PEPTIC ULCER

DR. THOMAS DOUGLAS ROSS, M.B., CH.B., F.F.HOM.

(Continued from page no. 414)

I would like to mention one other case where rapid relief to a long-standing marginal ulcer followed *Pulsatilla* helped by its complementary remedy *Stannum.*

Mrs. W. G., aged 52, a small bright woman weighing only 7½ stones but the mother of four large children, had had a posterior gastro-enterostomy twenty years ago for a "pretty bad" duodenal ulcer. The appendix was also removed. This cured her ulcer symptoms but for some years prior to consulting me in 1957 she had been troubled with abdominal pain of three different kinds.

1. Severe colic with distension relieved by vomiting (at fairly long intervals).
2. Low central pain worse after being up from noon onwards, relieved by resting and sometimes by eating.
3. A more recent colicky pain in the right hypochondrium extending round the right lower ribs.

There was at times distension with nausea and he occasionally wakened with abdominal pain which forced her to get up and walk about. The pain came on slowly and departed gradually and was relieved by doubling up and by pressure. The lower abdominal pain (not the colics) worried her most and it seemed to be better or worse during the whole of a monthly menstrual cycle. She easily got the sensation of fullness after eating and if she ate more than usual and then exerted, she felt faint.

Gynaecological examination was negative. There was distension of the upper abdomen with visible peristalsis, and a careful X-ray examination after a barium meal by Dr. Scott Park clearly showed a fairly large marginal ulcer, and a large tender calcified gland in the lower abdomen.

The patient wanted coolness and air, enjoyed cream, cheese

and butter, but hated other fats and was very depressed and upset before each menstrual period.

She improved at once after *Pulsatilla* 30 as to the nausea and upper abdominal pain, but the colics became severe and frequent until I gave her *Stannum* 30, since when they have hardly troubled her at all. It was necessary to give the *Stannum* fairly frequently at first—every time there was an attack.

Thereafter she has kept very well on doses of *Pulsatilla* 10*m* at long intervals given when nausea and distension begins. The last doses were in May and then December, 1959. Variability has been a feature, no two menstrual periods alike—and she is a classical *Pulsatilla* type.

10. *Thuja* has a stomach rather like *Pulsatilla;* the symptoms suggest gastritis, with much heartburn on stooping. The patient craves chocolate and drinks too much tea and is upset by anticipation, and from eating onions. Obese hirsute pituitary types with warts and moles and greasy face.

11. *Phosphorus* has controlled quite a number of ulcers for me. The keynotes are the thirst for big cold drinks and desire for and relief from ice cream and cold things, though unlike. *Pulsatilla* the patient wants to be warmly clad. Food is vomited in mouthfuls and the patient is weak, trembly and nervous about being alone and much comforted by someone being near, and worse from the dark and thunder. Less acute cases will crave salt and tasty things and stimulants and have an aversion to sweets and tea. *Phosphorus* people bleed easily, so give it fairly low in acute gastritis where it is often indicated, or acute exacerbation of chronic ulcer.

12. Borland praises *Phosphoric acid* for dyspepsia in adolescents with brain fag, styes, students' headaches with the right pupil larger than the left, and a sensation of pressing distension anywhere in the body. There is a great deal of abdominal rumbling and acute gastric discomfort half an hour after eating with crampy pains and regurgitation of food. But in contrast with *Phosphorus, Phosphoric acid* cases want warm drinks.

13. *Carbo veg. comes* in often in association with *Phosphorus, Arsenic* and *Kali carb.,* and gives wonderful relief in

acute gastritis with burning pain and great flatulence both up and down. Eructations and flatus ameliorate greatly. The basic pathology may be œsophageal ulcer, or gastric ulcer or carcinoma. The burning comes on soon after eating and is much worse from wine, heavy iced or spicy foods to which these people are addicted. Acute distension with air hunger and collapse may occur after a dinner party and *Carbo veg.* may earn, once again, its nickname—"corpse reviver". *Carbo sulph.* is similar in more chronic cases. I think of it as a *Carbo veg.* with features of *Sulphur* and like it in alcoholics and poor arterial risks, often chesty.

