PEPTIC ULCER

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This is a vast subject and I shall not be able to do much more than summarize present knowledge of casual factors, pathology, diagnosis and treatment. My chief aim is to plead for more medical treatment and therein I give an honoured place to the homœopathic remedy which I consider to be of paramount importance even if surgery is often necessary.

One need not emphasize to an audience of homœopathic doctors the importance of a full and careful history in the investigation of a dyspepsia. Details of the patient's curriculum vitæ often throw much light on environmental factors in the breakdown and also on the victim's reaction. We all know the predisposed types: those inwardly worrying, conscientious folk who appear to be tackling a big job successfully, but at a price. They may be plagued by restless driving ambition, often there is disharmony in their personal relationships: someone with whom the patient can't get on yet must conciliate, like a difficult boss, business partner, or wife, or mother-in-law. Financial worry is another big factor leading to many secondary frustrations.

Behind all this tension very often is tobacco; taken for its initial soothing effect and also perhaps to make the patient feel more at one with his fellows (the herd instinct), but leading to greater vagal irritability and vaso-constriction and I think making ulcers more difficult to heal.

While the classical duodenal type does occur frequently: the lean restless impatient individual with lined face and deep naso-labial folds—it is important to remember that peptic ulcer afflicts all types and all ages from infancy to old age. I have seen boys whose ulcers started at 7, 9, 11, and quite a few at puberty. I don't remember any girls starting so young, but peptic ulcers in young women are nowadays quite common, e.g. Mrs. B., aged 25, who couldn't stand her mother-in-law,

and who smoked cigarettes heavily. She relapsed twice after medical treatment with rest in hospital, and at operation there was found a deep chronic duodenal ulcer.

The fattest patient I remember with a duodenal ulcer weighed 17 stone and I have several heavyweights with proved ulcers under treatment now. In fact almost any ordinary citizen can develop a peptic ulcer, given enough environmental stress and some innate predisposition, and the disease is a very common one today. Even in such a small hospital as Glasgow Homœopathic Hospital with only 30 adult beds, we have had 229 cases of peptic ulcer since 1945 and seldom are without one or two cases in the wards.

Regarding pathology, the two big factors are: the acidity of the gastric juice, and the integrity of the mucous membrane of stomach and duodenum.

Oesophageal, gastric, duodenal, jejunal, and Meckel's diverticulum ulcers all have in common the presence of HCl in gastric juice, more or less concentrated. In duodenal ulcers the gastric juice is usually abundant and of high acidity, less so in gastric ulcers. But the two conditions have so many points in common that there is every reason for regarding them as variants of one disease while admitting differences in extremes of classical type of affected, geographical incidence, social class, etc.

Moreover, gastric and duodenal ulcers are quite frequently found together or following each other, the gastric ulcers usually secondary to the duodenal. It is doubtful whether simple non-maligant peptic ulcer ever develops in complete achlorhydria. Some cases without acid in the first test meal can develop abundant acid after two weeks treatment of gastritis—the thick mucus being washed away with hydrogen peroxide in daily lavage.

The secretion of acid is a complicated business into which I am not competent to go very deeply, but there are several things we should know. The parietal oxyntic acid-secreting cells in the fundic glands secrete when stimulated a fairly constant strength of hydrochloric acid (about 0.5 per cent.). This is a remarkably

corrosive fluid for a natural secretion. The total number of acid bearing cells varies from person to person and gastric acidity appears to depend on how many parietal cells are brought into action at one time.

People endowed with a very large number of acid secreting cells (and this may be a family tendency) will be more likely to have a high degree of acidity in the gastric juice. Illingworth states that the proportion of total parietal cells engaged actively in secreting acid also varies from time to time, e.g. 20-30 per cent. in resting conditions, 70 per cent. or more after food, and possibly nearly 100 per cent. after large doses of histamine.

The cells secrete acid firstly from nervous stimuli down the vagus nerve liberating acetyl choline which acts via histamine. This is the appetite juice caused by taste or smell of food or chemically by hypoglycæmia. Pavlov who pioneered the nervous factor in acid secretion observed that wolves in Russia when starving in winter developed a higher gastric acidity enabling them to eat bark, and recent work on rats has also shown an increase of acid under conditions of fear. May not fear increase similarly human gastric acid?

