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

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

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

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

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

—*The Homœopathic Recorder, October,* 1952

VOMITING IN INFANCY AND CHILDHOOD

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

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

INFANCY

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

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

Onset of Infection

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

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

[1] John Thomson and Leonard Findlay (1933): Clinical study and treatment of sick children, 5th Edition, p. 148.

[2] Ibid.

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

Intracranial Conditions

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

Abnormalities of the Alimentary Tract

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

Feeding Mismanagement

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

The colic or vomiting is unfortunately often regarded as an indication of overfeeding and the infant is made worse by having his diet reduced instead of increased. The exact position can readily be ascertained by test feeding for a day in the case of breast-fed infants who require 2¼-2½ oz. of milk per pound of expected body weight per day. The technique of feeding must also be checked. Holding the baby wrongly so that the nose is buried in the breast, or omitting to bring up the wind properly may be all that is wrong. It is often some trivial fault which is the cause of trouble.

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

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

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

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

(*To be continued*)

has come but it does not come. She goes on to 15, 16, 17 or 18 without development, the breasts do not enlarge, the ovaries do not perform the functions. When the symptoms agree Lyco establishes a reaction the breasts begin to grow, the womanly bearing begins to come and the child becomes a woman. It has a wonderful power for developing and in that respect it is very much like Calc Phos.—Kent.)

I have quoted in full an authority on whose teachings I seek support for my prescriptions in this case.

VOMITING IN INFANCY AND CHILDHOOD

DR. D. M. FOUBISTER, B.SC., M.B., CH.B., D.C.H., F.F. HOM.

(*Continued from page* 319)

Regular hours of feeding though on the whole perhaps the best method of infant feeding, is by no means universally practised. In Turkey and elsewhere, the infant is allowed to feed at any time, and it is said that very soon quite regular hours of feeding are adopted. A fairly common problem is that the infant is ravenously hungry in the middle of the night. As a rule it is best to give in and feed the infant at this time. Once the technique of feeding and quantity and quality of the feeds have been overhauled the infant usually soon sleeps through the night, and the mother's sleep is not interfered with for long. Occasionally trouble is caused by feeding with whole milk instead of half cream dried milk during the first three months. Sometimes regurgitation of milk with eructations occurs when diet and management of feeding are correct. Thickening the feeds with one or two teaspoonsful of Bengers or Sister Laura's Food often corrects this.

The use of *Carbo veg.*, *Lycopodium* and other remedies may be invaluable, but whatever homœopathic treatment is given the diet and technique of feeding must be put right.

On the other hand there are cases when nothing but constitutional treatment will enable the infant to digest his food.

Rapid changing of foods is greatly to be deprecated.

Because of the excellent work done in welfare centres problems of feeding mismanagement are now relatively few in hospital practice, but they do occasionally arise. A breast-fed baby of three months was admitted to Barton Ward suffering from diarrhœa and vomiting. It is very rare indeed to have non-specific diarrhœa (the old summer diarrhœa) in breast-fed babies. Out of a series of over 200 cases admitted to Great Ormond Street hospital only one was breast-fed. Breast-feeding was continued while the infant was in the ward. No pathogenic organisms were found in the stools. Test weighing showed that the baby was receiving the proper amount of breast milk, but on observing the technique of feeding it was discovered that the mother was not bringing up the wind properly. No other treatment was given than to demonstrate the right way to do this. The baby was discharged within four days and there has been no further trouble. A bottle-fed infant of four months was brought to the out-patient's department with the complaint that he had been vomiting after nearly every feed for two months and had offensive diarrhœa and sleeplessness for one month. The technique of feeding was checked and it was readily ascertained by tipping up the feeding bottle that the hole in the teat was far too small. Secondly, the young mother was not expert at bringing up the wind. The infant's expected weight and actual weight coincided. He was being fed with a correctly balanced milk mixture but was getting 48 oz. in the day instead of 34 oz. In other words he was being considerably overfed. The strain of mismanagement was beginning to tell. The hole in the teat was altered and the mother shown how to bring the wind up, and the feeds were reduced to 34 oz. in the day. He was given Lycopodium 30, t.d. 3 days, b.d.

4 days, on the following grounds: wrinkled forehead; aggravation in the evening; objection to any feeds which were the least bit cool and a tendency to sweat about the face. There was also excessive flatus but this might not be a high-ranking symptom under the cricumstances. Finally, his grandfather who was an old outpatient of mine, was a typical *Lycopodium* subject. Occasionally useful clues may be obtained in selection of a young child's remedy by finding out if it is not apparent which member of the family the infant takes after and then taking their constitutional remedy into consideration. This baby gained twelve ounces during the next week and diarrhœa, vomiting and insomnia disappeared.