14 Another friend of broken down poor risk peptic ulcer cases is *Kali carb.*—one of the very best. The cases are often complicated with bronchitis, poor myocardium, anæmia, and pyloric stenosis, hepatitis with spells of fever, and old age. The face is puffy, anxious, and irritable and there are pouches of upper eyelids and below the eyes. There is a great deal of flatulence and bloating and throbbing of the epigastrium soon after eating but an unpleasant empty feeling if long without food. *Kali carb.* patients often have much pain in the back or chest and there may be a tender spot over the mid-dorsal spine. Food sticks in the mid-œsophagus with choking and coughing. They wake about 3 a.m. and have a very bad time for two hours or so with pain and sickness. The patient is very nervous and fearful, worse if alone but irritable and very sensitive to noise or touch. Any fright is felt in the stomach and the patient puts his hand on the epigastrium in a characteristic gesture. The patient desires sugar and hates meat.

Now that we know about the importance of potassium loss in severe vomiting and its effect on the myocardium, we have a new reason for the use of this well-tried homœopathic remedy in appropriate cases of peptic ulcer. Here is a typical case; note the long action of a low potency. Mr. A. M., aged 61½, an engineer foreman, consulted me in January, 1959, because of frequent spells of stomach pain, nausea and water-brash. The pain extended downwards and into his back—where it seemed to explode, was worse 1½-2 hours after eating, and also at times almost all night. There was distension

but not usually vomiting. Pain was worse cold, noise, jar, slight exertion; ameliorated by milk. Bouts lasting two or three weeks recurred every six weeks or so. He had had his first hæmatemesis thirty years ago and thereafter attacks of melæna every two to three years; there had been one in 1958 and again shortly before I saw him.

He also had winter bronchitis with violent coughing bouts, and a recent angina of effort, with chest pains extending down the left arm, bleeding prolapsing piles and quite severe prostatism; also sharp sudden headaches behind the right eye, often waking him in the early morning. His indigestion and chest pain frequently wakened him at 2 a.m. He was liable to sudden anger and easy weeping but continued at his job as a rule and also had to cope with a good deal of worry at home.

Blood pressure on the first examination was 180/120 with regular cardiac rhythm but a ringing aortic second sound. The epigastric area was very tender. The prostate was hard but symmetrical, urine normal, the retinal arteries narrow, no obvious glaucoma. He was obviously a poor surgical risk but I did not feel very hopeful either about medical treatment of such an old ulcer in an arteriosclerotic man so liable to bleed. However, encouraged by the patient to try, I gave him *Kali carb.* 6c, six powders, with some trepidation. He had quite a severe aggravation of spasmodic abdominal pain for the first ten days after it but reported feeling very well a month later when blood pressure was 150/100 and epigastric area much less tender. He did not return till April and then reported no stomach pain but headaches of sudden onset and gradual relief for which *Pulsatilla* 30 was given. Blood pressure 155/110. The headaches cleared after *Pulsatilla,* but a month later stomach relapsed and I repeated *Kali carb* 6c. Thereafter he kept very well all summer and did not require another dose of *Kali carb* 6 till November 6th. Splashing in the stomach over three hours after food was present on the February consultation but not thereafter. The urinary frequency and slow stream persists but within the limits of his cardiovascular degeneration he has improved enormously under spaced doses of quite a low potency of *Kali carb.,* and has lost practically no working time

in the year he has been under treatment which is a record for him.

15. *Kali bichromate* is similar to *Kali carb.* in many respects and is well suited to the pathology of acute gastric ulcers and gastritis, and œsophageal ulcer. The sharp substernal pain extending to the back and stomach pain which can be covered by a finger point are keynotes. The pain is burning, worse 2-3 hours after eating and at 2 a.m and accompanied by vomiting of very ropy mucus. In beer drinkers' gastritis it also helps the fullness and heaviness that come soon after eating; there is no appetite but faintness and nausea if long without food. If there is also viscid greenish nasal catarrh with crusting, migraine headaches preceded by blurred vision, and a tendency for stomach and rheumatic pains to alternate—we have a sure thing in *Kali bichromate.* (But note that *Iris versicolor* has a similar headache and burning stomach pains but here the vomitus is very acid; and *Pulsatilla* has the same alternating gastric and rheumatic symptoms.)