Secondly comes the gastric or humoral phase. Many foods contain secretagogues and all food coming in contact with the pyloric antrum of the stomach activates, it is thought, the secretion of a hypothetical hormone, gastrin: Secretagogues and gastrin acting through the blood stream stimulate the oxyntic cells, again probably via histamine. The pyloric antrum can also, it seems, influence acid secretion even when excluded from the food passage, and greatly increase it when transplanted into the colon, showing that the faeces contain either a powerful secretagogue or some substance which stimulates the antral mucosa to produce its hormone.

Thirdly there is the intestinal phase of gastric secretion about which little seems to be known. Some foods when they reach the small intestine stimulate the flow of gastric juice, probably by a humoral mechanism.

Dragstedt, working with dogs in 1951, estimated that the nervous and gastric phases each accounted for 45 per cent. and

the intestinal phase for 10 per cent. of the gastric acid, but the proportions in humans are, I believe, unknown.

Kay's work in the Western Infirmary, Glasgow, using large doses of histamine while protecting the patient by anti-histamine drugs, to bring all the acid secreting cells simultaneously into action, has shown that in duodenal ulcer subjects the response to maximum stimulation is much greater than usual. This suggests an actual increase in the total population of parietal cells and hence a constitutional predisposition to high acidity.

It is obvious that histamine has a great deal to do with acid secretion but attempts to restrain its gastric action by anti-histaminics fail in peptic ulcer.

Recent work by Irvine, Duthie and others shows that efficient histamine destruction by the liver may be necessary to protect the gastric mucosa from continuous stimulation by histamine absorbed from the bowel (hence possibly the alimentary bleeding tendency in cirrhosis). (*Lancet*, 23/5/59).

The acid factor must then rank high, but there are others. Increased susceptibility to nervous stimuli leading to vasomotor congestion of the gastric or duodenal mucous membrane; motility disorders, reversed peristalsis, may all play a part.

Hurst stressed the infective factor and vascular irregularities. He postulated Infective minute emboli or thrombosis of small vessels in the mucous membrane.

Miller observed a tendency to spasm alternating with atony of arterioles, in the lips and mucous membrane of ulcer subjects. It would seem that such vasospasm could be increased by cold, emotions and infections, all known factors in peptic ulcer.

Recently Barclay and Bentley have shown a direct arterio-venous shunt mechanism in the gastric mucosa which can blanch the mucous membrane.

Most authorities explain the fluctuating pain in peptic ulcer by variations in local inflammation and congestion. Acid *per se* is not the cause.

Jacques Spira holds that it is the mixture of bile salts with gastric HCl that damages the mucous membrane. He states that regurgitation of bile is caused by fat in the stomach, and claims good results simply by eliminating fat from the diet and

giving small doses of alkali. This emphasizes the importance of deranged gastric motility and would explain phylorospasm as a protective reflex leading to dealy in emptying but to further damage of the gastric mucous membrane by the acid-bile-salt mixture acting much longer than normal. Spira explains the predilection for ulcers to affect the lesser curvature of stomach and corresponding area of duodenum by the fact that the food bolus travelling forward along the greater curvature is joined by regurgitated bile as it circles back along the lesser curvature.

Although it has not apparently been officially blessed by the authorities I must say Spira's theory appeals to me and for many years I have told ulcer patients to avoid greasy and fatty foods. But oilve oil I think should not be included in this restriction. It seems to have a beneficial effect on those who can take it and is said to act by causing the production of a hormone, enterogastrone, when it enters the duodenum. The hormone inhibits the flow of acid.

It is reasonable to restrict coffee, strong alcohol, curries, highly spiced foods and coarse irritants as damaging to the mucous membrane, but provided food is chewed to a fine pulp there seems to be no harm in a generous ordinary diet.

There are many other factors in the ætiology of peptic ulceration—for instance the endocrine one. Biggart and Willis (*Lancet*, 28/11/59) found the parathyroids to be abnormal more frequently in male duodenal ulcer patients and the adrenal glands five times more commonly involved in peptic ulcer. They link the adrenal changes with emotional stress and mention also the occurrence of gastric hypersecretion and peptic ulceration in Cushing's syndrome and following steroid therapy.