Pyloric Stenosis

The projectile vomiting of pyloric stenosis nearly always starts during the second or third weeks of life, not at brith. To begin with it occurs after every meal, but later when the stomach has become dilated there may be one or two large vomits in the day. This condition is usually found in first-born male children. There is some evidence that it is an inherited disease, but the precise nature of the inheritance is not clear. The mortality rate in untreated cases is 50 per cent. Infants who survive the condition undergo spontaneous cure at the age of about twelve weeks. The projective type of vomiting following a greedily taken meal is characteristic along with constipation and failure to thrive or loss of weight. Unless gastritis develops the infant is ready immediately after vomiting for another feed which indicates the purely mechanical nature of the disorder. Diagnosis is confirmed by the presence of visible peristalsis and by the palpation of a tumour between the umbilicus and the right costal margin which feels exactly like a knuckle. Repeated examinations at the beginning of a feed may be necessary. Pylorospasm begins earlier than the second week, is more often in females; it may be exactly similar even to the presence of visible peristalsis but the

tumour is absent. More rarely difficulty is experienced in eliminating congenital stenosis of the duodenum, which if situated below the ampulla of Vater may be distinguished by the presence of bile in the vomit. Surgical treatment is generally held to be best for pyloric stenosis. In the hands of an experienced surgeon with suitable provision for pre- and post-operative care the mortality rate is in the region of 1 per cent. In unskilled hands the mortality may be about 20 per cent. A minority advocates medical treatment or at least a trial of medical treatment in all cases. It is generally agreed that the more severely ill the baby is the more the indication for surgery. In infants who have almost come to the end of the natural course of the disease having not been greatly disturbed by it, who have made a fairly satisfactory weight gain, medical treatment is obviously the treatment of choice. *Dysentery Co.*, has a specific effect on the pylorus and claims have been made that it is effective in pyloric stenosis. I have not used it in this condition, but it seems to be highly efficacious in cases of pylorospasm in 200h potency.

Rumination

A more rare cause of persistent vomiting is the condition of rumination which begins after the age at which pyloric stenosis has run its course. Rumination usually occurs in bottle fed infants, and rapid changes in diet are said to be a predisposing factor. It begins at four to six months. The infant acquires a knack of regurgitating milk into his mouth by moving the jaw back and forth. As a rule they do not perform when kept amused or if anyone is present, and the diagnosis may have to be made by watching the infant when he thinks he is unobserved. Treatment is by thickening the feeds, keeping the infant amused—in hospital by other children—to stop the habit. Strapping the jaw is also advocated, but is not without danger. These babies are characteristically bright and cheerful, but if untreated the mortality rate is about 25 per cent.

Very occasionally an older infant gets into the habit of putting his finger in his mouth to cause vomiting. This can be stopped by a mechanical restraint of the elbows.

Nervous Vomiting

Infants and young children are extraordinarily sensitive to the emotional atmosphere around them. This is an accepted fact in pædiatric practice and it is a valuable key to the management of nervous children.[3] It is a well-known fact that the infants of nervous mothers vomit. This usually occurs during the second half of the first year of life. Having excluded other causes a change of environment such as taking the infant into hospital, or putting the infant in the care of a trained and capable nurse is usually followed by rapid improvement.

VOMITING IN OLDER CHILDREN

The protective function of vomiting which is so well marked a feature of infancy only gradually diminishes as the child gets older. Vomiting is still readily induced by unsuitable diet such as an excess of fatty food or the eating of unripe fruit. The diagnosis of dietetic indiscretion is often apparent when the child has been to a party and stuffed itself with fatty food. *Pulsatilla* is nearly specific for this sort of upset.

Vomiting may also be comparatively easily induced reflexly from causes outside the stomach or alimentary tract either physical or mental. Fatigue or fright or the onset of an acute infection, especially pyelitis, scarlet fever or lobar pneumonia may cause a single vomit. Rarely the whoop of whooping cough is replaced by vomiting—the cough centre and the vomiting centre are close together and this is presumed to be the explanation. Taking the temperature may aid in the differential diagnosis when vomiting occurs in a healthy child. Sometimes after an emotional upset or fatigue or injury vomiting does not occur till after

3 CAMERON, *The Nervous Child*; Oxford Medical Publications.

the child has slept for some hours. In diseases of the central nervous system or in surgical conditions of the abdomen, of which appendicitis is relatively common, other symptoms and signs usually make the dignosis apparent.

