amended, the following gentlemen have been nominated as members of the General Council and State Faculty of Homœopathic Medicine, W. Bengal in the vacancies as indicated against each:—

Name	*Vacancy*
1. Dr. Bankimbehary Chaudhuri, D.M.S., Secy., Midnapore Homœopathic College, Midnapore.	In place of Dr. Manindranath Chatterji, deceased.
2. Dr. J. N. Sarkar, M.B., D.T.M., Prof. Cal. Homœopathic College & Hospital.	In place of Dr. N. R. Quoraishe who vacated his seat under Sec. 7(1) of the Statutes.
3. Dr. Sadek Hossain, Ex-Councillor, Cal. Corporation.	In place of Dr. A. T. Moazzem who vacated his seat under Sec. 7(1) of the Statutes.
4. Principal Jatindra Kissor Chaudhury, M.A.	In place of Dr. Gangadhar Mukherji, M.A, B.L. deceascd.
5. Jonab Shamsul Huq, M.L.A.	In place of Dr. A. Ahad who vacated his seat under Sec. 7(2) of the Statutes.

We offer our heartiest welcome to the new members and expect that they will further the cause of Homœopathy in the province.

B. K. S.

THE TREATMENT OF CERTAIN HEART CONDITIONS BY HOMŒOPATHY

DOUGLAS MORRIS BORLAND, M.B., CH.B. (Glas.)

MR. PRESIDENT,

At the beginning of the Session I was asked by the Hon. Secretary if I would give a paper to the Faculty which would be of assistance to beginners in homœopathy when confronted with the problem of treating heart cases. I promised to see what I could do to help, and the following may, I hope, be of some assistance.

Personally, I have developed the habit of grouping cardiac cases under three headings for ease in prescribing. This does, I think, simplify one's work in the great majority of cases by promptly suggesting the consideration of quite a small number of drugs in the first instance, and if one finds that no one of the commonly indicated drugs, is applicable to the particular case, only then does one have to extend one's search.

The three headings under which I have come to group these cases are:

1. Cases of acute heart failure.
2. Cases of gradually failing heart with a tendency to dilatation.
3. Cases of an acute cardiac attack of the anginous type.

ACUTE HEART FAILURE

When confronted with a case of acute heart failure there are four drugs which promptly present themselves for consideration, and in the majority of cases the choice can be made almost at once, in fact as quickly as one can make a diagnosis of the pathological state. The four drugs are: *Arsenicum, Antimonium tart., Carbo veg.,* and *Oxalic acid.* I do not mean to suggest for one moment that these four will deal with every case of acute heart failure, but they do form pegs on which one can hang different types of case as a start.

Arsenic

Consider for a moment the case requiring *Arsenic.*

There will be the typical *Arsenic* mental distress, with extreme fear, extreme anxiety, mental and physical restlessness, with constant thirst and desire for small sips of ice-cold water.

So far as the actual local symptoms are concerned, the main complaint is of a feeling of extreme cardiac pressure, a feeling of great weight or constriction of the chest. Asso-

ciated with this the patients feel as if they cannot get enough air into the lungs, and feel that they are just going to die.

The patients as a rule are cold, they feel cold, though they may complain of some burning pain in the chest.

In appearance, they always look extremely anxious. They are grey, their lips are rather pale, may be a little cyanotic, and they give you the impression of being very dangerously ill. They very often have a peculiar pinched, wrinkled, grey appearance.

As a rule in these cases one gets the history that the attack has developed quite suddenly, and the response to *Arsenic* should be equally quick. In a case of that sort, if one does not get a response to *Arsenic* within a quarter of an hour the patient is not an *Arsenic* patient. The first response that one ought to get is a diminution of the patient's mental anxiety and extreme fear, the restlessness beginning to subside, and the patient beginning to feel a little warmer.

In a case of that sort my experience has been that one is wise to administer the highest potency of *Arsenic* available, because this is the kind of case that will die very rapidly and no time should be wasted on low potencies. The *Arsenic* seems to act very much like a temporary cardiac stimulant, and I find that in the majority of these cases one has to repeat the dose, certainly to begin with, about every 15 minutes.

There is a very important practical point in connection with these cases, namely, that one very often sees a case of this sort which responds perfectly well, the patient is better, everyone feels he is getting over it, and then in 3, or 4, or 6 hours the symptoms begin to come back, the patient no longer responds to *Arsenic* and collapses and dies. That was my experience at one time. Then it began to dawn on me that had I cut in with another drug during the reactive period I could have carried these patients on. I found that when I did this they did not get the secondary collapse, and one saved them. But to do that one has to get in the

secondary drug within 4 to 6 hours of the primary collapse while the patient is responding to the *Arsenic*, otherwise there is great danger of a secondary collapse which one cannot combat. This seems to be one of the very few instances in which one appears to ride right across the dictum that so long as the patient is improving one carries on with the same drug. In these acute *Arsenic* cases if one has set up a reaction at all one has to take advantage of the reaction, and if one does not do so the patient will sink.

