THERAPEUTIC HINTS

of

DR. MAHENDRALAL SIRCAR, M.D., D.L., C.I.E.

BY

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PREFACE

The twentieth century might be hailed as the Renaissance of Homœopathy. A new spirit of appreciation of the wonders of Homœopathic treatment imbues the present age. Homœopathy as opposed to Allopathy, has come to stay all over the world. India, in particular, seems to have grown of late, more attachment to this system of curing diseases than any other prevailing in the country. Of course, many a cogent factor has contributed to this undisputed success of its widespread practice. The hidden hopes that swam in the dreams of Hahnemann, as he researched and experimented, bore a silent promise too great to be overlooked or ignored by keen culture. Many an eminent Allopath was tempted, as a matter of fact, to take to Homœopathy in consequence of its immense potentialities. Dr. Mahendralal Sircar, M.D., D.L., C.I.E. of respected memory did actually take to its practice after four years of intense study, despite the fact that he was an eminent Allopath and an M.D. of the Calcutta University. A man of great culture, endowed with the clearness of vision, he at once set upon himself the task of fulfilling that great promise, and he did fulfil it to a large extent in his life time. Every household would surely testify to that.

This little volume written in the nature of a compendium of the unique success of Dr. Sircar, seeks to explain the miracles that can be achieved by Homœopathy. The wonderful performances of Dr. Sircar, which were nothing short of miracles, prove beyond doubt the outstanding efficacy of Hahnemann's Homœopathy. And the young aspirant would do well to go through this book, if he wants to be inspired or enlightened. Any doctor who professes to be an Homœopath must have the seeing eye of a scientist and the feeling heart of a poet. And a very fine attempt has been made in this compendium to reveal this fact to the students of this highly subtle system. It is to be always borne in mind that there are only sick people and not diseases and the Homœopath who wants to treat his patient with any moment of confidence must needs be intuitively sympathetic. The sole aim of the work in view is to impress this fact on all who are interested in Homœopathy. A patient perusal of it will, no doubt, convince the reader of its purpose. And that is, I believe, an ample reward for the author as well as the publishers.

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A. N. MUKERJEE

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DR. SIRCAR'S
THERAPEUTIC HINTS

A Case of Mental Disease and Convulsions brought on by sitting in Spiritual Circles

Babu C. L. P. thought it his duty to inquire into the truth of spiritualism. He accordingly began sitting in spiritual circles in July or August, 1867, and continued to do so for some months. While in these circles he used to get convulsions or shocks in the upper and lower extremities. These gradually became more and more threatening, till after the lapse of 4 months, they settled down into a serious disorder, of which the chief symptoms were the following—

He received nervous shocks during prayer and sleep at night, and sometimes also at other hours, in the hands and legs. He felt great heat in the head. Peace of mind forsook him. He would hear distinctly voices speaking from within him in abusive and filthy language. He felt much depression of spirits. A European friend of his, who was his guide in 'spiritualism', tried to

alleviate his sufferings by mesmerism and homœopathic medicines. The benefit derived from these was considerable; but he still had troubles, which were as follows—

It seemed as if small balls coursing along the hands and legs caused the nervous shocks. These shocks were generally felt during prayer and sleep as mentioned above. He would hear voices using expressions much less disagreeable than before, and sometimes as if singing hymns.

He had, however so far recovered that he could devote his attention to serious subjects such as theology and religion, and even attempt writing on them. He continued in this state till the middle of February, 1868, after which he became bad again. One night he felt severe shocks in his right leg, and thought as if somebody told him he must be mesmerized in order to recover. He now placed himself under the treatment of the late Dr. Berigny who gave him *Nux vom. 3* to take, and advised him to get mesmerized occasionally. The medicine did him some good. The heat of head was much lessened. But the attempts of a friend at mesmerizing him made him worse. His nervousness was greatly increased. The mental disturbances and the shakings of the limbs became aggravated. One day he felt as if the nerves were being

violently torn. It seemed as if fire coursing through the body, running from his left foot to the head, burning the forehead, the eye-brows, the ears, and partially the eyes. He now became a totally changed man. He forgot his prayers and hymns, which were his delight when he was well. He was now treated by his family physician in consultation with another medical man. The medicines given were valerian, musk, opium, and bromide of potassium. These gave him some relief; but three weeks after, he had again a terrible aggravation of his disease. His troubles grew worse and worse day by day. He felt a constant desire to put an end to his life. Reading, writing, and even conversation with friends were well-nigh stopped. He was always restless. His sufferings were greater in the morning. The only time that he had any relief was the evening. His sleep was disturbed. His peace of mind was almost gone. Prejudices and superstitious beliefs which would find no place in his mind, now began to trouble him. The shocks continued, sometimes increasing, sometimes decreasing.

He consulted me in the beginning of May, 1868, but he did not remain under treatment long. He went to Monghyr for a change, taking with him medicines from some Kavirajs. But neither these, nor the company of sympathizing friends by

whom he was surrounded there, nor the beautiful natural scenery in the midst of which he resided, availed him anything to soothe his troubled spirit, and relieve the pangs and the agonies which were tormenting him. After 3 weeks' residence at Monghyr he returned to Calcutta.

From the time of his return to Calcutta to the end of August he was sometimes under native, sometimes under English treatment. During this time his disease raged fearfully. The nervous shocks convulsed him frightfully. Vicious abominable thoughts, chiefly of a lustful character, troubled him continually. Sometimes the workings of his mind were of a ludicrous, sometimes of a grave nature. Sometimes he would laugh, and sometimes cry, against his will. He experienced sensations of various kinds, creeping, warm, throbbing, shifting, running, encircling, and such like. These sensations were felt in all parts of his body. Visions and apparitions of persons living and dead troubled him greatly. All hopes of his recovery were given up. Nothing was left untried, but everything now failed to do him the slightest good. Homœopathy was again thought of, and his friends and relations resolved to give it a fair trial this time.

