

## A COOK'S TOUR IN OPHTHALMOLOGY

BY L. G. SCÖULAR, M.D., Ch.B. (Glas.), D.O.M.S.

MR. PRESIDENT, LADIES AND GENTLEMEN, let me first thank you for asking me to read this paper.

I greatly appreciate the honour and also the opportunity of discussing some of my problems with you.

When your most excellent Secretary approached me I was somewhat hesitant in my reply, because I felt I was not fitted to give you that kind of address which you have come to expect from this platform.

I was not born with the gift of tongues, nor can I take you on a flight above the clouds into the rarefied air of physio-chemical philosophy where the going is smooth and the progress rapid.

If you would visit my province you must journey on foot, but the reduced speed has this advantage, that you can the better appreciate the difficulties and obstacles on the way, and if I mistake not, Hahnemann himself was not averse to such pedestrian rambles.

I have chosen this title as I want to deal with some of the commoner eye symptoms and conditions met with in every day practice.

This may result in my talk being somewhat discursive, but with much ground to cover there is little time for detail.

It is the custom with guides to start the day's tour with a brief history of the place to be visited, so I propose to begin by giving you a short history of ophthalmology with special reference to the Hahnemannian period.

In the beginning of the nineteenth century the leading ophthalmologist of the day was one Georg Joseph Beer who became professor of Ophthalmic Medicine in Vienna in 1812. He ascribed the ophthalmias prevalent in his day to chemical disturbances in the body, and in this connection you will note the similarity to views expressed by Hahnemann in his first edition of the *Organon* published in 1810.

Beer was opposed to the wearing of glasses, and in 1822 produced a treatise in which he enlarged on the dangers arising from their use.

At this time the surgery of the eye was in the hands of travelling quacks who couched cataracts in the market place, and the few medical men who practised ophthalmology were held in disfavour by their professional brethren.

The examination of the eye was confined to the anterior chamber, and the illumination was ordinary daylight.

In 1830 Mackenzie in Glasgow introduced the term asthenopia which he believed was due to retinal exhaustion.

Of all the landmarks in the history of ophthalmology the most outstanding is the invention of the ophthalmoscope by Helmholtz in the year 1850. At first it was a very crude affair, but in time was improved and slowly came into general use.

Five years later Von Graefe first described excavation of the nerve head in advanced glaucoma and embolism of the retinal artery, and it was not until 1856 that hypermetropia, myopia, and astigmatism were understood.

My object in giving you this brief history is to show you how very recent and how very great are the advances which have been made in the study of the eye.

So much by way of preface. If any of my remarks should appear unduly elementary, then I am sorry that I have under-estimated your knowledge. If others appear somewhat dogmatic, it is not that I am any lover of dogma, but because there is no time for elaborate explanation.

The first symptom I propose to deal with is lachrymation, and if you look up the Repertory you will find some thirty-four drugs listed under this head. Before doing so, however, let us consider some of the commoner causes of this complaint.

To begin with there is the ubiquitous foreign body, and I do not apologize for mentioning it because frequently it is so small as to be invisible to the naked eye of the observer, and on many occasions the patient does not re-

member anything having gone into his eye. If it is not embedded in the cornea it is frequently to be found in a sulcus on the under surface of the upper lid.

The next thing to look for is an ingrowing eyelash from either lid which, by constantly rubbing on the cornea, produces an excessive flow of tears. This likewise may be very difficult to see as these lashes have frequently lost their pigment and are much finer than the ordinary lash.

Irritation can also be caused by concretions which develop in some of the smaller conjunctival glands. These work their way to the surface and being hard have the same effect as a foreign body. They are to be found in people of all ages, but are commoner in the old. The immediate treatment is to remove them with a sharp eye needle.

Now let me say something about quite a common cause of lachrymation, and one which is not well known to general practitioners, as it is not often diagnosed, and that is dendritic ulcer. The patient comes to you with a painful watery eye, and on examination you will find nothing to account for this apart from a slight pericorneal injection. It is only when the eye is stained with fluorescein that you can make out the typical branching ulcer. The virus of herpes simplex is the causal agent and the condition is identical in nature with herpes of the lip. Treatment must be immediate and energetic, and in my opinion is best carried out by touching the ulcer with Tincture of Iodine.

Another cause of corneal irritation with its accompanying lachrymation, is recurrent erosion of the cornea. It is often started by a slight scratch, resulting in an abrasion of the corneal epithelium. This heals over, but not firmly, and later on the continuous movement of the upper lid exposes the bare area again, with a recurrence of the pain and watering.

Before going any farther I want to draw your attention to the fact that I have just given you five different

conditions which produce exactly the same symptoms, namely irritation and lachrymation.

Now what of the eyes which water, but are neither inflamed nor painful. In them we usually find some interference with the adequate drainage of the tears. A slight eversion of the lower lid is enough to do this, the punctum no longer being in apposition to the sclera, or a blockage anywhere in the nasolachrymal duct.

In many of the provings one comes across the statement that lachrymation is worse in the open air; but this is true of all eyes in an irritable condition no matter what the cause, and the same, of course, applies where the drainage is poor.

Though one finds a watery discharge in conjunctivitis, iritis and obvious corneal ulceration I have intentionally not mentioned them as they are diseases in themselves and will be treated as such.

This leaves us then with a small percentage of patients whose chief complaint is of irritable watery eyes for which one can discover no adequate explanation. There is often an increase of eosinophiles in the conjunctival secretion and if they are young, one may find adenoids or enlarged cervical glands. Older patients with this symptom look unhealthy, are too fat and the skin of the face may show a fine scaly eczema.

In my opinion these cases are allergic in nature, and this is the group which will respond to homœopathic treatment of a constitutional type.

The other causes, which for the most part are mechanical, should be treated mechanically.

My next symptom is photophobia for which you will find an even greater number of remedies. Let us examine the commoner causes of this complaint. To begin with any inflammation in the eye will produce an aversion to light, whether it be a conjunctivitis, a keratitis or an iritis.