The drugs which as a rule I have found these *Arsenic* cases go on to in the reactive stage are *Phosphorus* or *Sulphur*, but that is by no means constant, I am merely throwing it out as a help. One can easily picture that grey, pinched, anxious *Arsenic* patient responding, getting a little warmer, a little less grey, a little less pinched, a little less drawn, a little less anxious, a little more colour, and going on to a typical *Phosphorus*. Equally one can see them going to the other extreme where they are too hot, with irregular waves of heat and cold, rather tending to push the blankets off, still with air-hunger, and going on to *Sulphur*. These are the two commonest drugs, but whatever the response is one ought to be able to follow it up immediately the reaction is well under way.

Antimony tart.

The *Antimony tart.* patients present a somewhat similar picture, but there are clear points of difference. In *Antimony tart.* there is more a definite tendency towards cyanosis than in *Arsenic*, one never sees an *Antimony tart.* patient without very definite signs of cyanosis. This may involve the whole extremities or may be confined to the finger and toe nails.

One never sees the same kind of mental anxiety in *Antimony tart.* The patients are more down and out, much more hopeless, more depressed. They are never quite so restless and never quite so pale.

Again there is none of the thirst one meets with in *Arsenic,* in fact anything to drink seems to increase the patient's distress.

Another contrast is that the *Antimony tart.* patient is very much aggravated by heat, and especially by any stuffiness in the atmosphere. There is one point worth noting here as a contrast between *Antimony tart.* and *Carbo veg., Antimony tart.* patients do not like a stream of air circulating round them, they want the room fresh, but they like it still.

In most of these *Antimony tart.* patients there is a very early tendency to œdema of the lower extremities.

Another point which helps you in your *Antimony tart.* selection is that practically all these patients have a very thickly coated tongue—a white coat—with a rather sticky, uncomfortable mouth.

They have a feeling of fullness in the chest rather than the feeling of acute pressure found in *Arsenic.* And one usually finds pretty generalized, diffuse râles in the lower parts of the chest on both sides.

In contrast to *Arsenic,* if one has a case of that type—it is the kind of collapse one meets with after a pneumonic crisis—if the patient responds to *Antimony tart.* it will carry him through. One does not have to be on the jump to find the follow-up drug as one has to be in the *Arsenic* case.

Carbo veg.

Carbo veg. presents the classical picture of patients with all the symptoms of collapse. They have the cold sweaty skin, they are mentally dull, rather foggy in their outlook, have not a very clear idea of where they are or what is going to happen to them. They have the most intense air hunger, and, in spite of their cold clammy extremities, they want the air blowing on them, they cannot bear to have the bedclothes round their necks, and they do definitely benefit from the administration of oxygen.

They are very much paler than the *Antimony tart.* patients, the lips tend to be pale rather than cyanotic, and there is none of the underlying blueness one associates with *Antimony tart.*

The next point is that they always have a feeling of horrible distension. It is very often complained of not so much in the chest as in the upper abdomen, and their cardiac distress is always associated with a good deal of flatulence.

Like the *Antimony tart.* patients, any attempt to eat or drink tends very much to increase their distress, and they have none of the *Arsenic* thirst.

Another apparent contradiction you come across in *Carbo veg.* is that, in spite of their desire to be uncovered, and the intolerance of the blankets round the upper part of the neck or chest, these *Carbo veg.* patients complain of ice-cold extremities, they feel as if the legs are just lumps of lead, and they cannot get them warm at all.

I think in *Carbo veg.* one has to be careful as to how long one is to keep up the administration once the patient is responding—sweating less, the surface becoming warmer, and the distress less acute. It is wise then to hunt round for a second drug in case of need, because some *Carbo veg.* patients do relapse, although many of them make quite a straight recovery on *Carbo veg.* One does have to be careful. If one finds a patient who has responded up to a point on *Carbo veg.* it does not follow that a higher potency of *Carbo veg.* is going to carry on the good work. As a rule it does not, and it is much better to hunt round for a fresh drug to keep up the reaction. Often when the patient has responded only up to a point to the administration of *Carbo veg.* the follow up drug will be found to be *Sulphur,* but *Kali carb.* should always be considered.

Oxalic acid.

The last of these drugs which I commonly think of for conditions such as this is *Oxalic acid.*

Oxalic acid has one or two very outstanding symptoms which are often met with in cases of collapse, and which are a great help in the selection of the drug.

First, the patients always complain of a feeling of the most intense exhaustion. Associated with that exhaustion there is usually a sense of numbness. The patients very often tell you their legs and feet feel numb and paralysed, and often they say they don't feel as if they had any legs at all.

The skin surface is just about as cold and clammy as it is in *Carbo veg.*, but there is a peculiar mottled cyanosis in *Oxalic acid* which one does not get in the other drugs. The finger tips and finger nails and toe nails will be definitely cyanotic, but in addition to that there is a peculiar mottled appearance of the hands and feet which is quite distinctive of *Oxalic acid.* There is a somewhat similar mottled, cyanotic appearance in the face, very often over the malar bones.