The problem of recurrent bilious attacks will be dealt with shortly. Nephrocalcinosis which is accompanied by albumin in the urine is a rare cause of persistent vomiting.

Chronic Indigestion in Childhood

Although indigestion is a very common condition in childhood it is not so frequently associated with vomiting as it is in infancy. The clinical picture of chronic indigestion in children is, however, such a valuable conception in the practical management of the various aspects of this disorder that it may be worth while to briefly review it. Sheldon states that chronic indigestion in one form or another is one of the most common ailments of childhood. There is great activity of the alimentary tract during the period of growth. Add to this first dentition with the almost complete change in diet at weaning, together with a period of four years between the age of six and ten when the child is partly edentulous while the second teeth are coming through plus mismanagement of weaning, plus bad habits in feeding later on, and it is no wonder that indigestion is common. It is recognized that the onset of indigestion may be traced to the debilitating influence of whopping cough and measles. Sepsis of the upper respiratory tract of tonsils and adenoids (and sometimes carious teeth) is a very frequent finding in such cases. Mental stress, worry about examinations, are also factors in causing a digestive breakdown, just as later on these factors can precipitate a duodenal ulcer.

The clinical picture is one of great variety, and the main symptoms may be related to systems other than the alimentary. When digestion and assimilation are impaired the whole body suffers. Quite often the child is brought because he is not thriving. A very common complaint is that he suddenly turns deathly pale, or tends to have dark circles under the eyes. He may have slight œdema below

the eyes suggesting nephritis. Vasomotor instability may be expressed in other ways such as by constantly cold extremities. Disorders of sleep such as restlessness, jerking in sleep, insomnia, nightmares, sleep-walking may be present. At all ages sleep may be disturbed in one way or another by indigestion whether digestive symptoms are themselves prominent or not. Sometimes there are pains in the limbs, which occur in any debilitating condition, bronchiectasis, severe chronic indigestion, etc., as well as in rheumatic fever, postural defect or from emotional causes. Postural defect is common in this codition.

Persistent or recurrent fever of one or two degrees is a frequent finding in children, and very often no cause can be found. The mother can be reassured when it is an isolated finding. It is common in chronic indigestion and the tonsillitis which very frequently accompanies it.

Symptoms referable to the alimentary tract are naturally often found. Appetite may be deficient, and made worse by bribes given to encourage the child to eat. Abdominal pains are often present but characteristically not at all severe. The bowels may be constipated or loose with excessive mucus or undigested food. Threadworms thrive in the unhealthy gut. Enuresis is a common complaint in such children. The reason why threadworms and eneuresis are sometimes difficult to cure is that it takes time as well as special measures in the way of general management and diet along with constitutional homœopathic treatment to cure the underlying condition of indigestion. It is only occasionally that the attack falls mainly on the stomach. Then there may be frequent eructations sometimes vomiting of mucus, especially first thing in the morning—an atonic gastritis. There is fullness of the upper abdomen.

The diagnosis is often suggested by the history of sudden pallor, feeding mismagement, too much starchy food at the time of weaning, rushing to school with inadequate time for breakfast and evacuation of the bowels later on. The child is usually underweight and suffers from postural defect from

lax muscles, usually a lumbar lordosis. The tongue is furred, and sometimes the irregular patches of fur and redness give the appearance known as geographical tongue. Tonsils are usually pitted and the lymph glands enlarged. The liver is often slightly enlarged. Except in the case of atonic gastritis there is no enlargement of the abdomen and no tenderness.

The prognosis with regard to life is good, even without treatment it is rare for death to occur. When post-mortems have been done nothing special has been found, as this is a functional not an organic disorder.

Treatment can usually be carried out while the child is at school, but often takes several months before there is appreciable benefit. In severe cases, complete rest is required for a few weeks. In moderately severe cases a few weeks off school with rest in bed till after breakfast, ¼ to ½ hour rest before and after lunch and tea, and early to bed, combined with moderate exercise in the open air makes a useful start. Holidays by the sea, or in good surroundings, play a part in the general management of these cases. The wrong habit of rushed breakfast, etc., are corrected when the child returns to school.

Dietetic treatment consists mainly in the cutting down of starchy foods and root vegetables, with a high cellulose content allowing two tablespoonfuls of potato in the day. Secondly, roughage such as nuts, jam with pips in it, is cut out. Brown bread is replaced by toasted white bread till there are signs of improvement. Homœopathic constitutional treatment is of great value.

