taking into account the whole history of the patient.

We should always remember, that the patient as a whole, and not the label of any disease should be treated. That means, that every rheumatic patient represents a new problem and should be treated accordingly. It is indispensible to secure the co-operation of the patient. We should explain to him that, although all his rheumatic troubles might disappear, he still remains rheumatic and will always be liable to get relapses. He should have confidence in his physician's ability to deal with the ever-changing symptoms.

Before deciding any kind of treatment, we should search thoroughly for the causing factors.

Many factors are believed to play a part in the development of the different forms of rheumatic diseases.

Professor Lichtwitz propagates the theory, that rheumatism is a non-infectious disease; it is an *allergic* condition. That means a *sensitization* to *antigens*. Such rheumatic attack strikes at the fibrous tissues, which are to be found

in all organs. Therefore rheumatic disorders may develop in any organ of the body. The theory of Lichtwitz is, however, not generally accepted. It is especially contradicted by Dr. Hay, whose theory will be explained in connection with the question of *focal infection*. This is a problem which requires our careful consideration. The commonest septic spots are in the tonsils, the teeth, the nasal sinuses and the mucous membranes of the intestinal tract. Less frequently are the septic spots in the prostate, the womb or the gall-bladder. What should be our attitude, are we justified to treat such cases homœopathically or should we prefer surgical interference? This question may be very difficult to answer in complicated cases and I would prefer rather to communicate with an expert, before the patient is condemned to loose all his teeth, to have his tonsils removed or his sinuses operated on. I stress the point, that indiscriminate eradication of diseased tonsils or wholesale extraction of teeth is unjustified and does not in the least prevent relapses of rheumatic diseases.

There are certainly cases in which an operation should be performed, as every chronic focal sepsis lowers the general resistance of the patient. This is especially true when a closed abscess around the root of a tooth or in a tonsillar cavity is present. Pyorrhœa, however, is no indication for extraction of all teeth. Many cases of pyorrhœa can be cured by conservative constitutional and local treatment. On the other hand a dead tooth or an abscess in or around the apex or root of a tooth calls for extraction.

We should, however, always remember that the eradication of any septic spot, although it often improves, at least for the time being, the patient's general health, is no real cure for rheumatism for the simple reason, as Dr. Hay points out, that the cause for rheumatism is a much deeper thing than a septic spot. "Really, it is the condition, that produces the spot, and it is this condition which requires our utmost attention."

The clinical fact, that Colon bacilli are present in almost every septic spot leads to the conclusion, that the real cause for rheumatism, at least in these cases, is a more or less serious disorder of the bowels, where the Colon Bacilli come from. It was Dr. Hay who propounded the theory that rheumatism is nothing but the symptom of a disproportion in the chemistry of the body, and that rheumatism never attacks a person whose bowels are sufficiently emptied every day and really cleared of the fermenting and putrefying slacks.

Whether we accept Dr. Hay's theory or not, it is an undeniable fact, that almost every rheumatic patient suffers from a more or less marked insufficiency of the bowels, commonly known as *constipation*. The *Carmin* test discloses the fact that even patients, who have one or two stools daily, may suffer from a retarded elimination of the waste products from the colon.

To restore the normal function of the Colon, we should start in these cases the treatment with a fast-cure, adapted to the constitution of the patient.

The best known fast-cures are the Guelpa-cure and the Schroth cure. Both are drastic but highly efficient cures, which, however, should never be prescribed to anæmic, under-nourished patients, who rather need a fattening diet. We better start these weak patients off with 1—2 days fasting on a fruit diet and high colonic irrigation for 3 days running at the beginning, keeping this up once or twice a week, until the activity of the colon has been fully restored.

These biological measures are the best supplement to any homœopathic treatment.

Three outstanding drug pictures cover almost entirely the various symptoms and modalities of the rheumatic patients! (1) Salicylicum acidum. (2) Bryonia. (3) Rhus toxicodendron.

The Salicylicum acidum patient is characterised by neuralgias, buzzing in the ear, disorders of the eyes, urti-

caria, profuse perspiration, palpitation of the heart, rapid weak pulse, disorders of the digestive organs, diminishing quantity of urine, which often contains albumen.