These patients, in contrast to the *Arsenic* patients, want to keep absolutely dead still, movement of any kind vastly increases their distress.

In addition to their general distress, most of these *Oxalic acid* patients complain of peculiar, very definite, sharp, præcordial pains. The pain is not like the typical anginous pain, it is a sharp pricking sort of pain which usually comes through from the back and may run up the left side of the sternum towards the clavicle, or down the left side of the sternum into the epigastrium.

The most startling cases giving this picture that I have seen have been in the critical stage of an influenzal pneumonia where the patient was just petering out, seemed to have lost all strength, was dead beat, and the heart was just giving out. All the patients of that type that I have seen have had left basal pneumonias. I remember seeing two or three cases which apparently were doing quite well on *Natrum sulph.* and collapsed, and they reacted beauti-

fully to *Oxalic acid*. But one does get indications for it in chronic cardiac cases as well.

GRADUALLY FAILING HEART

Now I should like to consider those cases where the heart is just gradually giving out, beginning to dilate a little, becoming slightly irregular, and the patients obviously are going down-hill. If the condition is not so acute as to call for one of the four drugs we have been discussing, there is another group of three or four which one finds very helpful—that is quite apart from one's ordinary prescribing. In many of these cases in which there is a tendency to cardiac failure the heart picks up and the tendency to dilatation disappears in response to ordinary routine prescribing, and one does not need to stress the cardiac symptoms particularly, that is to say, the patient responds to the drug for their general symptoms. For instance, quite frequently in pneumonia, a bad pneumonia with the patient pretty worn out and indications for *Lycopodium*, there may be a tendency to a failing heart, with dilatation, but after the administration of *Lycopodium* the heart picks up, the pulse steadies, and the tendency to dilatation disappears. One finds the same in all acute illnesses where the patient is responding to the particular drug indicated. But there are cases in which the patient is doing quite well up to a point but there is a tendency to cardiac failure which is not responding to the individual medicine the patient is on, and then one has to stress the cardiac features of the case.

For cases of that sort the drugs to which one turns most readily are the *Snake Poisons*, especially *Lachesis* and *Naja*, and less commonly to *Lycopus* and *Laurocerasus*.

Lachesis and Naja

The *Lachesis* picture I think is pretty typical of all the Snake Poisons, but there are just a few indications which make one choose *Naja* in preference to *Lachesis*.

In all these cases indicating the Snake Poisons there is a rather purplish bloated appearance. They all suffer from

a feeling of tightness or constriction in the chest, more commonly in the upper part of the chest, and they are all intolerant of any weight or pressure of the bedclothes, or any tight clothing round the upper part of the chest or the neck. All are sensitive to heat; they feel hot, and they dislike a hot stuffy room. They all have a marked aggravation after sleep. They get acute suffocative attacks when they fall asleep, and they wake up in increased distress.

All these Snake Poison patients in their cardiac distresses have a marked aggravation from being turned over on the left side. All of them have a very marked tremor, their hands are shaky. And most of them, as they tend to get worse, become mentally fogged, confused, and very often they tend to become difficult and suspicious.

If there were nothing more than that one would give them *Lachesis*. But in a certain number of these cases there are rather acute stitching pains which go right through the chest from the præcordium to the region of the scapula, associated with very marked numbness, particularly in the left arm and hand. And where that numbness is pronounced one tends to give *Naja* in preference to *Lachesis*.

If the pain, stitching pain, is more marked, one tends to give *Naja*. If the feeling of constriction is more marked, one tends to give *Lachesis*. But their general symptoms are identical. I think possibly *Naja* is a little less red, less bloated looking, a little paler than *Lachesis*, but that is not very striking.

To my mind the choice of one of the other Snake Poisons as distinct from *Lachesis* and *Naja* in such cases is always governed by the general symptom picture rather than by the purely cardiac picture. For example, one may require *Crotalus horridus* in a case of failing heart associated with acute sepsis, but one would be guided to the choice by the septic state rather than by the cardiac symptoms *per se*.

Lycopus

Apart from the Snake Poisons there are two drugs which one finds very useful in these conditions. The first of these is *Lycopus.*

One gets indications for *Lycopus* in a case in which the heart is just beginning to fail; it is beginning to dilate a little, and the pulse is tending to become a little irregular.

The patients tend to be pale rather than cyanotic, and they are always restless.

The outstanding symptom of the *Lycopus* case is that the patients complain of a horrible tumultuous sensation in the cardiac region. They very often tell one it feels as if their heart had suddenly run away and was just going mad. This is accompanied by a feeling of intense throbbing extending up into the neck and right into the head.

The other *Lycopus* symptom which helps one is that accompanying this tumult taking place in the chest there is a very marked tendency to cough. It feels as if the heart just runs away, it sets up an acute irritation, and they cough.