Cyclical Vomiting

It is well known that acetone bodies are more frequently found in the breath and urine of children suffering from febrile conditions than in adults. Any feverish condition may be associated with ketosis in childhood. Some children are more prone to it than others for reasons which are not known, but the factor generally responsible for this ten-

dency is believed to be that the child's store of liver glycogen is easily depleted. The raised output of adrenalin associated with fever calls forth and exhausts the stored glycogen. Normal fat metabolism which can be take place only in the presence of an adequate amount of carbohydrate breaks down and ketone bodies are formed. In some children in health excessive exercise or going without a meal is sufficient to allow depletion of carbohydrates to such an extent that acetone is formed. Sometimes the balance may be tipped by giving extra nourishment in the form of eggs or cream especially in cases of cyclical vomiting which may be regarded as the extreme expression of this natural tendency to ketosis in children. Traces of acetone in the urine of children, especially when detected by Rothera's test which is very delicate, should be treated with reserve. It is a very common fiinding, and its significance must be judged in conjunction with the whole clinical picture. Frew[4] analysed the incidence of acidosis in children admitted to hospital and found that it varied from 15 per cent. under one year to 84 per cent. at 3 to 4 years, going down to 50 per cent. at eleven years.

Against this background of a general tendency to ketosis in children the condition of cyclical vomiting may be considered. It has been estimated that 30 per cent. of all children attending out-patients suffer from the group of conditions known as periodic vomiting, cyclical vomiting or bilious attacks. The average age of onset is three to seven years, and there is a tendency to spontaneous cure at puberty. Some writers recognize a periodic syndrone which may manifest itself as periodic vomiting or headache, or abdominal pain, or fever, or diarrhœa with pale stools.

The classicial type of cyclical vomiting occurs at very regular intervals; and is accompanied by severe ketosis. Most writers, though not all, include irregular attacks under this heading, and include recurrent attacks of ketosis

4 PAYNE, GARROD, BATTEN and THURSFIELD's, *Diseases of Children*, 1, p. 386.

associated with upper respiratory infection. There are two main clinical types with many variations and combinations. First there is the child who has regular or irregular attacks every few weeks or at longer intervals of feeling off colour for a day or two followed by vomiting, upper abdominal pain, headache, furred tongue and constipation. The breath and urine smell strong of acetone. There is a temperature of 101° or so occasionally it goes up to 105°. Tonsillitis is often present. The condition passes off after two or three days. The other type is the highly strung nervous child, often an only child, thin, stooping, intelligent, but lacking in concentration. He also has vasomotor instability and becomes suddenly pale. He gets an attack on excitement such as anticipation of going to a party. Eggs and Cream given as extra nourishment aggravate matters. Cream is a special offender, and such children should be given skimmed milk.

Cyclical vomiting is not infrequently met with in families or in families with a history of migraine. In some cases at puberty instead of clearing up, the attacks of acidosis merge into attacks of migraine. The pathology of cyclical vomiting is by no means clearly understood. Sometimes vomiting precedes ketosis and sometimes ketosis precedes vomiting. Payne[5] states "In the past these children were spoken of as suffering from bilious attacks and being liverish. Recent investigation tends to support this view. Thus jaundice is an occasional symptom and in many cases function tests show some deficiency of the liver to deal with carbohydrates. However, this seems insufficient fully to account for the occurrence of symptoms. It is generally aggreed that in these children the nervous system is unstable and a combination of this nervous instability with a deficient hepatic carbohydrate metabolism may account for the condition. Thus nervous or emotional disturbance leads to sympathetic over-stimulation, and an increased loss of sugar

5 PAYNE, GARROD, BATTEN and THURSFIELD'S, *Diseases of Children*, 1, p. 388.

from the liver and to a decrease in intestinal movements and to gastric stasis. Spontaneous cure results from breaking the vicious circle by exhaustion of the sympathetic and by the adoption of a new level of metabolism by the body with a diminution of ketosis as occurs in the third or fourth day of starvation."

The diagnosis is often in no doubt after repeated attacks and especially when there is a family history of bilious attacks or migraine. Pain is not severe and is diffuse over the upper part of the abdomen. Occasionally the liver is slightly tender. Pain in appendicitis is intermittent and colicky and comes on before the vomiting which is the important point in the history. The temperature in appendicitis is rarely above 103° and the site of the pain is at first in the umbilical region and then in the right iliac fossa. It may in some cases be extremely difficult to make a diagnosis in the early stages of appendicitis.