If there is no obvious inflammation, the commonest cause is an opacity in the media. In the cornea an opacity is invariably left by an ulcer of any size or by a previous keratitis. This may be so fine that it can only be seen under magnification, but it will nevertheless trouble the patient. There may be spots, K.P., on the back of the cornea as a result of an old standing cyclitis, or the aqueous may be filled with minute specks which can only be seen with a slit lamp.

Going still farther back, the lens may be slightly opaque or the vitreous may be filled with floating opacities.

All these will give rise to photophobia.

Most of you at one time or another must have driven a car the windscreen of which was covered with dust. With the sun shining directly on such a windscreen one can see very little, but turn out of the direct rays and immediately one sees well again.

This is exactly what is experienced by patients with opacities in the cornea or lens.

When on this question, there is one other point which I should mention, and that is, that if the opacity is in the centre of the lens the patient sees badly in a bright light, but if the striae are in the periphery he sees fairly well in a good light, but his vision is confused when the illumination is poor.

This leaves us with a small and somewhat motley group of patients who have this symptom, and in it I would include many fair-haired people, and others who, though not blonde, have what I would describe as an irritable nervous system. This is the group which will benefit from homœopathic treatment. Here the photophobia is part of the general make-up of the patient. In the others where it is due to opacities in the media it is optical treatment which is required—dark glasses, hats with brims, and seeking the shady side of the street.

The terms blurred vision and asthenopia I will lump

together and deal with in one paragraph. It is all they deserve.

Asthenopia as I said before was first used by Mackenzie in 1830 and was thought to be due to retinal exhaustion. This explanation is no longer accepted, as we know it is invariably due to some uncorrected error of refraction or a state of ocular imbalance.

Blurred vision can be due to such a variety of causes that it cannot be used either in diagnosis or in the selection of a remedy.

Now let me say something about headaches from eyestrain. If I were to allow myself a little rein I could paint you a very pretty picture under this heading, but the completeness of the picture would be at the expense of what I consider to be the truth, so I will content myself with a few rather disjointed observations.

To begin with I do not consider that children up to about the age of sixteen suffer from headaches as a result of eyestrain.

From this age to about forty a large number of headaches are due to refractive errors in people who use their eyes intensively. This refers to patients doing close work, or when driving a car or at the cinema. For the most part it is the small error which gives rise to this symptom so that these patients may quite well have a vision of 6/6 in each eye. With a large error the vision is poor and there is less unconscious effort to see clearly.

After forty the complaint is of difficulty with reading and sewing. This is the onset of presbyopia which makes itself felt sooner in hypermetropes, and considerably later in those who are slightly myopic.

From this age onwards till sixty is reached, headaches are often complained of first thing in the morning if much reading has been done the evening before, and this headache will be cured when the proper reading glasses are provided.

It is common knowledge that some people are predisposed to headaches, while others do not know what it is to have one. This being so, one cannot dogmatize and say that this or that type of refractive error will invariably cause a headache, but speaking generally, I would say that hypermetropic astigmatism is the most likely one, followed by reading glasses which are no longer correct.

Of glasses, their use and abuse, I could say much. In my opinion far too many people wear glasses constantly who only need them for particular purposes or when using their eyes intently.

For this oculists may be partly to blame, but I think the sight testing opticians must accept the greater part of the responsibility as they far outnumber the oculists.

*(To be continued.)*

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L. G. SCOLAR, M.D., CH.B. (GLAS.), D.O.M.S.

*(Continued from page 192)*

There are very few eyes which are absolutely emmetropic, but it does not follow that because one finds a refractive error that the patient need wear glasses. Thousands get on perfectly well, whose distant vision is much below normal, and if one has to live in a bomb-scarred area I consider this is no disadvantage.

It is those people who wear glasses which they do not require who provide a livelihood for the practitioners who give exercises and dispense with glasses. I am all in favour of exercises when these are necessary to strengthen the external ocular muscles, but how one can shorten a myopic eye or lengthen a hypermetropic one by any form of ocular gymnastics I have yet to learn.

To the above generalization about the excessive use of glasses, there is one exception, and that is the patient who suffers from migraine.

In this case, if one finds a refractive error of any size, and if the attacks are frequent, glasses should be worn constantly.

I have been driven to this conclusion after years of experience with migraine sufferers. Many can be cured by this treatment alone.

In others the attacks are less severe and less frequent and only a few derive no benefit. I had one man who could not eat sausages without bringing on an attack, but after wearing his proper correction he could take them with impunity.

My explanation, for what it is worth, is that any treatment which will help to stabilize these highly-strung individuals will lessen their liability to attacks, and by correcting a refractive error one removes a source of irritation to which they are unusually sensitive.



Now for a word on strabismus. When a mother brings her child to the Out-patient Department and tells me that she squints, as often as not she means that the child rolls her eyes about, or that she has got into the habit of screwing them up. On other occasions a child may come with what appears to be a convergent strabismus, but with no true squint. The appearance is due to the bridge of the nose not having developed, so that one sees more of the sclera on the temporal than on the nasal side. On pinching up the bridge of the nose the squint disappears. Adults often have an apparent convergent or divergent squint which is not a true one, but is due to a large positive or negative angle gamma. The point I am trying to make is this, that with proper instruments it is easy to diagnose a true squint; without them it can be very difficult, if not impossible.

In this connection I have gone through all the drugs in Hahnemann's *Materia Medica Pura* and those in his *Chronic Diseases*, and only once did I come across the word squint. It is under *Alumina* where he notes, "squinting of both eyes". Now in a true squint it is one eye which turns in or out relative to the other. I also looked up in Clarke's *Materia Medica* all the drugs which Kent gives in large type under the heading of strabismus. They are as follows: *Apis*—twitching of eyeballs; *Belladonna*—wild look, unsteady and wavering, spasms and convulsions; *Cyclamen*—double vision, strabismus; *Cicuta*—wavering of objects or may appear double; *Natrum mur.*—letters appear confused when reading, diplopia. Now I suggest to you that none of these are true squints, and that the word when it is used at all, which is seldom, is used in the same loose way as it is so often in the O.P. Department. I have yet to be convinced that a true squint can be produced by taking a drug, and by deduction that a strabismus can be cured by drug treatment. It is too large a subject to go into in detail, but briefly the majority of convergent squints fall into two categories. Those which develop in the first year or two

are usually due to a paresis, possibly congenital, of one or both of the external recti. Those which first appear about five or six when the child is beginning to look at picture books are accommodative.