Another *Lycopus* distinguishing symptom is that their distress is vastly increased by turning over on the right side—a contrast with the Snake Poisons which are worse turning over on the left side.

Lastly, these *Lycopus* patients have an intense dislike of any food, particularly the smell of food.

Laurocerasus

The last of these drugs I want to touch on is *Laurocerasus.*

The *Laurocerasus* picture is very definite, and I find the easiest way to remember it is to picture to oneself the appearance presented by a congenital heart of about 16 to 18 years of age. You know the peculiar bluish red appearance of the congenital heart, somewhat clubbed fingers, which, again, are rather congested, and the peculiar bluish appearance—almost like ripe grapes—of the lips. That is

the sort of underlying colour one associates with *Laurocerasus.*

These patients always suffer from extreme dyspnœa, and the type of dyspnœa is very nearly Cheyne Stokes in character. They take a sudden gasp for breath, then two or three long breaths, then the breathing gets gradually shallower, then a pause, then two or three gasps, and so it goes on.

Another feature is that the respiratory dyspnœa gets very much worse if they are sat up; they are better in a semi-prone position.

There is a marked tendency to the early development of hypostatic pneumonia in such cases, and once this has appeared the patient's cough is more troublesome unless they are reasonably propped up. When lying the cough is worse. Sitting bolt upright produces a feeling of extreme constriction of the chest. Semi-prone is the position of choice.

ANGINA AND PSEUDOANGINA

Cases of true or pseudoangina tend to fill the homœopathic physician with not unreasonable anxiety, but it is possible to have at one's call just a few drugs which will provide astonishing relief in many of these cases. Consider, for instance, the following drugs which have a relationship to conditions of that kind: *Aconite, Cactus, Arsenic, Iodine, Spongia, Spigelia,* and *Lilium tig.*

Aconite

If one thinks for a moment of any cases of the kind one has seen one finds, I think, that the outstanding characteristic of the majority of these cases in their first attack is an absolutely overwhelming fear. The patient is certain he is going to die, and that he is going to die very speedily, and he is terrified. He is quite unable to keep still, and yet any movement seems to aggravate his distress. In a case of that sort a dose of *Aconite* high will give relief almost instan-

taneously. I have seen such a case and put a dose of *Aconite* on the patient's tongue, and before the medicine could be swallowed the patient was feeling better. It is almost instantaneous. I usually carried 10*m* as my highest potency in general practice, and I gave *Aconite* 10*m*.

That man had a similar attack at a later date, and the anxiety, the distress, and the fear were nothing like so marked because he had come through one attack before, and *Aconite* had no effect at all. That has been my experience. Where one is dealing with the first attack and the patient is quite certain he is going to die *Aconite* does relieve him right away, but it does not act in a second or later attack. So if one gets a man in his first attack a dose of *Aconite* will probably help and in no time he will be feeling more comfortable. If he has had a previous attack, however, *Aconite* is unlikely to help him.

Cactus

If you have a patient who is having a later attack much the most likely drug to help is *Cactus*. *Cactus* has a good deal of anxiety and fear, but it is quite different from that of *Aconite*. It is not a fear that the immediate attack will kill him, it is a more conviction that he has an absolutely incurable condition which will eventually wipe him out.

That is one point about the *Cactus* indications. Another point is the type of the actual distress of which the patient complains. He feels as if he had a tight band round the chest which was gradually becoming tighter and tighter and that if this tightness does not let up soon the heart will be unable to function. It is that feeling of increasing tension which gives the *Cactus* indication.

In addition to the constriction there may be stabbing, radiating pains from the præcordium, but they are not so characteristic of *Cactus* as the intense constricting feeling, which is, of course, just exactly how the majority of anginous patients describe their feeling.

In these acute conditions I always give my drug high, because it acts much more quickly, and one must get relief as quickly as possible.

Arsenic

Occasionally one comes across a patient having an anginous attack with very similar constricting feelings, not quite so intense as in *Cactus* where it seems to dominate the whole picture, but still a definite feeling of constriction. The patient has been ailing for some time, is rather anxious and worried, very chilly, and accompanying the feeling of constriction there is a pretty acute, distressing, burning sensation in the chest. These anginous patients respond very well to a dose of *Arsenic*. I have never seen *Arsenic* do anything in an anginous attack except in the rather broken down, ill-looking patient, who is a bit pale, rather withered looking, very definitely anxious, fearful, with that sense of constriction accompanied by the burning discomfort in the chest. And *Arsenic* does relieve these quite quickly.

Iodine

There is another type of case which is very similar to that, with very much the same sensation, but the feeling of constriction, the feeling of tension, is described as being actually in the heart itself rather than involving the whole of the side of the chest.