Recurrent intestinal obstruction by intussusception or volvulus, or more rarely intermittent hydronephrosis may have to be considered. Intestinal obstruction of any kind is chracterized by a marked tendency to ketosis. The abdomen is usually retracted in cyclical vomiting, and distension of the abdomen is a strong indication that another cause must be found. When headache is severe, along with vomiting, meningitis may be simulated. There may even be slight head retraction and a doutful Kernig's sign in ketosis. Death is a rare event in cyclical vomiting. When it does occur it is caused by the toxic effects of acetone bodies on the heart or kidneys resulting in cardiac or renal failure.

During an attack of cyclical vomiting, or in the case of severe ketosis during any febrile condition the child should be in bed, and given as much water or lemonade sweetened with two teaspoonfuls of glucose and a teaspoonful of bi-carbonate of soda to the tumblerful as the child will take. If vomiting prevents this the stomach should be washed out with bicarbonate of soda, a drachm to the pint of water and then sips of sweetened water or lemonade

started, gradually working up to large quantities. In older children, if that fails, a rectal drip of 10 per cent. glucose to which sodium bicarbonate, one drachm to the pint has been added, may be given after a cleansing enema. Subcutaneous infusion of 2½ per cent. glucose in various strengths of saline (depending on an assessment of the electrolyte balance) is useful in younger children in febrile conditions. Large quantities of fluid can now be given subcutaneously by means of hyaluronidase. Sometimes resort has to be made to intravenous infusion of 10 per cent. glucose.

The homœopathic treatment of cyclical vomiting and allied conditions resolves itself into two parts, treatment during the attacks which is the less important and constitutional treatment in between attacks to alter the patient so that he does not tend to have them. During an attack a number of remedies including *Phosphorus, Pulsatilla* and *Dysentery* co. may be indicated. Constitutional treatment embraces a wide range of remedies and it is highly effective in reducing the number and severity of attacks, and in most cases eventually wiping them out altogether. *Phosphorus, Calc. phos., Tuberculinum* and *Dysentery* co., have been frequently indicated in such children, but the treatment depends, as all constitutional treatment does, on the individual patient's mental and physical make-up. In one case, the child was so prone to car sickness that the mother stated he could not ride in a bus or car for more than ten minutes without being violently sick. There were other constitutional indications for *Cocculus* and it was given as a preliminary medicine. Not only did the car sickness clear up, but the cyclical vomiting did too.

There is one remedy, however, which is invaluable in many cases of cyclical vomiting, and that is *Dysentery* co. My attention was drawn to it by a boy who had pyloric stenosis for which Rammstedt's operation had been performed with success, but he later developed cyclical vomiting which was rapidly cured by giving *Dysentery* co. as a cons-

titutional remedy. I found *Dysentery* co. 30 to *cm.* usually the 200th potency, so useful both in attacks and between attacks that I almost came to regard it as a specific. "Nervous tension," which Dr. Paterson stresses as the characteristic mental state of *Dysentery* co., is frequently found among these highly-strung children who get an attack on excitement. Fortunately it is not a specific. Specifics and Homœopathy could not co-exist! I usually prescribe *Dysentery* co. 200 three doses two-hourly, followed by three doses four-hourly at the commencement of an attack.

This use of *Dysentery* co. was, I found, no new discovery. In an old paper by Dishington it is noted as having a clinical record in recurrent bilious vomiting.[6] The use of *Dysentery* co. in abolishing, so to speak, over action of the sympathetic part of the automatic nervous system led to its use in a much rarer kind of recurrent vomiting. A girl of four years was seen in the out-patients' department, sent up because she had been having attacks of pain in the left side of the abdomen followed by vomiting nearly every week-end for the previous six months. There was abundance of acetone in the breath and urine during these attacks. Pain of a severe nature preceding vomiting and in the left side of the abdomen strongly suggested that this was not simply a case of cyclical vomiting. During the two or three days while the pain was severe, there was an oliguria and polyuria ensued as the attacks passed off. Examination revealed an enlarged left kidney, and an intravenous pyelogram showed dilation of the calyces. *Dysentery* co. 200 given two-hourly at the commencement of an attack aborted it, and after a few attacks were aborted in the same way they stopped altogether. This child has had no attacks for over two years. She is now seven. Blood pressure readings were made periodically in case a hypertension might develop, but the pressure has remained

6 DISHINGTON (1929). "The Pathogenesis of Dysentery," *British Homœopathic Journal*, p. 171.

normal, the left kidney is now no longer palpable, and the child seems very well.

DISCUSSION

Dr. PRATT asked Dr. Foubister three questions. Firstly, Dr. Foubister mentioned 100 cases of pyelities in which abnormalities in the urine were found in only sixty cases. What was found in the other forty cases to justify the diagnosis of pyelitis?