A squinting eye is a dislocated eye, and is in many ways similar to a dislocated joint. At first it is only occasionally dislocated, but if untreated may become permanent, and just as one can develop a false joint so does a squinting eye develop a false macula.

The treatment is to get the eye back into position as soon as possible, and this is done by prescribing glasses when necessary, giving a course of eye exercises by a qualified orthoptist, and if there is no decided improvement in six to twelve months' time the squint should be straightened by operation.

Glaucoma is not one disease, but a group of diseases, and the feature common to the group is a rise in intra-ocular tension. This rise in tension is not absolute, but relative, so that a pressure which is quite safe in one eye may be dangerous in another. What constitutes a pathological rise in tension depends on many factors—the resistance offered by the cribriform plate in the nerve head, the blood pressure in the retinal artery and the loss in visual field to mention, but a few.

Acute glaucoma is a surgical emergency and must be dealt with immediately. The patient with chronic glaucoma on the other hand may have no symptoms whatsoever. He may see perfectly well and read the smallest print, and as the loss in the visual field comes on slowly, he may be quite unaware of it, all the more so as one field overlaps the other. Occasionally coloured rings round a light may be seen which will last for half an hour or longer. In this connection it is to be remembered that glaucoma is not the only condition which gives rise to halos. A film of mucus on the cornea, an opacity in the cornea or lens will produce the same effect. Then there is the scotoma seen in a

migraine attack; though affecting both eyes it is invariably described by the patient as only occurring in one.

The point above all else which I want to make is this, that the patient with chronic glaucoma, unless he knows what he has and all about the disease does not complain of a feeling of tension.

The patient who makes this complaint is one with prominent eyes, and has as a result of this a low grade conjunctivitis, but no rise in intraocular pressure. I have been aware of this for a long time and if you will consult Clarke you will have it confirmed. Under tension.

*Phos.* Eyes seem sore to touch and feel full. Eyeballs seem large, difficult to get lids over them. Greenish or red halos round candle.

*Prunus.* Pains in eyes as if balls were torn out.  
Glaucoma.

*Spigelia.* Pains in the eyes as if they were too large.

*Sulphur.* Copious secretion of mucus day and night and halo round lamp light, together with aching and burning sensation.

These drugs have to do with a feeling of tension in the eyes which the glaucoma patient does not complain of. In other words there has been some confusion here and a feeling of tension is taken to be the same as a rise in intraocular tension which it is not.

I know of no drug which produces a rise in pressure unless it be atropine which does so by dilating the pupil and so blocks the filtration angle in an eye which is predisposed to glaucoma. This is purely a mechanical effect and thus it could not be in my opinion given homœopathically to cure the condition.

Until we know more about glaucoma the treatment must be to give the constitutional remedy, paying no regard to the word tension, and at the same time keeping the pupil contracted by pilocarpin or eserine.

If in spite of this the field continues to contract one or other of the filtration operations must be performed.

Now let me say a word on cataract.

As you know there are many varieties of cataract: congenital, traumatic, diabetic, those due to radiant energy and endocrine dysfunction, and many other less known varieties. By far the commonest, however, is senile cataract, and it is of this I wish to speak.

It has been asserted by a well-known authority that 90 per cent. of persons over the age of sixty have lens opacities and from my own experience I do not consider that this is an exaggeration.

The symptoms of early lens changes are well known to you. The patient complains of dimness of vision, of looking through a mist or fog. He may see several objects with the affected eye, as so many moons, etc. A common change is for the eye to become more short sighted due to a sclerosis of the nuclear part of the lens. The vision often varies from day to day and also varies with the illumination. This, as I mentioned before, depends on where the opacity is situated, whether it is central or peripheral. It also varies with the mental state of the patient. On asking one old woman to tell me when she saw most clearly, she replied, "When I have nothing on my mind." It is the mind that sees and not the eye which is but a camera.

There is a tremendous variation in the rate of development of lens opacities. Some increase very slowly, others rapidly. An opacity may remain stationary for years and then for no apparent reason it may increase in size and density. This fact has always to be borne in mind when trying to assess the value of any treatment.

Vogt maintained that the tendency to early or late degeneration of the lens fibres is inherited. According to this conception, senile cataract is nothing more than a senile involutionary change and the time of its appearance is governed by hereditary factors. It may be compared to the greying of the hair which develops at widely differing ages.

There is certainly something in this theory as numerous families have been reported with a high incidence of cataract.

Without, however, discounting the importance of the hereditary factors there do seem to be definite physio-chemical influences at work in the development of senile cataract. There is operative at all times a dynamic equilibrium of osmotic forces between the lens and the aqueous on the one hand, between the aqueous and the blood on the other. In pathological states the balance may be upset to such a degree that refractive changes and finally death of the lens occurs.

It is thought by many that this is the cause of diabetic cataract where there is an abnormal concentration of dextrose in the blood and aqueous humour, and at the same time a lowered sodium chloride content in the serum. In this connection it has been shown that a large percentage of patients with senile cataract have an abnormally high blood sugar content.

Similarly, cataract can be produced by the intravenous injection of many substances in hypertonic solution, as for example, sodium chloride, glycerin, galactose and others.

In cholera where the severe diarrhoea produces marked dehydration cataract frequently develops.

It is thus more than possible that a raised blood pressure, infective foci, or a dysfunction of the carbohydrate metabolism, may at least be contributory factors in the development of senile cataract.

*(To be continued.)*

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Before making any mention of the more strictly homœopathic treatment of cataract, I want to say this, that the diagnosis of this condition is easy if one uses either an ophthalmoscope or a retinoscope. If these are not used, then many a cataract will be missed, and just as often a diagnosis of cataract will be made when none is present. Apropos of this you will remember that the ophthalmoscope was only invented in 1850, and did not come into general use until about 1870 at the earliest.