Alvarez in his fascinating book gives many instances of the effects of emotion on digestive processes, e.g. "blushing" inside stomach or sigmoid, and cessation of all gastric movement and digestion for as long as six hours after a meal and the colon filling with gas from emotional causes. He also suggests that various secretions, e.g. those into the duodenum can be arrested by excitement while gastric acid continues to flow not now buffered by the alkaline juices, and he gives instances of

recurrence of hæmorrhage from the stomach following anger or worry. In Alvarez's opinion some people can't switch off their mental activity at bed-time and this leads to gastric hypersecretion from stimuli down the vagi. Every practising doctor knows the importance of those nervous factors but we have now to deal with the results, which can persist for a long time after the victim is "storm free" and can themselves, in the shape of painful ulcers, keep up nervous tension and anxiety.

ACUTE PEPTIC ULCER

We think of peptic ulcer as the chronic relapsing variety but acute ulcers must first be considered as the precursors of the chronic type, and because they occasionally cause tragedies in their own right. Acute peptic ulcers can occur anywhere exposed to peptic juice. They have been produced experimentally in many ways: by injection of gastric mucous membrane extracts (Bolton's gastro-toxic serum) by injections of streptococci (Rosenow), by injecting typhoid vaccine, by merely raising the acidity of the gastric juice.

They are well known to occur clinically during burns ; (less so nowadays probably because sepsis is less) ; various toxæmias even in infants ; during severe stress ; from A.C.T.H. and cortisone ; and, very important, from various forms of aspirin. Aspirin is responsible for many cases of quite severe bleeding. We had a young woman in G. H. Hospital recently who required a transfusion for bleeding after taking aspirin. And these cases are now quite common. Apart from the irritation of the aspirin there is usually some general toxæmia, influenza, headache, etc. for which the drug was taken and which may predispose to the formation of an ulcer.

The majority of acute ulcers, however, just appear out of the blue in a patient apparently well and may be symptomless ; or may perforate or bleed. Most acute ulcers are multiple, develop and heal quickly, but a few go on to a subacute stage and then become chronic due to some of the factors I have already mentioned.

Here is the explanation of many sudden perforations and hæmorrhages without any previous warning symptoms. These

acute ulcers would not show up with X-rays and even at autopsy might be missed. They can co-exist with chronic ulcers.

DIAGNOSIS OF CHRONIC PEPTIC ULCER

Ulcers may present atypically. Many quite chronic ones cause no symptoms beyond trivial dyspepsia, yet may bleed one day. Some patients with a posterior doudenal ulcer or large lesser curvature ulcer complain of nothing but a pain in the back: a persistent boring pain worse when tired and leading to much investigation of spine, etc., before the cause is discovered. In others the pain is unusually high, really in the chest (often præcordial) and in some it may be felt quite low in the abdomen. Most peptic ulcer patients feel chronically tired and many use the word "miserable" to describe their plight; not surprisingly they are often dubbed neurotic.

The case history is always important and may be almost diagnostic. The duodenal ulcer patient tells of the episodes of epigastric or right hypochrondriac pain lasting for a few weeks, worse when empty, relieved after food, and often waking him in the night. But pain in the morning before breakfast is not a feature of duodenal ulcer although some *Natrum carb.* cases have an empty feeling then. Heartburn, acidity, waterbrash are common and the last is especially diagnostic.

Later the picture becomes more blurred. Fullness quite soon after eating, a feeling of bursting tension, flatulence, bad tasting eructation and occasionally vomiting become more marked but there may still be the pain in the night and also day pain which is ameliorated by a little more food. Vomiting always gives great relief, and as pyloric stenosis advances it becomes the prominent symptom but it can occur quite early in some cases, especially of gastric ulcer. Nausea is not common in early cases but there is the fear to eat.

Illingworth recognizes three kinds of ulcer pain.

1. A diffuse epigastric pain, which extends to the back and is relieved by food and alkali. He regards this as a visceral pain due to hyperæmia from the acid.