16. It is becoming a little difficult to decide which remedies to include in this lengthy list—there are so many we have not yet considered. But *Graphites* must not be left out in duodenal ulcer although I don't use it so often as some of those already mentioned. The *Graphites* stomach pain is a burning heavy distension, ameliorated by warm milk, eating, eructation and lying down and accompanied by congestion to the head, bitter or rotten egg tastes, and aversion from sweets, salt, meat and fish. There is constipation: big knotty stools with mucus, or offensive diarrhœa with undigested food. The *Graphites* patient is chilly and eczematous with cracks at sides of mouth and anus, blepharitis, crippled nails, and often a poor circulation to the lower limbs. The mood is sad, anxious, weepy, forgetful and notably irresolute.

17. *Petroleum* touches *Graphites* at certain points—the eczema and the need to eat frequently, but in *Petroleum* it is the nausea which is ameliorated by eating; the pain comes soon after eating hence one thinks of it more for gastric ulcer. There can be abdominal colic as severe as in *Colocynth* and violent offensive diarrhœa worse during the day. The patients are thin,

with dry rough cracked itchy skin, chilblains, offensive foot and axillary sweat, and catarrh. They are rather muddled and confused, and may have notions of duality, with occipital headache, and general tired aching. The feet are hands can burn like *Sulphur* but the patient is worse in cold and there may be a strange coldness in certain areas.

18. *Anacardium* has stomach pain like a plug or ball, passing off with gurgling; pain worse two hours after eating and ameliorated by eating again and worse from cold drinks and excitement, and with salivation. There is a strong impulse to swear or break out in some way and the patient is too timid or so situated that he can't express this frustration. This remedy has greatly helped for me several such people with duodenal ulcer. The memory is very poor in *Anacardium* cases, and writer's cramp may occur. The chief mental symptom resembles that of *Staphisagria* but the latter does not correspond so well to peptic ulcer.

19. *China* is an indispensable remedy in peptic ulcer, especially in hospital where so many come in after hæmorrhage. It is the most common remedy for severe anæmia due to blood loss with rushing in the ears, coldness and profuse sweating, and I usually find it indicated on the second or third day, after *Carbo veg.* or *Arsenic* or *Cadmium sulph.* or *Ipecacuanha* have dealt with the initial bleeding.

But *China* is also curative in more chronic states of peptic ulcer where ærophagy is extreme and the patient emaciated, with very sensitive abdomen which strangely does not mind firmer pressure. *China* cases are sensitive to everything: noise, touch, odours, tastes and have a slimy mouth with hatred of fats and desire for tasty things. There may be diarrhœa, worse after eating and at night, and the stools contain undigested food and mucus. It is obviously a remedy to consider in gastro colic fistula. The patient is depressed and may even feel suicidal and often has never properly recovered from a hæmorrhage or some severe illness.

20. *Natrum sulph.* has resemblances to *China* in the depression, slimy mouth with bitter taste, diarrhœa and liver involvement. But the *Nat. sulph.* diarrhœa is mostly first

thing in the morning and the patient is sensitive to heat and to damp, and to light, and better when moving about. This valuable remedy is more often needed in cholecystitis and septic appendicitis with abscess extending up to liver, but it has also the stomach pain relieved by eating.

21. *Natrum mur.* is so frequently needed for all sorts of ills that it must not be forgotten in peptic ulcer. In addition to the well-known general indications, the mapped tongue, dry lips and mouth, forenoon sinking hunger, cravings for salt, fish and milk and sensation of a lump in throat or stomach are prominent. Borland praises it for gastric ulcer and states he has not found it indicated in duodenal cases. But just to show that one can't exclude it in duodenal ulcer let me quote this case of J.R. where a duodenal ulcer has been cured with *Natrum mur.* as the principal remedy. It was quite a bad ulcer with severe pylorospasm and gave me a good deal of worry at first.