Going through the *Materia Medica Pura* and Hahnemann's *Chronic Diseases*, I only came across the word cataract once, where it is under *Cannabis sativa*. The original Latin is "infusiones oculorum" and there is a footnote which says, "Though technically this phrase may mean cataract, yet it seems unlikely that the author means to hazard in this manner so startling an assertion as that hemp can cause it." In Allen's *Handbook of Materia Medica* the word is very seldom used.

The following are the drugs appearing in large type in Kent, and this is what Clarke says of them.

*Calc. carb.* Confusion of sight as if there were a mist or veil before the eyes, chiefly on reading.

*Calc. fluor.* Cataract.

*Causticum.* Obscuration of eyes as if covered by a skin.

*Mag. carb.* Obscuration of crystalline lens.

*Silica.* Blackness before eyes after headache. Cloudiness of crystalline lens.

*Sulphur.* Cloudiness of crystalline lens.

In my opinion these statements are much too vague to prescribe on, especially if the diagnosis of cloudiness of the lens was made without the use of an ophthalmoscope.

There are, however, a few substances which in poisonous doses have definitely produced cataract in man, and these might well be used homœopathically if one is looking for a specific tissue remedy.

*Ergot or Secale.* This was first reported, following an epidemic in 1857, among some people who had eaten rye containing the fungus. The latent period was three to eight months. It was thought to be due to a spasm of the ciliary vessels resulting in an abnormal aqueous humour.

*Naphthalene.* The ingestion of this substance causes a hyperglycæmia, and the cataract produced is supposed to be similar to that found in diabetes.

*Dinitrophenol.* This drug was taken by many people in America in 1933 for obesity, and shortly after there were reports of several cases who had developed cataract. The mode of production in this case is not yet understood, but it is thought that the increased cellular metabolism produced by the drug reduces the amount of oxygen available for the lens.

Reports of recovery of transparency of an opaque lens are viewed by many ophthalmologists with scepticism, but that they do occur, even though rarely, is admitted by such authorities as Fuchs and Hess.

I have never seen this myself, though I have tried all manner of local and general treatments and have had many of my patients treated by the physicians. Sometimes an early diffuse opacity will reduce the vision to say 6/18. Later on the opacity may break up into more definite lines and fissures with a few relatively clear chinks between, and looking through one of these the vision may come up to 6/12.

This gives the impression that there has been an improvement, but in my experience it has always been of a temporary nature. More streaks develop, the chinks are closed and the vision deteriorates.

With regard to rate of progress, I think it is true to say that it is slower when the pathology is deep in the lens and more rapid if the changes involve the more superficial layers of the cortex.

Treatment should consist of a general overhaul, including a search for infective foci, hypertension and glycosuria.

Proper glasses should be given to correct any refractive error and remove accommodative strain.

The patient should have a well-balanced diet with a sufficiency of vitamin C and vitamin B complex as these are necessary for lenticular metabolism, and an adequate fluid intake should be maintained to ensure the proper elimination of waste products.

It is doubtful if local treatment in the form of drops and ointment is of any value, and the same applies to glandular and gonadal therapy.

Homœopathic treatment, in my opinion, should be directed to improving the general health of the patient by treating the constitution as a whole, and if a tissue remedy is sought, *secale*, *naphthalene* or *dinitrophenol* might be considered.

In this short paper I have said something on lachrymation, photophobia, asthenopia, glasses, squint, glaucoma, and cataract, and I am only too well aware that none has been adequately dealt with.

I have been discursive, but intentionally so, as I want to emphasize the fact that eye symptoms fall into three distinct groups.

In group one we find those symptoms which are due to physical or mechanical causes, as for example the irritation caused by an ingrowing eyelash, or the lachrymation from a blocked duct. Here the treatment is mechanical.

In group two are the symptoms arising from defects in the eye regarded as a camera, e.g. blurred vision from lens opacities; eyestrain and headaches from refractive errors. Here the treatment is optical.

Lastly, we come to the third group in which the eye symptoms are part and parcel of a general systemic disturbance; allergic conditions, glaucoma, cataract. Here the treatment must be constitutional.

I fully realize that there is no hard and fast line between these three groups and that they overlap to a certain extent, but nevertheless they are sufficiently distinct to be



recognized, and before embarking on any line of treatment one should know to which group the symptoms belong.

Let me finish with a quotation from Hahnemann: "The rational nature of the art of medicine manifests itself pre-eminently in the rejection of all systemic and other prejudices, in the refusal to act without good grounds, in the adoption of every possible measure to achieve the desired action, and in confining attention as much as possible to that which can be definitely ascertained." Which, Sir, I think you will agree is very sound advice.

#### DISCUSSION

Dr. PEARSON said that when he was invited by the Secretary to join in this Cook's tour he was intrigued by the title of Dr. Scouler's paper, and he began to wonder if he had discovered any new homœopathic remedies. Dr. Scouler had not mentioned any new remedies, however. One would think that the outlook in ophthalmology, especially the treatment, would be very much affected in the light of recent research and discovery of new remedies such as penicillin and the sulphonamides and not forgetting the vitamins. He thought all of these would have some considerable effect upon the future treatment of eye disease.

With regard to lachrymation, he found himself in full agreement with Dr. Scouler in much of what he had said, but he would mention some of his own experience in eye treatment obtained in the hospital's out-patient department where he had worked for twenty-five years, and where he had a good deal of experience of homœopathic remedies in the treatment of eye diseases. Dr. Scouler spoke of the dendritic ulcers: it was known that the dendritic ulcer, also the superficial punctate of the eye and the marginal ulcers and bullæ were produced by a lesion of the short ciliary branches of the fifth nerve. He found, for pain in these ulcers, especially the dendritic, that *Hypericum* was a great help. When the patient suffered from a great deal

of spasm *Conium* was a great help. These drugs alleviated the symptoms, but he quite agreed that it was necessary to cauterize these eyes, especially the dendritic. He must, however, give credit to homœopathic treatment because he had found it most successful in many of these ulcers of the eyes.