2. A fingertip spot of pain in the epigastrium super-

imposed on (1), due to irritation of the parietal peritoneum; situated to the left of mid-line in gastric and to right in duodenal ulcer, sometimes with tenderness. The first two types of pain are relieved after hæmorrhage suggesting their hyperæmic cause.

3. A tension or bursting type of pain when pyloric stenosis is threatening, aggravated by coarse foods, relieved by emptying the stomach.

SIGNS OF ACTIVE ULCERATION

I lay a good deal of stress on a succussion splash in the stomach occurring two hours or more after food. Even in quite early ulcers this may be present, probably due to pylorospasm, and I think it is a valuable sign, in the absence of gross visceroptosis or ileus. In late cases with pyloric stenosis it is, of course, invariable along with visible peristaltic waves passing from left to right, and sometimes a palpable tumour at the pylorus.

Tenderness on palpation is often absent, and would not be expected in posterior ulcers.

The children with peptic ulcers had usually been diagnosed as having acidosis, or bilious attacks, and the succussion splash led me to the correct diagnosis. Acetone in a young person's urine is a very common occurrence in vomiting from any cause including acute appendicities, and acidosis is a risky diagnosis, to be made only after careful elimination of more serious causes of votmiting.

To clinch the diagnosis an X-ray by an experienced radiologist is essential. Occasionally even the expert will miss an active ulcer, but not often nowadays, and he can usually state whether the ulcer is active from the presence of spasm, local tenderness, irregular mucosal pattern in the vicinity, irritability leading to transient fleeting filling of the niche. A definite ulcer crater at times may not show up radiologically if it is filled with clot or debris, and œdema sometimes gives a smoothing out of the mucosal pattern round a gastric ulcer with quite a large filling defect which may simulate neoplasm (Dr. S. D. Scott Park, personal communication).

The history, signs and symptoms in carcinoma of stomach are usually quite different from those of peptic ulcer, but an

X-ray diagnosis of gastric ulcer or antral ulcer always leaves one a little dubious. There is no worry with doudenal ulcers as carcinoma does not occur in this site. In doubtful cases the presence of free HCl in the gastric juice is reassuring, its absence worrying; but one must remember that carcinomatous change in a gastric ulcer can occur with acid present, and a peptic ulcer with apparent achlorhydria.

Length of history is in favour of peptic ulcer but again the carcinomatous change in old ulcers may deceive. A short history and anorexia in an older person are very suspicious of carcinoma.

If the gastric ulcer is not much smaller radiologically after a month's medical treatment, and particularly if the HCl is low, one should not hesitate to advise operation. No gastric ulcer, even in a young person, should be lost sight of till really healed. I had a lesson from this tragic case—a woman of 25 whom we treated medically in Glasgow Homœopathic Hospital was anxious to get home for domestic reasons. The gastric ulcer crater was much smaller on discharge. She did not report again until too late and laparotomy revealed a carcinoma of stomach with liver involvement.

Now that fæcal occult blood can be so easily tested for by Hæmatest tablets, this test should be used freely in practice to screen suspected cases and to assess progress of ulcers. This tablet test is not very sensitive and if positive it really means something. The F.O.B. should become negative quite quickly, say in the first two weeks. A persisting positive test in the absence of piles or bleeding gums and on a meat free diet always arouses the suspicion of carcinoma. But one other common disease can cause it: cirrhosis of the liver, besides rarer medical conditions such as blood dyscrasias and pseudo xanthomatosis elasticum.

We had a woman in Glasgow Homœopathic Hospital recently who was very anæmic on admission and required a transfusion. She had quite severe dyspepsia and abdominal pain which responded to *Stannum* 30—the slow increase and diminution of the pain being typical. Barium meal was negative but the gall bladder was non-functioning. In view of the persistently positive F.O.B. tests a laparotomy was done, to reveal not gallstones

or carcinoma but cirrhosis and a big spleen which none of us could feel before operation even under anæsthesia. It is fair to add that the patient was very obese and the spleen enlarged down in the left abdomen and not across as it usually does! I am glad to say she is very well now.