J.R., a boy of nearly 14, was brought to me in February, 1947, with a story of attacks of upper abdominal pain and vomiting since age 11 when he went away to school, where he had to eat badly cooked food. Acetone was found in the urine and the condition diagnosed as acidosis but he got no better, in fact steadily worse, and was only 5½ stone when first I saw him. The boy was nervous, weepy and rather spoiled and noticed his stomach pain to be worse in warm weather. He had a desire for salt and meaty things and an aversion from fat and eggs and appetite generally was very poor. Although chilly he hated to wear a coat or underwear. I noticed visible gastric peristalsis and X-ray after a barium meal revealed a duodenal ulcer with slight ileus.

My first prescription was *Natrum mur.* 30, after which he was worse for a month with quite projectile vomiting every second or third day requiring *Pulsatilla* 30 to palliate. Thereafter I gave at intervals of one to three months *Dysentery co., Lycopodium,* and *Sepia* and *Sulphur* and *Tub. bov.* He responded well to *Sepia* and *Sulphur,* but got much deeper and longer relief from *Natrum mur.,* to which I always returned from time to time. He had a long run of relief from repeated

doses of *Argentum nit.* and again from *Sulphur* but since 1954 when I gave *Natrum mur.* 30 in the plus method for a week on two occasions he has had no serious stomach trouble at all. An X-ray in 1957 showed a scarred narrow duodenum but no delay and no signs of activity. I gave him *Natrum mur.* 1m in 1957 and he has required nothing since and says he eats anything now.

Admittedly other remedies were needed but I think *Natrum mur.* deserves the main credit. Although this patient had a proved duodenal ulcer with night pain and relief from alkalies, his symptoms were rather more like those of gastric ulcer than usual. I gave him *Natrum sulph.* once only, 1956 for headaches after a car accident, but his stomach was well by this time.

I have another case of duodenal ulcer in a woman of 45 proved by X-ray, where diarrhœa and loss of flesh were prominent symptoms, also breaking backache. She got much better and rapidly gained weight after *Natrum mur.* 30.

22. Finally *Ornithogalum* whose pathogenesy closely resembles the picture of pyloric stenosis with extension of the stomach pain to back and down arms, worse at night and better from warm drinks. There are sensations of tense pressure throughout the whole body, and a creepy tingling in the lower limbs with œdema. I have never been able to convince myself that *Ornithogalum* did much good in extreme pyloric stenosis either in tincture or potency, but others have praised it. I would prefer surgery in stenosis from ulcer. The remedy, however, should be considered as a palliative in inoperable carcinoma along with *Carbo veg., Arsenic, Cadmium,* etc. And I have recently had two very good results from the *Ornithogalum* 200 in men with attacks of acute distension. Neither had any X'ray sign of duodenal ulcer, but one had an operation for Meckel's diverticulum and the other had had the duodenum opened for an impacted gallstone. The former case also had unexplained œdema in attacks.

It remains to thank you, Mr. Chairman, Ladies and Gentlemen for your patient reception of this long paper. If it engenders a more hopeful attitude and encourages some to try harder

to cure peptic ulcers medically I shall be happy. I regret that I could deal with so few drugs and these not fully. The resources of our homœopathic materia medica are far richer than I have been able to indicate in the time. The treatment of ulcers medically is admittedly a long diffcult business requiring usually quite a few remedies and a good deal of skill and experience, but that makes it all the more interesting.

REFERENCES

Hurst and Stewart, *Gastric and Duodenal Ulcer* (1929), Oxford Medical Publications.

J-Jaques Spira, *The Causation of Chronic Gastric and Duodenal Ulcers* (a new theory, 1931). Oxford Medical Publications.

Ibid., Gastro-Duodenal Ulcer (1956), Oxford Medical Publicaions.

Walter C. Alvarez, *Nervousness, Indigestion and Pain*, Heinemann; 1943.