The patients are just about as anxious as the *Arsenicum* patients—in fact all these anginous patients are anxious—but instead of the intense chilliness of the *Arsenic* they are uncomfortable in heat and in a stuffy atmosphere. They are just about as restless, but, instead of the pale, drawn appearances which you get in *Arsenic* they tend to be rather more flushed, and as a rule they are dark-haired, dark complexioned people. They are usually rather underweight, in spite of the fact that one gets a report that they have always been pretty good livers, and they very often have an appetite above the average although they have not

been putting on weight. These cases respond exceedingly well to *Iodine.*

Spongia

There is yet another type of case in which instead of the complaint being of constriction it is of a sensation of progressive swelling in the heart region. It feels as if the heart gets bigger and bigger until it would finally burst, and this sensation of fullness spreads up into the neck.

This sensation of fullness and swelling is very much aggravated by lying down, when the patient feels as if he would nearly choke, and it is accompanied by pretty acute pain.

The patients themselves are chilly, and any draught of air increases their distress.

In addition to their feeling of distension, they usually complain of more or less marked numbness, particularly of the left arm and hand, though very frequently there is numbness of the hand without any involvement of the arm, and not infrequently they complain of numbness of the lower extremities too.

As a rule, the face and neck give you the impression of being somewhat congested, they do not have the pale, drawn, wrinkled *Arsenicum* appearance.

These cases respond well to *Spongia.*

Spigelia

There is another drug which is useful in the case which has not got the typical anginous constriction, but has much more the pseudoanginous stabbing, radiating pains—sharp, stabbing pains starting in the præcordium, spreading up into the neck, may be across into the right side, or may be down the left arm. Following these shoots of pain, there may be more or less numbness involving the whole affected area, and as a rule the pain that they stress is a little eased by turning over on to the right side.

Accompanying the stabbing pains there is always more or less marked hyperæsthesia over the præcordium. If

you attempt to percuss out the area of cardiac dullness the patient resents it extremely.

Any movement aggravates the pain, or brings on a violent attack.

These cases respond very well indeed to doses of *Spigelia*.

Lilium tig.

There is a condition which is not an angina at all but which one meets with in hysterical women. One fails to find any cardiac lesion, but the patients will produce a symptom-picture which one finds difficult to distinguish from a true anginous attack. That is to say, they have very marked stabbing, radiating pains, and they very often have an intense hyperæsthesia of the chest wall. They are very depressed, they are very frightened, and they are intensely irritable. They are sensitive to heat, and their distress is aggravated by any movement.

In addition to their stabbing pains they have the anginous sense of constriction, tightness, of the chest wall.

These cases are usually associated with some kind of pelvic lesion, or a history of having had some gynæcological illness.

I have seen quite a number of these cases now in which I have had an electro-cardiogram done which showed no lesion at all. And all the symptoms have cleared up entirely on doses of *Lilium tig.*

Mr. President, all I attempted to do in preparing this paper for the Faculty was to sketch the lines along which I have been accustomed to approach the type of cases I have indicated to you, in the hope that others from their experience will say what they in turn have come to look upon as of value in the treatment of so-called cardiac disorders.

DISCUSSION

The President said that it was a very great privilege to have this opportunity of opening discussion on a paper by Dr. Borland.

There was one remedy which had not been mentioned and one which he personally would not be without in the treatment of acute heart conditions, it was *Veratrum viride* and this remedy he had found very useful indeed in cases of acute cardiac failure and collapse.

He had a habit of reading current medical journals with a pair of scissors with which he cut out anything of interest and put away for future reference and he had before him an article from the *B.M.J.* of July 20th, 1940, entitled "The Toxicity of Potassium Salts" which was of interest because potassium salts had been well proven in allopathic medicine; the writer stated that the action of potassium had been known to physiologists for over a hundred years, and it was surprising that this knowledge had had so little influence on therapeutics, and offered as possible explanation the observation that the action on the heart was usually symptomless and the first clinical evidence of damage be sudden death. Homœopathic physicians were aware of this fact that in the potassium case there were often no prodromal symptoms and the first evidence an acute cardiac collapse.

It was to be noted that Dr. Borland wrote, that *Kali carb.* should always be considered in heart cases.

The article also made reference to a probable stimulation of the vagus nerve by potassium salts, and he was particularly interested in heart conditions which might be attributed to vagal stimulation, that is with some disturbing factor in the abdominal area as he was of opinion that many cases of sudden heart collapse had been associated with a source of vagal reflex.

He had the opportunity being himself a patient under the care of Sir James Mackenzie at the end of 1914-18 war.

Sir James was known to have "unorthodox" views upon cardiac conditions and in this case diagnosed his cardiac symptoms as secondary to a primary abdominal condition, probably duodenal in origin, but he was very definite in his expression of opinion that intestinal toxæmia, so far obscure in type, was a factor in many conditions diagnosed as "cardiac."

As most of these present at this meeting were aware, he had been carrying on research work on the bowel flora and this had afforded evidence that there was a definite relationship between intestinal flora and symptoms related to heart. In the clinical proving of the *B. Dysenteriæ*, a close relationship was found between cardiac and duodenal symptoms, and it would seem that this type of toxæmia had specific action in these areas.