I retain an old-fashioned belief in the value of the test meal as showing: the total fasting secretions, the type of acid curve: (high climbing in doudenal ulcer) blood in active ulcers or carcinoma, offensiveness in carcinoma and pyloric stenosis, especially carcinoma; much mucus in gastritis; absence of acid in cancer or gastritis. Where this lack of acid occurs a histamine test meal is required after gastric lavage for a week to get rid of excess viscid mucus in gastritis and so reveal either genuine anacidity, or the presence of acid, which may now be abundant.

TREATMENT

The surgeons, as we well know, are pessimistic about medical treatment and not too happy about surgery as the final answer either. It is a pity they don't know the value of Homœopathy either in curing the condition completely or in giving much quicker and longer lasting relief. Even when the patient must come to surgery I consider homœopathic treatment before and after operation to be of vital importance.

The types admitted to hospital are usually long standing, deep indurated ulcers, penetrating to pancreas and gall bladder or transverse colon. Illingworth probably had this type in mind when he wrote that "the long term progress of ulcer patients treated in hospital is influenced little or not at all by the medical treatment they have received". I must admit that I have frequently advised such cases to have surgery and when one sees the condition at operation one is not too ashamed of a medical failure to heal this sort of ulcer, especially when duodenal. Where the ulcer is gastric it often heals surprisingly quickly if put to rest and given medical treatment.

X-rays are reliable to show healing of a gastric but not of a duodenal ulcer, and it must also be remembered that spells of freedom from pain and bleeding occur in quiet phases of duodenal ulcers which are not really healed.

Hurst's indications for operation in peptic ulcer are valid still. These were:

1. Where a chronic ulcer does not heal after eight weeks thorough medical treatment as shown by persisting pain, tenderness and positive F.O.B. tests. Gastric ulcers particularly must not be left long unoperated owing to the possibility of carcinoma.
2. Where ulcers keep recurring in spite of medical care.
3. Hour-glass constriction of stomach; pyloric or duodenal stenosis.
4. Perforation.
5. Rarely hæmorrhage.

IN MAKING UP OUR MINDS ABOUT ADVISING SURGERY

Each case requires individualization and consideration of factors such as:

1. The type of work the patient has to do.
2. The economic status and opportunity for rest and spells off work; future prospects; is the person likely to reach a less stressful life soon? Would medical treatment get a fair chance?
3. The age of the patient. Young people don't do so well with surgery and also, as Ogilvie says, "We know that a gastrectomy well performed is good for twenty years of trouble free service; we do not know that it will last for the forty-five years it will be called on to serve a man of twenty."
4. But length of history comes in here and a deep chronic fibrosed ulcer can occur nowadays in quite a young person. If medicine fails we must give them their surgical chance. Wide extension of pain, e.g. to back, suggests a big penetrating ulcer.
5. Frequent vomiting usually means pyloric stenosis is threatening.
6. Women seem to do better with medical treatment or less radical surgery than men, and are more liable to have severe nutritional anæmia after a gastrectomy.
7. Some people obviously will not discipline themselves enough to give medical treatment a fair chance. Unfortunately this inability makes them more liable to relapse after surgery.

As to the choice of operation one can only choose a good surgeon and leave it to him. Gastro-enterostomy has gone out

of fashion because of the 23 per cent. long-term development of stomal ulcer leading to severe dyspepsias and hæmorrhages, and possibly gastro-colic fistula with persistent diarrhœa, or perforation. Vagotomy with gastrojejunostomy is said to be better. Severing the vagus fibres to the stomach blocks the nervous stimuli to acid juice but not the acid response to the hormonal or intestinal phases of digestion. Vagotomy also stills excess gastric motility. But these effects persist only for a year after the fibres are divided.

Partial gastrectomy is now the popular operation but even surgeons cavil at such a mutilation where so much work is thrown on the jejunum which might later stenose or ulcerate. In expert hands gastrectomy can give near-perfect results to date, but when things go wrong it is a bad business and the immediate mortality due to leakage from the doudenal stump, hæmorrhage, injury to the pancreas, kinks or intestinal ileus is quite considerable. It is of great importance not to operate if possible in an active phase when the ulcer and tissues around it are swollen and congested. Rest in bed for a week or two before operation with lavage, blood grouping and the indicated remedy is well worth while.