C. F. W. Illingworth, *Peptic Ulcer* (1953), E. & S. Livingstone Ltd.

Sir H. Ogilvie, *Surgical Judgement* from *No Miracles Among Friends*, Max Parrish, 1959.

D. Borland, "Digestive Drugs", *Homœopathy*, 1940, 1941, and 1942.

APPENDIX

A postal follow-up of cases of peptic ulcer admitted to Glasgow Homœopathic Hospital since 1945 shows the following figures.

Duodenal ulcer	males 135	Total peptic ulcers 229.
	females 63	
Gastric ulcer	males 13	
	females 18	

Of these duodenal ulcers 65 males and 25 females underwent gastro-jejunostomy and 12 males and 4 females gastrectomy.

Of the totals there were 20 cases of hæmorrhage and 5 of the gastric ulcers were malignant.

120 patients replied to a postal questionary and 109 patients could not be traced. Some who were quite old at the time of operation or hospital treatment were known to have died, others had left the area. Of the 120 who replied 103 were duodenal and 17 gasric ulcers.

Duodenal Ulcer. Of 54 gastro-jejunostomies, 34 reported complete success from the operation, 14 moderate success, and 6 faliure. Of 9 gastrectomies, 6 reported complete success, 1 moderate success, and 2 failure. Of 41 treated medically, 14 reported complete success, 14 moderate success, and 13 failure.

Gastric Ulcer. Two females had gastro-enterostomy with moderate success, 3 males and 3 females had gastrectomy, 5 with complete success, 1 failure, 9 were treated medically; 5 with complete and 1 with moderate success; 3 failures.

DISCUSSION

Dr. L. R. Twentyman, in opening the discussion, said it was always a very great pleasure when Dr. Ross came "south of the Border and was able to deliver to them the fruits of his experience and wisdom, with a soundness and earnestness which made an excellent basis for a discussion.

There had recently been published a very interesting text-book of medicine, edited by Garland and Phillips, the first text-book of medicine published for students and general doctors which aimed at cutting through the old text-book pattern, and included the psychological and social aspect. Reading the sections having to do with this particular subject, one could not help feeling the inadequacy of the present position. The introduction to the study of stomachs, duodenums, and the alimentary tract pointed out that in regard to the human digestion practically nothing was known. Practically everything in the courses on physiology referred to experiments on animals—things which had not been proved or verified in the human. Almost every detail of the human digestion was wrapped in total uncertainty, and the theories put forward to account for any details were untenable. It was an interesting fact that gastric and duodenal ulcers were unknown in animals, except under extreme experimental conditions. They were an exclusively human phenomenon. Nobody knew why they did not occur in animals.

Another fact which might be a clue to the ætiology was that after the first world war, when people had been subjected

to extreme and ghastly experiences, there was a flood of gastric and duodenal ulcers. Might not today, at the back of many of these ulcers be the undigested experiences of modern life—the colossal amount of impacts on people which they do not have time to digest. We gobbled our food and did not sit down to digest it, or lie down for the ten minutes Dr. Ross mentioned. It was eaten under the most unæsthetic conditions in coffee houses, cafes, and help-yourself bars, rushed down and no time taken to digest it. But there was also impact after impact from the newspapers and the rest of modern life, none of which was ever digested, but simply taken in as a poison into the human organism.

The great increase in peptic ulceration in this century was not confined to a certain type of person, angry, aggressive, or anxious—these things happened to quite differing types of people. In a long-term follow-up of people with high acid curves there was no greater incidence 20 years later of those who developed ulcers than would be expected in any other section of the population. It might be that it was not nearly so much the type of person, or amount of acid, as how much courage a person had in facing life and overcoming the bitterness of modern life with all its shocks and fears.

The problem of peptic ulcers was claimed as one of the great unsolved problems of modern medicine. Incidentally their orthodox colleagues never mentioned what were the great solved problems of modern medicine. Acute epidemic disease and tuberculosis were vanishing in the course of nature, but was it a fact that anybody had solved them? In the health of the nation peptic ulcers were one of the largest causes of ill health, misery, and distress today.