The rheumatic pains of these patients are more frequently located in the limbs and joints, than in the muscles.

Patients characterized by these symptoms should be given salicylicum acid 6x twice a day.

We better replace salicylicum acidum by herbs containing salicyl. acid. namely Salix purpurea, Sambucus nigra, Spiræa ulmaris or Stellaria media. These herbs are especially indicated, when the symptoms of the patient are aggravated by wet and moving about.

Salix purpurea is indicated in cases where the fever is not very high, where there is profuse perspiration, increased quantity of urine, where the rheumatic process shifts from one limb to another and where the muscles and nerves are involved as well.

Spiræa ulmaris is best suited to rheumatic patients with wandering pains in the muscles and limbs, coupled with itching skin—eruptions, such as acne, congestion of blood to the head, headache, burning and reddening of the eyes, all kind of visual disorders, buzzing in the ears, sneezing and nasal catarrh with watery serous secretion, foul smelling diarrhœa, perspiration even in cold weather, aggravation of all symptoms by cold water.

The *Bryonia* patient with his irritable and angry mood is very well known to every homœopath: aggravation of all symptoms by movement, by *dry* cold, by slight touching, but improved by strong pressure and local application of heat. The joints are hot, reddened, inflamed and swollen. The pains are stitching. There is always profuse yellowish perspiration giving no relief; excessive thirst, constipation, agonizing headache, bleeding of the nose.

The *Rhus* patient on the other hand is the counter-part of the Bryonia patient. All symptoms of the Rhus patient are in one way or the other connected with wetness. They are either due to wetness or they are aggravated by it.

The aggravation by wetness is coupled with aggravation by rest. It is this symptom which distinguishes the Rhus patient from the Salicylicum acid. patient. Both are worse by wetness, but only the Rhus patient is worse by rest as well. The Rhus cases are not too frequent in acute rheumatic fever.

The Rhus patient are all alike, they show great nervousness, restlessness, general weakness, skin eruptions, wandering pains, better by moving and heat, the joints swollen, but neither reddened nor hot; the pains are located in the ligaments, tendons and capsules of the joints.

It goes without saying, that many other drugs may be called for in acute rheumatic patients. I mention only Arnica, Apis, Chamomilla, Pulsatilla, Sulphur. Furthermore there are Aconite cases, characterized by restlessness, fear of death, thirst, high fever without perspiration, palpitation of the heart. Aconite is best followed by *Ferrum phosphoricum* or *Chininum sulphuricum*. The Chinin patient is characterized by aggravation by the slightest touch and movement, the joints are swollen, reddened, inflamed, the urine contains granular brick-red deposit.

Fluoricum acidum is one of our most valuable drugs in cases of chronic rheumatism. It is frequently called for in acute rheumatism as well. Its drug picture is characterized by congestion, general weakness and exhaustion, perspiration giving no relief, aggravation by wet, cold bathing, cold weather and movement, although the patient has the permanent desire to move. The pains are better by pressure. The joints are swollen, extremely sensitive to touch.

Benzoicum acidum is the drug for rheumatic patients, when the symptoms develop in the lower part of the body with the tendency to wander upwards. On the whole the small joints and knuckles are involved. There is always profuse perspiration at night and aggravation of the symptoms by rest and at night. These modalities are almost identical with the drug picture of *Mercurius solubilis*. Both

drugs are more often called for in sub-acute cases of rheumatic affections.

Owing to the limited space at my disposal I cannot review the many, many other drugs which may be called for in rheumatic patients. We all know that our principle rule: "Let like be cured by like," will make us master of the disease, provided that we are able to understand not only our particular patient's body, but his mind as well. We should remember, that when the patient's mind gives way to gloom and panic, his disease will progressively deteriorate. This applies especially to patients suffering from chronic rheumatism. There can be no doubt, that in spite of the great progresses of medical knowledge there will always be hundreds and hundreds of hopelessly crippled human beings, who will need something other than drugs or ointments. They have to be comforted, they need our understanding. Whoever attends such unfortunate patients can only hope to succeed, if he can show a keen sense of cheerful sympathy with all sincerity.

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