Even if well performed a gastrectomy can be followed by various disagreeable syndromes such as anastomotic ulcer, with possibly fistula; dumping syndrome, afferent loop syndrome (persistent bilious vomiting), anæmia, and nutritional failure from rapid transit of chyme through the jejunum.

In duodenal ulcer I usually encourage the surgeon to do a gastro-enterostomy only. After all, it is followed as a rule by healing of the ulcer and I rely on Homœopathy to prevent stomal ulcer. The difficulty is to get people to keep at treatment when apparently well and I must admit to some stomal ulcers from this cause.

I shall not weary you with figures but I have put the findings after a recent postal follow-up in an appendix to this paper. Of the 54 cases who had gastro-jejunostomy, 34 reported complete success from the operation, 14 moderate success, and 6 failures. This is apparently higher than the average success rate and it may be connected with the fact that I have always

stressed the importance of continuing after-care and Homœopathy for some years.

The most outstanding success is a man who is now 65 who had a severe ulcer after the first War and was finally operated on in 1926, the floor of the ulcer being in the pancreas. After a gastro-jejunostomy he rapidly gained weight and has never looked back although he is completely edentulous and refuses to wear his false teeth!

At the worst gastro-enterostomy can be followed by a gastrectomy but after the latter nothing surgical can be done except anastomosis between the two jejunal loops for the afferent loop syndrome.

So there is a lot to be said for medical treatment getting a good trial before the surgeon is called in! Hurst claimed cure in a great many cases and I think we should be quite optimistic where Homœopathy is also available.

The regime I advise for severe attacks is the usual. Rest in bed and warmth for a month ; attention to the teeth and mouth, a generous bland diet with avoidance of irritants like strong coffee, bovril, neat alcohol, tobacco, fats ; frequent milky feeds between main meals if milk is tolerated, olive oil half-an-hour before meals if it can be taken, and a drink of milk and hot water in the night if pain awakens the patient.

I have not much use for regular alkalies but would allow a little baking soda occasionally to relieve severe pain. Some people find Roter tablets suit them well, in others they do no good.

In pyloric stenosis daily aspiration of stomach contents is required and dehydration if present must be treated by generous intravenous infusions of 5 per cent. glucose and saline in proportions and amounts as advised by the biochemists even to ten pints daily. I am not very happy about giving potassium intravenously but might give it orally if the figures were very low. The blood urea should be estimated and renal failure watched for. Medical treatment insuch severe conditions is usually just a preliminary to surgery. Most ulcer cases, however, are less severe and can be treated while going about at

work and hope for a cure. These I enjoin to take relatively dry meals and liquids between meals, and always to rest for ten minutes after eating, preferably lying down. I got these two rules from Gibson Miller and find them invaluable. (Hurst showed that on lying down during digestion the full duodenal bulb emptied.)

And now to what is probably the best thing we can do for these sufferers—find the indicated homœopathic remedy for the whole individual. This will smooth out their motility disorders and nervous over stimulation better than a vagotomy, and more permanently. Even if the ulcer is too extensive and fibrosed to cure without operation the homœopathic remedy will make post-operative progress much smoother and greatly help towards a good final result.

It is obvious that we have to treat the whole man and that almost any homœopathic remedy might be indicated, especially one of the big polychrests, prescribed on the general reactions of the individual. But the pathology requires consideration too and in practice some remedies turn up oftener than others.

The best essays on digestive drugs that I have read have been Borland's published in *Homœopathy* during 1940, 1941 and early 1942. Unfortunately these are hard to come by today but we hope they may soon be reprinted. Today time permits mention of only a few remedies that have served me well.

1. *Arsenic. alb.* is often required when acute gastritis with burning pain are prominent and the 12-2 a.m. aggravation time marked. The mouth is hot with thirst for cold sips but the burning in stomach is ameliorated by warm fluids though milk does not always agree. The generals: fear, restlessness and chilliness and great weakness confirm our choice. When *Arsenic* has controlled the acute phase very often the bowel nosode—

2. *Dysentery co.* does valuable work on a deeper plane. The relief from eating and vasomotor instability are marked and pylorospasm.