Turning to the homœopathic side, Dr. Twentyman said that in listening to the remedies given by Dr. Ross, he felt all he had to say was eminently sound and in the line with his own experience. The vast majority of his remedies were remedies known to act very strongly on the liver. It would seem that apart from all those factors of hyper-secretion and the rest, there was the problem of the liver, and he thought the experience with these remedies would go to prove that hypothesis.

Whether duodenal and gastric ulcers constituted two different diseases was another most fascinating subject which would be worth while studying more from the homœopathic angle. He did not know whether he was just trying to "play" one of the things which interested him when he said that the remedies which acted largely on the duodenal cases were right-sided and the remedies which acted on gastric cases were left-sided remedies. That, too, might be inquired into.

Most of the research at present went into the cause of peptic ulcers, or the cause of other diseases. It would be most interesting to know what prevented every stomach and every duodenum getting ulcerated, to know what the defences were against the acid digestive juices, and what, in the normal person, continually prevented ulceration taking place. What was behind the production of mucus in the stomach, what determined its amount and quality?

He again thanked Dr. Ross for the enormous pains he had taken in the preparation of his paper and he hoped by drawing attention to this problem it would encourage the profession to attack it more vigorously, and to develop the science of Homœopathy, which would help the patients and save them from the, statistically at any rate, unsatisfactory solution of surgery. Admittedly surgery was useful at times, but the experts were swinging against it.

Dr. Ross thanked Dr. Twentyman for his kind words. His theories and ideas about origins were most interesting; he was sure the psychosomatic angle was the right one. But they had to deal with the results further on, and the presence of an ulcer did make a patient anxious and nervous. There was one part of his paper which he had not read which was relevant to Dr. Twentyman's remarks about the role of the liver. Therein it was suggested that the liver might in health have a function in destroying excess histamine absorbed from the bowel.

The secretion of mucin was the natural protection for the gastric mucous membrane and in gastritis this was deficient.

A gastric ulcer was almost always secondary to a duode-

nal ulcer, because the food stayed longer in the stomach, with accumulating acid which eroded the mucous membrane.

Dr. Foubister said he would also like to thank Dr. Ross for coming and giving them of his vast experience. Regarding the general management of the patient, some years ago in the Royal Infirmary in Edinburgh a number of men with peptic ulcers were admitted and fed on beer, fish and chips, and everything that was "wrong", but they were all rested and the results were excellent.

Smoking was generally bad, but it was well worth while, if it was impossible to get a patient to stop smoking altogether, to forbid smoking before breakfast.

He wished to ask Dr. Ross what he thought about the use of aluminium cooking utensils, as aluminium had a very definite effect on the alimentary tract.

Regarding the question of acetonuria, about half the children who suffered from the periodic syndrome were found to be tense, nervous children, who responded to *Dysentery co.* and one wondered, if the symptoms were not the result of a pyolorospasm rather than actual ulceration as Dr. Ross suggested.

The older homœopaths used to use low potencies of pathological homœopathic remedies such as *Uranium nitrate* and *Ornithogalum.* These remedies obviously had some place in the treatment of peptic ulceration and it would be interesting to hear what Dr. Ross had to say about such remedies.

Regarding nosodes, *Dysentery co.* was often useful, as Dr. Ross said, for the arsenical type of patient, when "mental tension" was the keynote.

Ulceration affected the gut, and dysentery was often followed by duodenum ulceration. He wondered what Dr. Ross thought of the bowel nosodes in peptic ulceration.

Another nosode which might be important was *Diphtherinum.* The late Dr. Watts of Edgware was very keen on the use of *Diphtherinum,* almost as a universal remedy in cases not doing well; and Dr. Illingworth-Law said he used *Diphtherinum* as an inter-current remedy in pathological states in regions supplied by the vagus and other nerves coming from the tractus solitarius.