Dr. Foubister said that mother's milk was very seldom unsuitable for a child. Was it his experience that certain strongly flavoured foods and medicines did upset the infant, things like coffee, onions, strawberries, cascara? If that was his experience it presumably constituted an additional argument in favour of homœopathic treatment for the mother as well as for the infant.

Thirdly, he was very interested in Dr. Foubister's mention of the inheritance of the constitutional remedy and he would like to ask if there had been any published paper on that subject going into it in more detail.

Dr. P. G. QUINTON said that he was rather grieved that Dr. Foubister did not give more remedies for the conditions he mentioned and he was also grieved that he himself was born about forty years too soon. In his young days he was sat in front of food and there he sat until it was consumed.

With regard to cyclical vomiting, had Dr. Foubister ever tried giving a child *Senna* 6 every four hours during an acute attack and afterwards a dose of *Lycopodium* in a high potency? If specifics existed that was as near as possible a specific for acidosis or cyclical vomiting. It was a good many years since he read of this treatment and he had proved it many times. Very often the type of child who suffered from cyclical vomiting was the *Lydopodium* type, and the effect of this remedy on the liver, which was familiar to them all, might explain why it was of constitutional value for acidosis.

Replying to Dr. Pratt, Dr. Foubister said that the local symptoms of pyelitis did not differ from the adult cases, having frequency, pain in the side and dysuria. Substances to which the mother was allergic were most likely to affect the infant, but it was believed that infants could become sensitized to allergens which did not appear to affect the mother at all. He did not know the answer to the question about diastase, except the obvious one to cut down carbohydrates.

He had not used the treatment with *Senna* 6 and *Lycopodium*.

Dr. LEDERMANN said that *Abrotanum* 3 had been found very useful in infants with continued vomiting. He had seen many babies who had benefited greatly from it. It was Dr. Borland in one of his lectures who had suggested it.

Dr. MCNEILL said that one of the remedies which he used for cyclical vomiting was the constitutional remedy *Bacillinum*. Children who had

cyclical vomiting very often had a tendency to a papular urticaria or heat spots as the mother called them. He had found that where there was this tendency *Bacillinum* was nearly always the remedy which was most useful. With regard to acute attacks any remedy might be indicated. He had found *Phosphorous* very valuable in many cases. He was greatful to hear about *Senna* 6 and he must try that when he had a bad case.

Dr. K. G. PRIESTMAN confirmed that she had found that in early infancy mismanagement was one of the frequent causes of vomiting. She remembered one particular patient where the mother telephoned her because the child had been sick, saying that it was the most dreadfully sick child she had ever had. When she got to the house she found a baby of five or six months old almost as round as it was long being stuffed with a huge plateful of food. She asked the mother if this was the child who had vomited its breakfast and the mother replied, "Oh, yes, I cannot let her get away with that."

Dr. Quinton told her about *Senna* 6 for cyclical vomiting, she had not used *Lycopodium* with it. *Senna* 6 would operate in early vomiting. She had never used *Dysentery co.*, but she would try it in future.

Dr. Ross thought that the hospital was fortunate in having a pædiatrician who knew the orthodox treatment and was such a good homœopathic prescriber as well. His wards were delightful. The bowel nosodes were of tremendous value to children. *Dysentery co.*, was one of the best remedies for pyloric stenosis or pylorospasm; and for indigestion associated with malnutrition, *Gaertner* came out, especially with the *Silica* type of child; and for bilious attacks *Morgan* would complement *Lycopodium*, which was frequently indicated.

He would like to pin down Dr. Foubister just a little; he did not know if he had seen a sufficient number of cases to dogmatize, but would Dr. Foubister like to say whether, in his opinion, medical treatment sufficed in the genuine pyloric stenosis of infancy? There was one little point which over the years had struck him, that duodenal ulcer did occur in childhood, though rarely. He had seen one in a boy of 7 and another in a boy of 12 or 13 whose illness started when he was 10. It was supposed to be cyclical vomiting but it was very difficult and finally he got X-ray proof that the child had an active duodenal ulcer. It cleared finally with *Sulphur* after about two years.

He would like to ask if *Aethusa* was used by Dr. Foubister. It was a remedy for a collapsed baby vomiting curds of milk.