3. Few of us would care to treat stomachs without *Nux vomica*. The irritable, tense, impatient mentality gives the clue, and there is much reversed peristalsis and colicky pain

with difficult vomiting and defæcation, and relief from vomiting and after stool. The patient will note a close connection between his indigestion and stress, anger, worry, loss of sleep or indiscretions in diet. He wakes about 3 a.m. and lies worrying till nearly 7 a.m. when he will fall into uneasy sleep. He loves all the things he shouldn't take and after a night out will have a horrible "hangover". These people are oversensitive to everything especially pain. They are intensely chilly but feel faint in a warm room. Borland praises *Nux* for its power to revive quickly a person who, having wined and dined too well in a stuffy room, gets acute gastric distension with colic and urging to vomit and to stool, and a sensation of extreme faintness. In these circumstances *Nux* will restore peace very quickly and perhaps prevent a catastrophe. The *Nux* indigestion and distension is usually worse two or three hours after eating but the face flushes during a meal and sleepiness often comes on soon after. *Nux vomica* when well indicated will carry a patient a long way and may be repeated as required.

Here is a letter from a doctor friend dated January 12th, 1960. "Regarding remedies which helped me most for peptic ulcer: *Sepia* did help but the next remedy you prescribed, *Nux vomica* 30, was really the only one which proved to hit a 'bull's eye'. I have scarcely had any pain or even discomfort for four years and three months and that after some 35 years of pain almost every day. The ulcer was confirmed by radiological examination."

4. The *Sulphur* case has an excellent appetite and is usually cheerful in spite of his pain. He will feel the gnawing emptiness in the forenoon especially, heartburn will be prominent, and often early morning diarrhœa. A history of an itchy skin eruption of some sort is common.

5. *Lycopodium* comes in very often, particularly in Scotland, because of our starchy diet. In fact, I think it is the commonest remedy I use for duodenal ulcer. I am chary of starting it too high and prefer not to give it during a spell of acute congestion in the ulcer which *Nux vomica* or *Chelidonium* or *China* or *Carbo veg.* or *Arsenic* might smooth over more

safely. *Lycopodium* cases have tremendous flatulence and feel the distension affecting the whole body even to the head. Pylorospasm is obvious and stenosis threatening. The focal pain, an acute burning is well to the right and extends through to the right inferior scapula like a gallstone pain. There is much waterbrash, sourness, hiccup and hunger, also "hungry headaches." Though hungry they feel full after a few mouthfuls and then eructations begin. The flatulent pains affect the abdomen also, in knots which the patient rubs, and there is constipation with painful anal spasm like *Nux.* All the symptoms are worse from 4 p.m. and the stomach pains also waken at 2 a.m. like *Arsenic, Kali carb.* and *Medorrhinum.* Warmth internally comforts the pain and there is aversion to coffee and tobacco which aggravate, and to meat. The patient has usually a sweet tooth and has increased flatulence after sweets (like *Arg. nit.* which, however prefers cold drinks and is worse lying on the right side).

The *Lycopodium* appearance is often typical: anxious frown, thin sallow lined face looking older than his age, fibrillary facial twitchings, yellow teeth, arcus senilis, grey hair, full hairless abdomen, often hernia. The *Lycopodium* woman is more obese as a rule. Loss of confidence is the chief mental symptom. I have seen long relief in ulcers follow a 6 or 12c *of Lycopodium* after an initial aggravation. It is one of the remedies which often carry the patient through to a cure without the need to use other remedies. As the potency scale is ascended I find that high and highest potencies (10*m* to *cm*) do longer and deeper work till repetitions are needed very infrequently—say once a year or even less.

An example is the case of J.B., now managing director of a big firm. When I first saw him at the age of 30 in 1931 he had typical duodenal ulcer pain and also rather violent hiccups after eating, the symptoms having been present in bouts for 1½ years. X-ray in 1952 showed a chronic duodenal ulcer with an active niche close to pylorus. He has had very little else but *Lycopodium* and the last doses, in 50*m* potency, were given in December, 1956, September, 1958, and January, 1959, and after the doses an old impetigo of his chin came out for

a bit. *Lycopodium* always clears up any pain and flatulence he has without loss of a day's work.