Dr. Foubister recalled the case of a policeman invalided out of the army on account of duodenal ulceration at the beginning of the last war. He was performing a policeman's duties during the blitz and attended the Out-Patients Department of the R.L.H.H. The symptoms appeared to call for *Graphites* which helped to some extent, but he kept on relapsing. The only childish illness from which he suffered was diphtheria which he had badly. Radiologically there was evidence of commencing duodenal stenosis. *Diphtherinum* 200 was given. It had to be repeated six months later, and eighteen months later the radiologist reported normal findings. He had seen this man since the war and he had had no recurrence of indigestion.

Another nosode which might be worthy of greater consideration in peptic ulceration was *Influenzinum,* especially as peptic ulceration was a feature of "gastric flu" and influenza was such a common and often serious illness.

Dr. Ross agreed that often patients did well on a ridiculous diet; probably the mental relief from strict dieting had a lot to do with it.

Regarding the question of aluminium cooking utensils, he was not quite happy about aluminium, and if patients could afford it he would rather get them to do without aluminium. In chronic cases the odd symptom of *Alumina* turned up far too frequently to be ignored.

As to the periodic syndrome cases, in his experience they were often rather cheating. Two of the boys mentioned in his paper had deceived quite an eminent pædiatrician.

He had found splashing very reliable—more so than the books admitted. It was very common not only in pyloric stenosis but also in early cases of ulceration. It was necessary to be sure there was not a hot-water bottle next the patient when testing for splash!

Regarding pathological remedies, he did not use them at all. He agreed with Dr. Twentyman that the causes of ulcer were way back in the brain somewhere, and the remedies, fundamentally, should be those covering the whole person. He agreed there was a place for a low potency remedy in acute

cases, but he was very pleased with *Ornithogalum* 200 and preferred it to the tincture.

Regarding bowel nosodes, he agreed with Dr. Foubister as to their value, especially *Dysentery co.* and *Morgan* (Bach.). He was grateful for Dr. Foubister's suggestions of *Diphtherinum*, which could affect the vagus, and *Influenzinum.*

Dr. McCready said first he would like to thank Dr. Ross for his very erudite paper.

Concerning diagnosis, he did not know if it was just a diagnostic point, but some years ago a man of about 50 came to him complaining of symptoms very much suggesting duodenal ulcer, but it was quite impossible to confirm this. Before coming to him the man had seen an eminent radiologist who took a lot of pictures, but nothing confirmed this. It was decided he was a neurotic. He was treated for two or three months successfully, but then slowly began to get worse. More X-rays were taken, but they were very doubtful. In the end, very reluctantly, the surgeon was called in. He was reluctant to operate, but as the man was getting worse the surgeon was pressed to open him up and discovered a very advanced duodenal ulcer, which turned out to be a bad bleeding ulcer, which indicated that X-rays sometimes could be completely uninformative.

On the subject of ætiology, when he was a medical student a man had come in who had a perforated gastric ulcer, and between bouts of hideous pain he tried to be as helpful as possible. He confessed it might be helpful if it was known he was a heavy drinker and when asked how much he drank he said, "Never less than 30 pints a day". That sounded rather exaggerated, but on consulting the Senior Pathologist he said that was a reasonable amount because brewers' draymen before the war had competitions as to how much they could drink and he knew a man who had drunk 49 pints a day.

Dr. Nicholson asked if he might mention two cases which had interested him recently. Dr. Ross had mentioned the need to be careful with *Phosphorus*, because phosphorus patients tended to bleed. He thought Dr. Ross would be interested to hear of a case treated with a single dose of *Phosphorus* while he

was still bleeding. As this was in an orthodox hospital he was able to give only one dose. The patient was very shocked and had lost a lot of blood and was very sick. A few hours after a dose of *Phosphorus* 12 there was an amazing improvement; the patient never looked back and had no more symptoms. A blood transfusion planned for the evening was not given for technical reasons, which was possibly a good thing. Anæmia was treated later with ordinary iron.

The second case concerned *Ornithogalum*. Traditionlly, this remedy was given in the unit doses of mother tincture, following the teaching of Dr. Cooper. Dr. Borland advised *high* potencies. Regarding the choice of the remedy, to avoid disappointment, certain indications should be looked for, but they were rather difficult to separate from the ordinary symptoms of pyloric spasm.