Dr. FOUBISTER said that each case of pyloric stenosis should be judged on its own merits, keeping in mind the availability of expert surgery, the clinical course of the disease, the age of the infant, and the severity of the effects: the more ill the infant, the more the need for surgery. They had not seen any cases for some years at the hospital. He would not, however,

feel certain of *Dysentery co.*, except in cases of pyloric spasm, although further experience might alter this view. Regarding *Aethusa*, it was not so commonly indicated in infantile vomiting as the books might lead one to suppose. The majority of cases of vomiting in infancy were caused by feeding mismanagement, and once the diet was put right there was no further trouble. It was in his experience not nearly so commonly indicated as *Lycopodium* or *Carbo. veg.* for instance.

Dr. LEES TEMPLETON said he had hoped that Dr. Foubister would have given some hints in his paper on the more serious causes of vomiting which one could eliminate in a very short time with safety. This was a problem to-day because many children were brought to the doctor *before* they were really ill. In the old days when a child was brought there was usually something to find; the mothers brought them now before trying any simple measures at all. Must one examine them from top to toe or were there some useful tips which Dr. Foubister could give? When he said that two-thirds of the causes of the trouble with infant feeding were mismanagement, it seemed that the figure was rather low. Personally he thought more than two-thirds were due to mismanagement in these days of incompetent mothers. He hoped Dr. Foubister would draw up a leaflet with a few suggestions as to what was normal in children, such, for instance, as the regurgitation of a few spoonfuls of milk. Most young mothers did not know what was normal or to be expected, and a leaflet would solve many of the doctor's troubles.

He had also hoped that Dr. Foubister would speak about acute gastro-enteritis. He believed the opinion now was that if there had been vomiting for more than forty-eight hours the cause was elsewhere than in the gastro-intestinal tract, e.g. otitis media and the number of paracenteses mentioned in published series was large and if one examined drums routinely many were reddened though with no infective symptoms. If one had the guide of a child complaining of pain or having its hand to the ear one should have a look, but was it necessary to look in all cases? He would like some guidance on this matter and to hear what modern views were.

Then regarding the question of *growing* pains: there was an article recently in the *British Medical Journal* in which the authors proved, to their own satisfaction that growing pains were not of importance and were not even rheumatic in origin whereas *he* was brought up to think that they were of the greatest importance.

He was sorry that drugs had been so infrequently mentioned. No one had mentioned *Ipecac.* The lack of thirst with a clear tongue would be a very useful guide and one hoped that one would hear from individual prescribers as to why and on what indications they prescribed certain drugs. *Pulsatilla* was very useful, particularly on the history of food indiscretions. Another useful drug was *Kreosotum*. He used to find it of the greatest value in the vomiting of food which occurred *two or three hours* after a meal; the

time interval was all important. It was almost specific in many of the cases he could recollect. *Aethusa* had been mentioned. He thought the guiding symptom here was that the child was sick, vomited, and then wanted to feed again, *Ant. crud.* was the opposite. Of all the drugs for vomiting he would say the most useful in his experience was *Phosphorus*. It covered a lot of the cyclical vomiting; it had relation to the liver and the glycogen content, and again the time of vomiting after food seemed to be important, though this time interval was also present in appendicitis. Children who vomited *immediately* after food indicated *Ars. alb.* and also *Cadmium*.

Having a pædiatrician at the leetern he would like to ask a question which had nothing whatever to do with the subject. Why were children up to the age of 5 or 6 lovable for the most part and why later were so often impudent, beastly little devils? Was it environment, heredity, or what was it?

Dr. DOROTHY MASON said that she had found when doing infant welfare work that there was a tendency nowadays for young mothers to be told to feed their babies from both breasts and the baby did sometimes get overfed. The symptoms might be vomiting or green stools and it could be cleared by reducing the feeds a little, especially the early morning feed and usually the 10 a.m. feed as well.

Another point where general practitioners especially could help was when a young mother came home from hospital with her first baby. She was often nervous and needed help especially at this time, and it might be well worth while to spend some time in helping her, even to watching her feed the baby and doing a test feed. With this help, she might continue to breast feed rather than put the baby on artificial feeds.

Dr. MANASSE said he had seen many cases of indigestion in childhood in schoolchildren, with sickness and vomiting with light-coloured stools and he thought they were due to too fatty school meals. They usually cleared up quickly on *China* 3 and on *Phosphorus* 6. He had seen, over some years, three cases of pyloric stenosis, one had an operation and the other two cleared up with *Calc. carb.* 30 and *Nux vom.* 30, in about two weeks.

Dr. FOUBISTER replying to Dr. Templeton said that it was not easy to draw up a simple accurate comprehensive scheme for the differential diagnosis of all cases of infantile vomiting as the number of occasional causes was so large, but it would be worth while to try to work out a scheme of that nature. It was, however, not quite the object of this paper, which was to draw attention to trends in pædiatric practice.