6. *Natrum carb.* patients have a great deal of flatulence and acidity and the relief from eating is marked but short-lived. There is great emptiness in the early morning and late evening. The patient is tired, sad, weepy, jumpy and oversensitive to people, to sun, and to thunder, and can't tolerate milk. There may be herpes on lips or face, oral thrush, and a dry skin. *Nat. carb.* cured for me a woman who had rheumatoid arthritis and peptic ulcer. It was striking because the cure followed the failure of several remedies previously given and both conditions cleared up on the one remedy.

7. *Medorrhinum* has somewhat similar mentals: the patient is weepy, jumpy, hurried, forgetful and also sensitive to storms. Sweets, salt, oranges and ice are craved. This nosode of the gonococcus has helped a great many peptic ulcers for me and also gallbladder cases. It can cause quite severe aggravation with sharp pains as of pins sticking in, violent retching and vomiting, and abdominal distension. The epigastric region is very sensitive to touch. The tender hot feet sometimes draw attention to Medorrhinum.

8. *Sepia* again is similar but more irritable and sullen as though she had a chronic grudge against fate. She may weep on telling the story like *Kali carb., Medorrhinum,* and *Pulsatilla,* and she hates being cross-questioned or contradicted. The nausea is prominent, much worse from cooking smells, and associated with emptiness ; there is constipation with jelly-like mucus and a lump sensation remaining in rectum. I have found *Sepia* more useful in pregnancy sickness, visceroptosis and carcinoma than in ulcer but it might well be needed in gastric ulcer. It has helped me in bilious vomiting following gastrectomy. It is a mistake to reserve *Sepia* for females ; in spite of its strong menstrual symptomatology the remedy has helped many men, often sallow and asthenic types with a history of bed-wetting in their childhood. *Ptelea* is similar to *Sepia* but with more liver congestion ; marked aversion to meat, fats, and general relief from eating. The liver discomfort is worse lying on the left side. *Aristolochia clematis* should also

be considered. Without regards it as having the mentals of *Sepia* and the physical features of *Pulsatilla.*

9. One can't consider weepy remedies without reference to *Pulsatilla.* I have several patients with peptic ulcer, both men and women, who do very well on it. Gentle souls with dry tongues and slimy bitter taste—yet no thirst; eructation greasy and tasting of the food eaten, who can't tolerate the least fat and want their environment both external and internal as cool as possible, although they may feel chilly when sick. Like *Nux vomica* they have desires for tasty indigestible foods and the constipation is somewhat similar but the temperaments are poles apart. *Pulsatilla* people like to walk up and down quietly to relieve their gastric distension. One bright little boy with a duodenal ulcer is doing well on this remedy at present.

Anthony, aged 9½, was brought first in January, 1959, because of spells of nausea, malaise, abdominal tenderness and vomiting which had been going on for a year. Shortly before I saw him he had had diarrhœa with the vomiting and had been given an antibiotic by a pædiatrician; sprouts eaten two days previously were noticed in the vomit.

He was a bright affectionate little boy weighing only 4 stone 3 lb., and liking ice cream and cold milk and tasty foods. There was an undercurrent of anxiety and restlessness and he did not like to be alone. His mother is healthy but his father had had pulmonary tuberculosis, now healed, and is rheumatic. An elder brother is eupeptic.

During the year he has had *Dysentery co., Pulsatilla, Tub. Bov., Medorrhinum, Sulphur, Lachesis,* and in the last four months *Pulsatilla* 200, repeated three times, since when he has been very well and has gained half a stone. Vomiting stopped after the first dose of *Pulsatilla* and splashing is now seldom present. The X-ray taken a year ago showed a large but normal stomach, spasm and deformity of the duodenal cap with an almost constant spasmodic constriction round it about halfway between its base and apex—appearances most suggestive of active duodenal ulceration. The family are most impressed with the improvement in this boy's health—even examinations

don't upset him now—and I think we can be hopeful of a very good result.

On the whole I think the prognosis of peptic ulcer in children is very good, much better than in young adult life.

(To be continued)

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ERRATA

The name of the author of the article "Drug Relationship" published in July 1961 issue is Dr. B. S. Luke.