Dr. Scoular also said that a great many people suffered from headaches due to errors of refraction, but the speaker thought that a great many of these people suffered because they were uncorrected cases. One found on refracting many of the patients who suffered from headaches that they had not been properly corrected, in fact, the deviation of the cylinder was 5 or 10 degrees, and this would make all the difference to the patient's comfort.

With regard to squint he thought that the general practitioner was often in a quandary as to the kind of squint. Many doctors looked at squints and said that nothing could be done for it in the way of glasses. Concomitant squint was fairly common and the paralytic was less common. One could do a lot for such cases by orthodox treatment. Headaches could be produced by the phorias. An exophoria would cause a great deal of pain, but the hyperphoria were responsible for a great deal of headache, especially at the end of the day.

With regard to cataract he quite agreed with what Dr. Scoular had said. They were overlooked by the general practitioner because they might be hidden behind the periphery, in the periphery of the lenses, under the iris, and it was only when one put in atropine or a dilator that one found the manifestations. With regard to treatment he had never really found any homœopathic drug arrest these opacities. The central opacities, those on the supra-inguinal and intra-inguinal, produced a tremendous amount of reduced vision. The last few years he had adopted the line of treatment of giving very large doses of vitamin C, ascorbic acid, about 100 milligrams three times a day, increasing it to 1,500 in a month and instilling

albicid (10 or 15 per cent.) into the sac. He had seen an arrest of the cataract in quite a number of cases with this treatment.

Sir JOHN WEIR said that he was particularly pleased with the reference to allergic conditions because that was one of the points which Dr. Neubert was keen about. If there could be some homœopathic remedies which showed an effect, a great deal could be done to convince the allopath that there was something in homœopathic treatment. He had made statements about the sight improving in patients with cataract, and he was questioned by his oculist friends as to whether he had used an ophthalmoscope, but like Dr. Benjamin, they came with diminished vision having seen the oculist who told them that they had a cataract, and to come back so and so. *Phosphorus* had been his remedy. He had had a case in which the medicine was repeated once in thirteen months. There was no doubt that homœopaths did get good results with these cases. *Phosphorus* had a sensation of pressure, it dealt a good deal with "as ifs". There was a feeling "as if so and so" and that was very potent in calling attention to certain remedies.

There were three eye cases which he had seen recently:

(1) A woman, aged 62, seen in November, 1946. She had had eczema since July on left eye, swelling below and above, irritation over eyebrows, water slightly, itch annoying. Uses witch hazel. Burning sensation at times. Slight eczema on ear for years. No peace for six years. Had three oculist friends, not one had done her any good. *Rhus tox.* 30 given—I.S.Q.

Eight days later the left eye was pricking as with a gnat bite, the swelling was considerably worse for the heat of the fire and for any hot application. He wanted to give *Apis*, but did not do so as it was inimical to *Rhus tox.*, and he gave *Euphrasia* as a lotion. It did not do any good, so on December 4th he gave *Apis* 200, and within eight days the symptoms were modified. There was general improve-

ment in the condition until February, when he gave her *Apis 1m.*, and the improvement again set in.

(2) A doctor friend who had been seen in Edinburgh with a retinal hæmorrhage. There was great thickening of the vessels of the right eye with numerous hæmorrhages in the left eye. There was no retrogressive change and blood pressure was up. He was seen in the hospital, and it was said that there was considerable hæmorrhage up and around the right disc, and there was some moderate patches of white beside the disc. He went back to Glasgow and went to an oculist who told him that there was no hope of improvement, there was so much damage. He asked Sir John if he thought that homœopathy would do anything. He gave him *Phosphorus* and the patient went back to see his oculist in Glasgow. He said that the trouble had not progressed, and a year later he said his right eye was quite healthy. Ten years later he said he had kept well for the ten years, he was able to give up his glasses. He was very keen on exercises until, with pressure of work and so on, he got a few more retinal hæmorrhages.

(3) At the last meeting he made a statement about a student he had seen with a very bad eye infection. He had looked up the case since, and the details were as follows: It was *staphylococcus pyogenes aureus* of a strong type. The patient had a single dose of *Argentum nit.* 200 which helped him, he had a few more and he did not require any other treatment.

These granular lids which were very sore were *Pulsatilla* and *Hepar sulph.* Dr. Pearson spoke about *Hypericum*, but *Calendula* must not be forgotten. A friend got a cinder in his eye, and he gave him *Calendula*, he took out the cinder, and the relief was remarkable.

*Phosphorus* seemed to be the best remedy for glaucoma. It was easy to learn the remedies for the eye; *Kali carb.*: swelling above the eye, *Apis* below, and *Phosphorus* for the eye itself. *Causticum* and *Rhus* were helpful in paresis. The aggravation from wet weather, or the effect of the wet, differentiated. *Causticum* improved with damp whereas *Rhus* did not.

(To be continued.)

moment. But it is terribly infectious, and the best thing to do to avoid offence is to send your friend your "remedy epidemicus" if you know it, or recommend a doctor who may.

So boast not of 'flu. It may be lurking round the corner and it is one of the diseases which neither M & B nor Penicillin can do anything for. That too, is worth remembering as is also the fact that Gelsemium frequently can and does.

—*Health through Homœopathy, November, 1947.*

### A COOK'S TOUR IN OPHTHALMOLOGY

L. G. SCULAR, M.D., CH.B. (Glas.), D.O.M.S.

(Continued from page 268)

Dr. W. R. McCRAE wished to add his quota of praise to Dr. Scular for his excellent paper. There were three drugs which Dr. Scular mentioned which were of very special interest to us. They were secale, naphthalene and dinitrophenol. We had a good knowledge of the first, but of the other two we had much to learn to fill in our detailed knowledge. The homœopath of course could not carry his proving to the extent of creating pathological conditions and so such observations as others can give are pre-eminently important. When we are able to collect the picture of a drug from good provings we can build in the details of a possible pathological condition such as Dr. Scular describes and in this way the remedy may be the more accurately selected in suitable cases. In such a manner we should be more certain of success in our treatment of such very difficult conditions. A very interesting point concerning the treatment of eye conditions was the large number of acute states which presented outstanding

ocular symptoms. The indicated remedies for such states was most effective in clearing such conditions. *Belladonna*, *Apis*, *Hepar sulph.*, *Arsenic*, *Aconite*, *Conium* and so on, were well known. There was no doubt that the local indications were of great importance for the treatment of quite chronic conditions, because the delicate structures of the eye so readily took on the appearance of acute disturbances, even in chronic disease.