Returning to the question of potassium, it has been noted that the serum of patients suffering from malignant hypertension tended to show a lower level of potassium than that of normal blood pressure in persons partaking of the same diet.

There was some disturbance of metabolism in hypertension and in allopathic prescribing there was always a warning given about giving Digitalis and Potassium salts together because they acted synergetically.

Dr. W. R. McCrae said that he had looked forward to hearing Dr. Borland's paper and it was a great disappointment that he was not well enough to be present, he would congratulate Dr. Quinton on giving it with such clear diction.

Dr. Borland said that he liked to group his patients and that appealed to the speaker very much. He chose his remedies from the different groups which was very interesting from the emanometer angle. He gave *Aconite* in the first emanometer group, he went on with the snake poisons in the second, but missed out the third group, which was a very uncommon group but he was surprised that Dr. Borland did not mention any remedy in the fourth

group. In the fourth group one got *Digitalis*. *Digitalis*, as they all knew, was not often indicated in the homœopathic field. That would strike the allopath as a great surprise. In that group there was *Bryonia* which was a wonderful remedy when it had the associated symptomatology in cardiac cases. The great heart medicine, *Strophanthus*, was also in this fourth group. Dr. Borland went on to the fifth group and there he had *Spigelia* and *Oxalic acid*, then to the sixth group with *Arsenic*, *Antimony*, and *Spongia*, and in the seventh group *Kali carb*. Kent said that it was often extremely dangerous to give *Kali carb*. to a patient suffering from cardiac conditions, the indications had to be precise in order to be successful. It was interesting, from the emanometer angle to know why it might be dangerous. *Kali carb*. came into the seventh group which was a most uncommon group and because of its near relationship to the sixth group on the one side and on the other side, the eighth group, therefore in a dangerous cardiac condition if the patient happened to be in the sixth or eighth group and *Kali carb*. was given a very dangerous aggravation may be caused, if not a fatal one.

Then Dr. Borland went on to speak of the eighth group and he quoted *Sulphur* and *Iodine*. There were other remedies, of course. *Stramonium* was in that group. The ninth group was not mentioned and that was natural because it was very uncommon but the tenth group was mentioned where he gave *Laurocerasus*. Another very important remedy for cardiac conditions in that group was *Arnica*. *Arnica* was an outstanding remedy for patients who suffered from sudden cardiac disturbance as a result of some great physical shock, as it frequently did. The eleventh group was a fairly common group especially because of its relationship to the related eighth and fifth groups. In that group there was *Thuja* which one would not think of readily in its cardiac respect. He would like to mention the remedy *Cypripedium* which was also in the eleventh group, it had not been very fully proved and it

had on some occasions showed how useful it could be in cardiac disturbances. That brought out one detail in the provings which was very important. When a medicine was proved, if it was pushed far enough serious cardiac symptoms might be elicited but one did not do that intentionally and therefore amongst many uncommon remedies which had received very little proving there was no doubt much to be discovered for the treatment of cardiac conditions.

As an instance of this, there was a patient in hospital just now who came in with all the usual symptoms of coronary thrombosis. The speaker doubted whether he did have coronary thrombosis but he had many acute anginal symptoms. He was not a man to exert himself very much but he got a slight cold and developed the symptoms of pain round the chest extending down his left arm to his hand. He responded to *China arsenicalis* of the tenth group. He had a fluctuating temperature with all his symptoms aggravated during the time of the rise in temperature and was really very ill, but from the day of taking *China arsenicalis* his temperature came down to normal, stayed normal, and he was to be discharged fit in a day or two.

We knew that Dr. Borland would always insist on giving the indicated remedy whatever that might be, and that he would never dream of restricting his search to a limited few. We were again grateful to him for the clear focus on these fascinating medicines through his precise thought for our guidance in the future.

Dr. Alva Benjamin said that he had listened to Dr. Borland's paper with very great interest as, indeed, one would expect to do. Dr. McCrae had mentioned *Arnica*: he had found *Arnica* useful not so much in the acute condition but in the so-called tired heart. Two remedies he associated with anginal conditions were *Kalmia* and *Latrodectus*. The patients were not particularly anxious and there was nothing else to indicate other remedies; and if the pain was not very severe he gave *Kalmia*, if it was

very bad and yet the patient did not show anxiety he had found *Latrodectus* extremely useful.