Otitis media with or without mastoid involvement was either to be considered as a parenteral infection with a symptomatic diarrhœa and vomiting or as a result of infection within the alimentary tract. It was well known that in a great many cases it might be impossible to say which came first.

He would not disregard all limb pains in children. It was perhaps significant that the tendency in pædiatric text-books now was to attempt to draw a distinction between the pains which were rheumatic and those which were not. This was done in the recently published text-book by Professor Ellis, and in Sheldon's *Diseases of Infancy and Childhood.* The pains which are more likely to be rheumatic in nature come on during the night, and are sharp in nature. Non-rheumatic pains often associated with postural defect or coming on in damp weather tended to come on after exercise—in the evening, and especially after a strenuous day. There was undoubtedly many cases in which there was nothing organically wrong with the child, and when the pains were confined to the lower limbs, it would nearly always be found that there was a slight postural defect which could easily be put right by simple manipulative treatment.

Dr. LE-HUNTE-COOPER said that to discuss Dr. Foubister's paper adequately one would need a very much wider experience in the treatment of children than he himself had enjoyed, but there were one or two points which he wished to touch upon.

Dr. Foubister had given them a very comprehensive treatise on the various causes of vomiting in children, these mostly depending on deranged metabolic conditions, dieting, their surroundings, and varying incidents entering into their individual lives, on the other hand, "toxic causes" had not been given their due.

For example; the introduction of preservatives, and other substances into foods, as well as the fortuitous entrance of deleterious substances through carelessness, or ignorance. In addition, there was the advisability of guarding the children's food, as far as humanly possible, from contamination by that "metal" which, in the last fifty years, had so seriously undermined health as a whole.

He had himself had ample proof of its powerful effects in deranging metabolism, and he would like to ask Dr. Foubister as to his personal experience of the effect of aluminium in relation to "acidosis" in children. The late Dr. Eric Pritchard, who was fully recognized as a very great authority on children's diseases, found the health of the inmates of Children's Hospitals gravely undermined by the use of culinary vessels made of this material. In addition, he also found a remarkable diminution in the quantity of bicarbonate of soda used by each hospital when other cooking vessels were substituted.

They had been dealing, this evening, with "vomiting", as an undesirable symptom, and one to be removed whenever possible, but it was, nevertheless, a most desirable symptom when poisonous substances had to be eliminated from the system. Those people who were fortunately able to vomit whenever some substance taken into the stomach disagreed, were most difficult to poison, and he had had cases illustrating this point, more especially in that

of a man suffering from, or rather "enjoying", what he, Dr. Le Hunte-Cooper, had named a "discriminating stomach". This individual could imbibe a comprehensive, and varied meal, but if any one substance taken did not agree, he would reject this, while retaining the rest of the meal.

Dr. Templeton had expressed his hopes that this Meeting would produce some "tips" as to specific remedies relating to the subject of this paper and he, Dr. Le Hunte-Cooper, offered him one, for which Dr. Clarke was responsible; "In cases of vomiting of pregnancy which fail to respond to *Symphoricarpus* try *Mancinella*."

Dr. FOUBISTER said that he was fully aware of the danger of aluminium sensitivity. When there were indications for aluminium and the food was prepared in aluminium cooking utensils, he stopped the use of Aluminium, a id usually antidoted by giving *Alumina* 200.

Dr. FOUBISTER said that sometimes great help could he obtained in prescribing from the parents constitutions, especially when a young child was nearly a replica of one or other of the parents. *Sepia* had a feature in its make up which sometimes helped to decide on its prescription, that was the love of dancing which often characterized *Sepia* patients. One could often confirm the choice of *Sepia* for a child by finding that the mother had the intense enjoyment from the rhythm and movement of dancing which was so very prominent in these patients. Another remedy which was often confirmed in this way was *Phosphorus*. The typical appearance of *Phos.* in the mother confirmed its indication in the child.

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MIRACULOUS ACTION OF THE HOMŒOPATHIC REMEDY IN INFANTS AND CHILDREN

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It is well known that the homœopathic remedy acts more promptly and, as a rule, more completely in infants and growing children, than it does in adults. The reasons for this are obvious. The child's nervous system is more sensitive and responds more readily to both intrinsic and extrinsic stimuli; its tissues are softer and more pliable; all its functions are more active; new cells and fibres are being added every minute of the day, and, what is usually overlooked, it is free from the anxieties and the worries that