Dr. PAUL said that it would have been better if Dr. Scoular had not mentioned the homœopathic drugs given in Clarke and Kent. The symptoms of the eye which he mentioned under strabismus were not concerned with homœopathy, they were localized symptoms. In these cases one could forget the eye symptoms and consider the general symptoms. In his little experience he had seen many eye symptoms due to strain cured by *Ruta*, and the corneal symptoms had been treated by *Pulsatilla* and other drugs. He had seen many conditions in the cholera epidemics in Bengal, but he had not seen cataract and did not know much about it. With regard to corneal ulcers he followed the symptoms and cured by *Merc. cor.*, *Apis*, *Arg. nit.*, and *Kali carb.* He thanked Dr. Scoular for his interesting paper.

Dr. ALVA BENJAMIN also spoke on the question of cataract. One could influence cataract markedly with homœopathic remedies. He thought he was correct in saying that all the cases he had treated had been the peripheral types, and not one had had to go to operation. If one had a result such as that one must come to the conclusion that one had done something for the patients. It was true, as Dr. Scoular said, that the patient's vision varied very much with his general state of health, but one had quite definitely seen improvement in the density of the spokes which one could see in the lenses. As so many people had a great fear of operation, in order to help them, it was good that one could say that homœopathy has some influence on the condition. Whenever possible a constitutional remedy was used, but, if this was not possible, the remedies for cataract

in black type in Kent could be used, and one certainly had got results.

He said that all his cases of cataract were confirmed by ophthalmoscopic examination.

Dr. AGNES MONCRIEFF thanked Dr. Scoular for treating the audience as beginners. With regard to the conditions she saw at the children's out-patient clinic, styes would be the most common and they were easily treated with the child's constitutional remedy. The next common would be blepharitis which occurred in the type of child with the rough skin and crusty margins of the lids and this also reacted to the child's constitutional drug. With regard to lachrymation, the most common cause was hay fever, and as Dr. Scoular had said, that would be eminently treated by homœopathy. She found it fairly difficult to treat. On the whole, one was more likely to cure the child by treating the concomitant symptoms or conditions which arose during the rest of the year than in treating the child who was suffering from the attack of hay fever.

A certain number of squints were brought to her and she was quite willing to hear that it was possible that the squint was due to the bridge of the nose being deficient or that it was more apparent than real. Not knowing that Dr. Scoular did not approve of glasses for children, she tried to send them to the orthoptist because she found that the orthoptist made the children grow out of their squint without using glasses.

She got a great deal of cases of headache and most of them were of the allergic type. She had a boy who had headaches every Sunday night during term, because there was some difficulty at school. One or two headache cases came with kidney conditions, but that was more in an acute illness. As far as the migraine cases were concerned again these required constitutional homœopathic treatment. One or two bad migraine cases seemed to verge on *petit mal*, which she felt might be included in allergic conditions. One child she had had with severe headache had slight twitching of the right arm; she cleared up entirely on *Tuberculinum*, which was a drug she found very useful in various allergic conditions.

(To be continued)

Capsicum is suitable in quotidian and quartan malaria and in recurrences after quinine abuse; chronic cases. (Hartlaub.)

86a. Boy of 3 has suffered for ten days from tertian malaria, but the last four days has had daily attacks coming always an hour later. Thirst during the chills followed by heat and perspiration. Very hungry after attack. *Capsicum* 30c. was given, followed by two days of only chills, and then cured. (Schreter.)

86b. Woman of 30, weak, pregnant, has had quotidian malaria for nine weeks for which she had been given quinine, etc., then *pulsatilla*, *sabadilla*, *veratrum*, *china* without result.

Symptoms: Every forenoon for about an hour she has severe chills over entire body without heat following or perspiration; but during the day she has often alternating chills and heat. Face pale, no thirst, chills after drinking; does not like to move; very weak; *capsicum* cured lastingly. (Y.)

87. Man of 28 has had tertian malaria for nine months. Severe chills with thirst, then mild heat without thirst; perspiration; complete apyrexia. One dose of *capsicum* 3c. cured lastingly. (Y.)

(To be continued.)

## A COOK'S TOUR IN OPHTHALMOLOGY

L. G. SCULAR, M.D., CH.B. (Glas.), D.O.M.S.

(Continued from page 306)

The CHAIRMAN said that he felt that he could now observe, diagnose and treat an eye with much more knowledge than he had previously done with the help of Dr. Scular's division into three groups, although they overlapped. He would confirm the value of *Conium* in



cases of blepharospasm. He thought the usual description was "with the slightest abrasion the most acute photophobic spasm". He may have missed the small ulcer, but the cases he had seen, though they had not been cauterized, had cleared up on the *Conium* and nothing else.

He wondered if Dr. Scoular could tell him why people wearing glasses for the first time become so much more conscious of their defect of vision than they were before they had the glasses? Referring to Dr. Moncrieff's remark about the boy who had a headache on Sunday nights, it was not uncommon, he believed, for boys to be allergic to school! With regard to migraine, before the war Dr. Scoular and he had treated cases jointly, and he would say that on the average 50 per cent. gained 50 per cent. improvement from corrections of ocular defects. The other 50 per cent. were probably allergic in origin, e.g. the migraine which occurred at the time of the menstrual period was allergic, and these required constitutional treatment. He wondered too, what was the truth of Aldous Huxley's claims about eye exercises? He wanted to know if there was such a thing as a spasmodic squint? If rest, which he presumed was the essential basis of the treatment by orthoptics, could cure the condition, why should not a drug?