Dr. P. G. Quinton said that arising from the paper there was a point as to the treatment of heart conditions between the acute attacks. With a heart which was liable to the anginal attack there was a time between the acute states when something could be done for the heart and the patient and so possibly avoid further trouble. These cases were often associated with high blood pressure although as one knew there were numbers of anginal patients who had a low blood pressure and it was even more difficult to deal with them. With a high blood pressure one could expect to bring it down with a proper regime, diet, and graduated exercises and homœopathic prescribing, but if the blood pressure was low and the patient had acute attacks one was up against a difficult problem. The response was not so good, it was difficult to get the blood pressure up to a more normal level and get the patient better. With the high blood pressure case it was not often that one failed to get help from certain remedies and those he would put first and foremost were *Sulphur, Aurum* and *Lueticum.* All these old hearts with high blood pressure did well on *Lueticum.* A dose of *Lueticum* about once a month might be bad homœopathy but it did help the patients. With high blood pressure in the sulphur type of patient he had had some remarkable results by giving *Sulphur.* The question arose how to give it, was it to be given by high potency once a month or a low potency more frequently? He had experimented with all sorts of cases and found that there was no general rule. He had tried giving 30c once a day for a month, and it was remarkable how the very high cases would respond to that and by giving one daily dose they came back in a month with their blood pressure gone down 10 or 20 degrees and then one could begin to space out the doses. If there was high blood pressure associated with depression and irritability, and especially if the depression was rather of the

suicidal type, or the patient tended to feel that life was not worth living, a most valuable remedy was *Aurum*. He usually gave the 200th potency at more infrequent intervals associated with an intercurrent dose of *Lueticum*. He doubted if one ever got complete action of the metals without the use of *Lueticum* from time to time. It was the underlying remedy which one would expect to be needed in conjunction with the acids and the metals and it had to be given whether the indications were very marked or not or whether there was any past history or not of syphilitic infection or inheritance.

MR. CUTNER said that a common cause of distress was chronic abdominal shock. If a man was standing all day with a protruding abdomen and relaxed abdominal muscles, this caused a drag on the abdominal sympathetic plexuses and pericardium.

He had seen a patient who was 47 inches round the waist and 5 feet 2 inches in height, marked lordosis, splay feet and relaxed abdomen being treated for low blood pressure, fainting attacks, ? coronary disease, the first thing here was to reduce the weight, and teach posture, and breathing exercises.

In injuries to muscles in patients with "hearts", patients often said, "My heart is better", and a man such as he described would not get better unless his abdomen was pulled in. He wished medical men would pay attention to the control of the abdomen, the correct use of the diaphragm, the rudimentary physiology of breathing rhythm and the relation of the liver which was the heaviest organ in the body, to the diaphragm, the liver hung on the diaphragm, and the diaphragm hung on the pericardium, and the latter *via* the pre-trachial fascia to cervical spine, thus, if the neck was held up the diaphragm was held up, and this held up the liver, then this is flexibly locked in position by a balance of power between gluteal muscles and the abdominal wall, this is more important than any drug in these cases. If these patients corrected their posture

they would reduce mechanical factors causing and prolonging heart trouble. He could not see the value of giving drugs unless the tone of the abdominal wall, and posture was improved. The study of mechanical factors must be encouraged.

In a recent discussion at the Royal Society of Medicine some points of circulation in relation to deep and superficial veins was discussed, this question was now being studied in relation to the use of radio-opaque sclerosing solutions and in a patient lying in a horizontal position the long saphenous vein was injected with this substance and its course through the veins was watched, it went up the vein to fossa ovalis then down the deep femoral vein as far as the knee, *i.e. against* the so-called "rapid flow" of the deep veins, and remained for weeks (on valve cusps). One would expect therefore to find varicose veins in people with bad posture, particularly if they perform heavy manual work.

The circulation must be assisted by co-ordinating the rhythm of diaphragm and abdominal wall, remember abdominal veins have no valves yet it was in a deep vein surrounded by muscles that it went against the flow, when the injection was made the superficial veins went into spasm and the material went back into the deep vein and stayed there for weeks.

Returning to the question of drugs and the heart he felt that physicians should not become obsessed with giving drugs, they should look at their patients and if they had marked lordosis and a relaxed abdomen what a powerful asset to treatment if this is corrected. In shock all the blood in the body could be accommodated in the intestinal veins with ease, and remember again the abdominal veins have no valves, and supporting belts should only be used if voluntary muscle control cannot be obtained.

Mr. Cutner said that microscopical investigation of the walls of varicose veins showed that there was marked hypertrophy of the muscular layer being four or five times

as thick as the normal vein, proving that the primary fault was in the valves, and the vein wall first hypertrophied *then* gave way. These were vital points if one looked at it in the right way. He did want to bring this enormous hypertrophy of the muscular layer to members' notice as this would explain why *Arnica* helped many of these patients.

One final point, as we now know the superficial veins go into spasm immediately injection is made, we should never inject more than 1·5 c.c. of any sclerosing solution, and certainly *none at all* in certain patients who have a tendency to phlebitis. Mr. Dickson Wright reported such a case recently, when an arm and leg had to be amputated after a single injection, in such a patient.

DR. FRASER KERR wished to thank Dr. Borland for this further beautiful and very comprehensive chapter on comparative materia medica. He had on one occasion seen *Aconite* 10 *m.* give peace and comfort within five minutes. The Homœopathic physician in general practice did not see these acute heart failures so frequently as he presumed the consultant would.