Dr. Nicholson met with this case only the previous week. The man was convalescing well from a bleeding duodenal ulcer, but got a relapse of slight vomiting and distension. The symptoms seemed to be those of pyloric spasm. He was given two doses of *Ornithogalum* 30 at an interval of 12 hours which cleared the trouble up completely. In fact he said he felt better than he had done for years, which was an interesting point, commonly seen in homœopathic treatment.

Literature about *Ornithogalum* referred to its use mainly for cancer, but it was possible that a wider scope should be found for this remedy in less serious conditions, particularly affecting the pyloric region.

Dr. McCrae asked to be allowed to pay his congratulations to Dr. Ross for his most interesting paper. As a personal exponent of duodenal and gastric ulcers he had a lot of experience in the treatment of this condition, personally as well as through other people. He said it seemed to have been his lot to attract this condition to his practice. It was often said that doctors who treated a certain condition were rather liable to develop the condition themselves. Whether that was true or not, it might be one of the reasons why he became so personally acquainted with it.

It was interesting to notice that study from the electro-

physical point of view showed that remedies for the treatment of gastric conditions fell into three rather big groups, and that in the other groups there were remarkably few remedies. Dr. Ross had mentioned about 25 medicines, and he would not go into any details of the 50 remedies he had found classified, but would like to run through them for the benefit of those who might care to study them in particular with relation to gastric conditions.

Dr. Ross said that Dr. McCrae's was a very interesting list of remedies and if a sequel could be written to this paper it would make the symposium on the treatment of ulcer much more valuable. He hoped the tremendous amount of ground Dr. McCrae had covered could be put down on paper at some time.

Dr. Foubister asked if he might add one comment to his previous remarks. Dr Ross mentioned the danger of *Lycopodium*. Some years ago Dr. Foubister had a patient with typical symptoms of *Lycopodium*. He had had a duodenal ulcer for twenty years. He was given *Lycopodium cm* and the ulcer ruptured within a week. However, he was much better after an operation. Dr. Foubister said it only needed one case of that sort to suggest that one must be careful.

The President said he would like to thank the members present for the splendid discussion, and more particularly once again to thank Dr. Ross for his delightful paper. He was sure the members would wish to join with him in a very hearty vote of thanks.

GROUP 1
Agaricus
Bovista
Ptelia
Sepia

GROUP 2
Lachesis

GROUP 4
Ignatia
Kali bichrom.
Kali carb.

GROUP 5
Collinsoni
Cuprum met.
Dioscorea villosa
Leptandra
Lycopodium
Natrum carb.
Natrum mur.
Ornithogalum
Phosphorus
Plumbum met.
Selenium
Silicea

GROUP 6
Anacardium
Antimonium tart.
Argentum nitricum
Arsen. alb.
Baptisia
Capsicum
Causticum

Graphtes
Nitric acid

GROUP 8
Carbo veg.
Chelidonium
Colocinthis
Hydrastis
Ipecacuanha
Kali sulph.
Magnesium carb.
Magnesium sulph.
Merc. cor.
Merc. dulc.
Merc. sol.
Nux vomica
Opium
Stannum
Sulphur
Triosteum perfoliatum

GROUP 10
Comocladia

GROUP 11
Chenopodium
Cina
Natrum sulph.
Naphthalum
Pœonia
Tabacum
Teliurium
Thuya

—Jourl. of the Am. Inst. of Homœopathy, Oct., '60.

HOMŒOPATHIC FUNDAMENTALS

(*Contd. From Page 444*)

pathic totality of the case) comes into conflict with a popular and well-established tendency of our modern times. How can the specialist, who might lose his valued standing before his specialty board should he become too interested in the whole patient, adjust his necessarily restricted point of view to the concept of disease as a total personal affair? He cannot; and this has led to some ridiculous situations in which the residents in a specialty hesitate to act in an emergency because they fear it would compromise their standing with their specialty boards.

—Jourl. of the Am. Inst. of Homœopathy, May-June, '60.