With regard to Dr. Scoular's reference to glaucoma, he thought his remarks "that one does not look up as often as one looks down" a very useful dictum for the times. Regarding symptoms of tension quoted by Dr. Scoular, Clarke's symptoms were, of course, *subjective*, not *objective*, and he would draw Dr. Scoular's attention to the fact that the list of drugs in Kent contained many "clinical" symptoms. Sometimes a list of drugs under certain diseases was proof of the fact that a number of cases with a definitely proved condition have been cured or alleviated by the use of that drug, not necessarily appearing in the provings in very high type. It was the personal experience of many people. The important point in choosing a remedy was

that the local symptoms, e. g. of the eyes, did not come at the top of the list, but at the bottom. So undue emphasis was not laid on the local condition.

Another query he had to make was: Did cataracts stand still or did they usually progress? If they stood still normally, then some of them could not claim very much. If that did not happen normally, then apparently homœopaths did do quite a lot. He wondered what Dr. Scouler meant when he said that "We did not see with our eyes, we see with our ego." What did a blind man see? Did he only see his memories? If blind from birth he had no memories even! Dr. Scouler stated that *Belladonna* produced tension: if this were so, then *Belladonna* used homœopathically should, in a suitable case, cure tension, given in a smaller dose. That was a general truth.

Dr. Scouler was to be congratulated on his researches into homœopathic materia medica. He might have shown up the paucity of symptoms and provings as far as eye conditions were concerned, but his researches were valuable, and most valuable of all had been his emphasis on the fact that one did not treat the local condition if there were the symptoms to treat the patient; in other words, one treated the patient with the eye conditions and not the eye condition in the patient.

Dr. JOHN PATERSON said that he was very sorry he had arrived too late, owing to the hold up in the train service, to hear the paper, because he had anticipated an interesting discussion on the local versus the general treatment of eye conditions. He had been thinking of the remedies used locally; here were just a few, Mercury, Zinc, Belladonna, and Argentum nit.; all sheet anchors in prescriptions for local application in eye conditions. Looking into these remedies homœopathically one found that they had provings with relation to the eye, and it was possible even to consider the eye from a pathological standpoint. Starting

from the outside one might note a drooping of the upper eyelid, possibly associated with exposure to cold winds, which would be found under *Causticum*, or blinking of the eyelids under *Agaricus*. The eyelids might be bulging with discharge, but *Argentum nit.* seemed to have selective action on the conjunctiva, while *Apis mell.* has œdema of the eyelid. Zinc so often used in eye lotion, would be found to have action on the inner surface of the conjunctiva and the inner canthus, and one thinks of this as a remedy in pterygium. It was also possible to prescribe on a constitutional basis, iritis being generally accepted as having a constitutional factor. Syphilitic ulcers call for *Mercury*, and he believed that one characteristic of this was the intense photophobia. Somewhere in the literature, under *Mercury*, is the description of the child who hides under the table to escape the effect of the light. Tubercular ulcers needed *Tuberculinum*; rheumatic affections, *Rhus tox.* or *Bryonia*.

From the purely homœopathic method, using rubrics, it was possible to select remedies for the eye, *Mercury* was very sensitive to heat and cold, *Hepar sulph.* sensitive to touch and better from heat.

*Pulsatilla* is better from cool air, has profuse watery discharge while in contrast, *Alumina* is characterized by lack of lachrymation, dryness of the mucous membranes. There was no doubt that one could select, on homœopathic principles, remedies for eye conditions to be given internally as well as locally. He had never seen cataract clear up on a homœopathic remedy, but he had had patients diagnosed as cataract by the ophthalmologist, who under treatment came back and reported that they could see better. He could not distinguish any clearing or could he explain it, but it was a very definite statement by the patient.

Dr. SCOLLAR, in reply to the discussion, said that he mentioned one new drug, dinitrophenol, which should be potentized. It was demonstrated that it caused cataract

in 1933. He thought it would be worth while trying. With regard to dendritic ulcer, he most certainly wanted general treatment, but what he wanted to emphasize was that one must treat it energetically at the time and stop it growing, or, as he had demonstrated, it would cover the cornea with scars. He would like to ask Dr. Pearson how he knew that his treatment of cataract was effective. The great trouble was that cataracts did stand still, they might do so for years, and that was why it was difficult to know whether one's treatment was effective or not.

Dr. Benjamin made a good point when he said that many of his patients did not require operation. If they were properly diagnosed, and if he had seen a big enough number of patients, his was a significant statement, and he should publish his cases. As for an improvement in the number of spokes, that would be a very difficult thing to tell. It meant that the patient must be examined every three months or so, and the spokes counted. There were not only large spokes, but very little spokes, and unless one spent a great deal of time over it, it would not be of much value. The best thing to do was to take the patient's vision with the best possible glasses identical conditions each time.

Sir John Weir spoke about allergic conditions. Many eye conditions were allergic and that would apply to some cases of iritis, conjunctivitis and to many cases of choroiditis. One did not now believe that many of these were due to organisms localized in the eye. It was thought that the eye had become sensitive to the poisons and toxins circulating in the blood, and not to the organisms themselves. Some cases of conjunctivitis were due to latent tuberculosis, and here *Tuberculinum* might be effective.

He intentionally did not say very much about the homœopathic drug treatment for eye conditions; the whole point of the lecture was that the various eye conditions should be clarified and homœopathy should only be applied

to those where it was applicable. One should think of mechanical causes or whether there was an interference with the optical mechanism. One of the Indian speakers said that many eye symptoms were caused by bad conditions. While he did not care for general statements he would like to know exactly the symptoms, for instance, in cholera, why cataract would appear some considerable time after the cholera. If lachrymation was an allergic condition it would respond to drug treatment; if the cause was mechanical it was doing homœopathic treatment an injustice to apply it where it would not do any good.

In reply to Dr. Sharma on the question of whether he (Dr. Scoular) would rather work with an allopath or homœopath, the allopath would not pretend to be able to do anything for a case of cataract or glaucoma, but the homœopath could. That had been borne out; he concentrated on the constitution of the patient and that was why if he had a patient with glaucoma he would ask the homœopath to treat him, but at the same time advise the physician not to pay any attention to the drugs in the Repertory listed under the heading of tension. If the homœopath would treat the constitution as a whole, some results might be achieved in the treatment of incipient cataract and glaucoma.