He completely agreed with what Mr. Cutner had said regarding physical causes for heart failure. These are removable causes and must be dealt with if we are to succeed fully. There is a chapter on this subject in the book by Dr. A. T. Todd of Bristol *Treatment of some Chronic and "Incurable" Diseases.* Recently he had had five cases in men of this "pseudo heart failure" where the failure was really due to insufficient use of the chest for breathing. In the most flagrant there was a difference of only one half inch from extreme expansion to extreme deflation of the chest. As he reasoned this out, the heart was not being supplied with blood to pump. The heart being soft walled could only pump blood out and could not draw it to itself; being placed within the cavity of the bony walled chest this latter by its expansion acted as a suction pump and drew the blood from the veins, specially the large veins

of the abdomen. The right side of the heart has relatively flabby walls when compared with the left ventricle. In these cases the indicated remedy can do little or nothing to help if not aided by proper use of the physical apparatus of the chest as a suction pump.

DR. D. MAZEL, in supporting Mr. Cutner in his statement that posture played an important part in heart troubles, said that she had once given a paper citing five cases of angina pectoris, diagnosed as such by eminent specialists, and showing the typical signs. In every case the head of the fourth or fifth rib on the left side was twisted, when this was adjusted, there was no return of attacks; one case had been followed for over ten years.

The heart seems to react to any abnormal pressure such as that of the edge of a twisted rib or the lifting of the diaphragm through flatulence.

The pain of angina is mostly caused by the irritation of the appropriate spinal nerve which follows the inferior surface of the rib and supplies the skin of the thorax frontally and laterally. Thus it was interesting to note Dr. Borland's mention of Spigelia, for that remedy is the special one for nerve pains such as Trigeminal neuralgia, also "heart affections and neuralgia"—"Very sensitive to touch" (Boericke).

The PRESIDENT said that the discussion had been very interesting, and the end was getting more interesting than the beginning. The orthopædic side had been mentioned and the mechanical side, and he would speak again on the homœopathic and biochemical aspect. He mentioned the question of potassium because the cases he was thinking of were the type of case which had been described. If one looked up *Kali carb.* or studied the biochemistry of potassium it would be found that it was related to muscle, and in the *Materia Medica* stress was laid on the fact that under *Kali carb.* provings one did get relaxed muscles. With relaxation the muscles did not hold the bones in place. He had a patient who was attending an osteopath to get his

bones put into position. He had no criticism about that but it was no use putting bones into position unless there were muscles to hold them in position. If *Kali carb.* was given to these relaxed muscles they were strengthened. There was no use giving exercise to develop muscles unless they were also given a source of energy. He was thinking of a great many cases in which there were symptoms of heart trouble and yet the cardiograph showed no sign, yet they had suddenly collapsed and died. Most of them had been cases in which if he had known better he would have prescribed *Kali carb.*

The question of potassium was a very interesting study and the fact that in the proving of potassium there were no symptoms until there was complete collapse of the main muscle, the cardiac muscle, was of extreme importance. One could link up what had been said by the orthopædic surgeon with the biochemical approach. He did not know what Dr. McCrae meant when he said that *Digitalis* was seldom indicated, he supposed he meant that they did not run to *Digitalis* simply because a heart condition had been indicated. He had found that *Digitalis* was often indicated homœopathically and in such cases it worked very well. *Digitalis* was given by the allopath to slow the pulse rate, whereas the homœopathic indication would be if the heart beat was abnormally slow. In cases, however, in which the pulse was not markedly slow, but in which there were other symptoms present, *Digitalis* was quite a useful remedy.

There was one other point, that very often a "cardiac case" had received mass doses of *Digitalis* and he had found it a good plan in such cases to prescribe *Digitalis* in potency to antidote the effect of this mass dose.

When Dr. Quinton was speaking about remedies which he thought indicated, he mentioned *Aurum* and *Lueticum*, and when doing so turned and addressed the chair. He did not know whether Dr. Quinton was thus addressing him personally and was aware that in 1918 when he had been declared medically unfit, the diagnosis had been "Aortic

Murmur". He could produce the evidence of a negative Wassermann reaction taken at that time, and would like to inform Dr. Quinton that *Kali carb.* had been the remedy which seemed to suit the case.

Lueticum might come in as a basic drug in some cases, but he had never seen it have much effect in any case he had tried.

One must always think of the constitutional background or the general picture rather than symptoms relative to heart.

If there was a disturbed potassium metabolism, and the picture was that of *Kali carb.*, the potentized dose would not only correct the muscle tone but make possible a correct posture.

He wished to thank Dr. Quinton for reading the paper, and would ask him to convey to Dr. Borland the meeting's thanks for his paper, and to wish him good health that would allow him to be with us again in person.

—*The British Homœopathic Journal, July, 1940.*