With regard to glasses for children, the answer was "What is the refractive state of the child's eyes?" If a child was hypermetropic, in order to see clearly it had to focus. There was a definite connection between accommodation and convergence. The child might have to accommodate to see clearly in the distance, then if it went down with measles or some other childish complaint it could no longer hold the eyes straight and one would turn in. In this type of case glasses are necessary. When one is dealing with a pseudo-squint where the bridge of the nose has not developed, glasses are not required.

(To be continued.)

## A COOK'S TOUR IN OPHTHALMOLOGY

L. G. SCULAR, M.D., CH.B. (Glas.), D.O.M.S. \*

(Continued from page 412)

With regard to Dr. Templeton's question regarding the awareness of a defect, one could go on quite well until one reached forty-five or so, and then it was not a muscular weakness which produced the inability to accommodate, but that the lens capsule had lost its elasticity and one strained to see with little result. If glasses were obtained, that relieved the strain, but if one made an attempt to see without glasses one felt some strain. One was always coming up against this question in the prescribing of glasses. A patient would say, "If I have glasses I shall be dependent on them." The answer was that they had reached an age when glasses were necessary for reading and close work.

Migraine cases were allergic, and the only way in which glasses had any effect was that they stabilized a somewhat irritable nervous constitution, and that was why he believed his patient was able to eat sausages because his system was in a more balanced condition.

With reference to Aldous Huxley's book, he had read it, but frankly could not understand it, and he did not think many people did. He talked about rolling the eyes, and about palming, but the speaker did not think that could do any good to a patient who really required glasses.

The Chairman asked what Huxley suffered from, and Dr. Scular said that he did not know exactly, but that among other defects he had opacities in the cornea. With regard to strabismus, many a child could hold the eyes straight when fit, but if run down for any reason, one or other eye might tend to squint. Rest was not a treatment for squint. The treatment now was that the children were put in a position where they used the two eyes in the squinting position, which was the reverse of rest. The aim

was to get the vision of each eye to the same level, then exercises were given on a synoptophore and in many cases the eyes became straight with this treatment alone. If after several months of treatment some degree of squint remained, the eyes should be straightened by operation.

He would agree that the localized symptoms must be put at the bottom of the list, and that was why he was keen on people not looking up the Repertory and saying, "this person has cataract", and give this, that, or the other drug. Apart from the three drugs he had mentioned, he did not think many of the other drugs had been properly proved. He did not think *Belladonna*, given homœopathically, would be effective in the treatment of glaucoma. Atropine given locally might produce glaucoma by dilating the pupil, and so blocking the filtration angle.

Dr. TEMPLETON: How does that differ from the glaucoma? The mechanism is the same.

Dr. SCULAR said that it was the same, but it was purely mechanical.

Dr. TEMPLETON thought it could be said that the mechanism in glaucoma was the same as in *Belladonna*, and so *Belladonna* could be said to be "homœopathic" to glaucoma.

With regard to what the blind man saw; he did not see anything with his eye, but he saw with his brain just as one saw in one's dreams. The eye was simply a camera which transmitted impulses to the brain, it was the brain or the ego, or the soul which saw.

Dr. D. HARISH CHAND said that the paper was stimulating or provocative to those who claimed to practise homœopathy. The Chairman had invited Indian doctors present to participate in the discussion, but he did not think that Indians got more than a due share of the diseases of the eye. It was true that bad sanitary conditions prevalent in certain parts of India and lack of medical aid in the remote villages made some of them complicated, and these very naturally gravitated to the lot of a homœopath being more

or less incurable from the point of view of the ophthalmologist.

Dr. Scoular mentioned the causes of lachrymation which brought a case to his mind. A lady doctor aged about 24, had lachrymation and a fissure at the external canthus of the eye. Lachrymation was brought on whenever she did any work like reading or sewing, needing a close application of the eyes. The more troublesome symptom, however, was the pain in the fissure. Being a doctor, she had had the privilege of being examined and treated by many eye specialists, but with no benefit at all. There were very few other symptoms to work on except a doubtful craving for salt. She was given *Natrum mur*, 200, one dose. There was immediate improvement, but two months later it showed signs of recurrence, and so she got another dose of it, and repetition was again needed after about four months. Thereafter she had been all right for over two years. A more complicated case he saw being treated was one of bilateral embolism of retinal arteries with total loss of sight in a wee boy, two years old. Specialists reports were, "Bilateral embolism of the central artery of the retina. It is incurable as no treatment would be of the least avail, and no power on earth can revive the cells of the retina, which are all dead", and " . . . . Bilateral embolism is very, very rare, but there it is. The prognosis is hopeless." Under homœopathic treatment after about six months the sight showed signs of return, and at the age of five when the boy was last seen, he attended school and had normal vision. He wished to ask Dr. Scoular if after six months of total loss of sight the establishment of collateral circulation could account for the cure, especially when the retinal cells were said to be atrophied.

Dr. SCOULAR asked if any attempt at classification of the cause of lachrymation was made in the first case.

To this Dr. CHAND replied that he did not think it could be precisely classified into any group, but it did not appear to be allergic, as the symptoms came on only when she did



something needing a close application of the eyes. It might be called eyestrain, but she never complained of headache; possibly she could not carry on her work long enough to develop a headache. He pointed out that though there was a doubt about the cause of the trouble, there was no doubt about the beneficial result of treatment, and this again was a trump card for homœopathy where it was not essential to know the cause before being able to treat.

Dr. SCÖULAR said with regard to the case of embolism in the retinal artery of a child, that this was a very rare condition, and if the child did recover, then it could only have affected a branch of the artery and not the main vessel.

Dr. CHAND said that the ophthalmologist said that it was very rare.

Dr. SCÖULAR said that if the central artery was blocked and the child's sight recovered a circulation must have been set up with tiny little arteries which did not come from the central artery, but which came from the short ciliary arteries.

Dr. CHAND said that the eye cleared in about five months. It started on homœopathic treatment after about six weeks.

Dr. SCÖULAR said that the fact that it was such a young child gave it a better chance of developing a collateral circulation.

—*The British Homœopathic Journal, July, 1947.*

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