I visited him on the 30th August, 1868, in

company with Babu Rajendra Dutt. We found him in very bad condition. He seemed to recognize us, but did not speak to us at all. He was suffering continually from convulsive shocks. We were told that for the last fifteen days he was particularly bad. He sometimes falls down as if paralyzed. He would walk with heavy steps. He would run as if in fright. He would utter the loudest lamentations and cries, evidently in agony. He would not eat, unless forced to do so. His appearance was quite changed. Pale and emaciated, with suffering and distraction in his countenance, he was an object of the greatest commiseration. An old friend, we could not help shedding tears at his wretched condition. There was not the slightest hope of his recovery—he had not that hope himself, his friends and relations had it not (otherwise they would not have had recourse to Homœopathy!), neither had we any hope ourselves of being able to do him any good. The disease had advanced so far, and had taken such a deep root, a strong mind had been so thoroughly perverted and a robust frame had been so much shattered, that we feared to take up his case, lest the failure, that appeared to us inevitable, should jeopardize the credit of the system for which I had made so much sacrifice. For it is

a curious phenomenon for which we had often to suffer, that though it is at the last moment that Homœopathy is had recourse to, she is always blamed for the unfavourable termination which is inevitable and indeed at the prospect of which her aid is sought. These considerations did not, however, deter us from undertaking the treatment of our friend.

We gave him no medicine on the day we first visited him. We took time to study his case. On the following day we prescribed *Zinc. met. 6*, as very nearly covering his mental state and his physical disturbances. The very first dose had a most remarkable effect. The dose was given at about 8 in the morning, and at 9 sleep, which seemed to have forsaken him came over and spread balm over his troubled spirit. He had enjoyed it for about an hour or a little upwards, when he was awakened by a noise. Nevertheless, though thus disturbed, he felt considerably relieved and refreshed. In the course of two or three days, the nervous shocks were a great deal subdued. In the course of a week he could go out to a neighbouring friend. The first sign of real improvement in the mind which he perceived was, he tells us, rise of a desire to sing a hymn which was his wont in health.

After the lapse of a week from the commencement of treatment, an inflammatory blush was visible on the skin a little below the middle of the right clavicle. There was pain on pressure, and in the course of two or three days, the part became swollen. There was some feverishness associated with it, which was subdued by a few doses of *Aconite.* The swelling not subsiding, we prescribed *Hepar sulp. 6*, which brought it to a head in a day or two. We opened it and found it deep-seated, beneath the pectoralis. The wound healed in about a week. It is remarkable that the nervous shocks greatly subsided, coincident with the first appearance of the swelling, and they well-nigh disappeared after the healing up of the abscess.

Thus in the course of a month our patient was so far himself again as to be able to write long letters about his illness to his friends. Since then he was steadily improved and can now be safely pronounced to be all right. He only occasionally suffers from abnormal sensations, and from his old biliousness, but these are easily dissipated, the former by a dose or two of *Zincum*, and the latter by similar doses of *Nux vomica.* There was this thing remarkable in the treatment of this case, which we have often observed also

in the treatment of other chronic complaints, namely, that we had to intermit our remedies and we had to change their dilutions. We had to go higher and higher till we reached the 200th, and we have now descended to the 6th which we find useful again.

Remarks

This case is peculiarly interesting in many respects. In the first place, though it does not throw any light on "Spiritualism", a great topic of the day, it shows at least one thing, viz—that what is called a spiritual circle, formed by several individuals sitting round a table with the hands of each individual being in contact with those of his neighbours, and with their attention directed towards one object, is an arrangement, which whatever might be its 'spiritual' effects, does produce appreciable physical effects, more or less felt by all the members of the circle, but especially by one or two of delicate fibre and peculiar nervous susceptibility. I have known several individuals who have received shocks while sitting in the circle, and I have known a few who have suffered much in health, from continuing the experiment for sometime: and I have known one who, after long-continued illness, traceable to this cause, at last fell a victim to it. I am almost sure our friend's fate would have been the same, had it not been for the interposition of Homœopathy. Whether the circle fits any one for the reception of impressions from the spiritual world is a question which we are not in a position either to prove or disprove; but this is certain that there is transference of force probably electric, from individual

to individual till equalization is effected in the circle as a medium through which electricity or its analogue nervous force can circulate. Now in this transference of force, it must be that the individual, who has more than the mean of the whole force in the circle, shall lose, and he who has less shall gain. The effects of the loss or gain being perceptible in the shape of disturbed action of the nervous centres, manifested by loss of consciousness, delirium, hallucinations, and spasmodic action of the muscular system, these disturbances being greater or less in proportion to the greater or lesser amount of gain or loss, we believe the consequences are serious and may become disastrous, more in cases of loss, than of gain, of force.

Secondly, it places, we believe, in the most convincing light the value of Homœopathy. Here we have a case of a most grave disorder, involving both mind and body; it is treated for a good length of time with all the resources of orthodox medicine, and it becomes so bad that all hopes of recovery are extinguished, when the aid of Homœopathy is sought, and the infinitesimal dose, the laughing-stock of the dominant section of the Profession, saves the patient from the very jaws of death. The disease had not its origin in an "idea", and there was no faith to back our placebos of "plain water" and "sugar pills". The disease had got possession of the patient against his better nature, and our medicines were at first taken "unwillingly and with suspicion," till at last faith was established upon conviction forced by the remarkable efficacy of the medicines.

We cannot avoid taking this opportunity to draw attention to the especial, inestimable value of Homœopathy in mental disorders. A grand distinguishing characteristic of the

system, one which shows its founder to have been a profound observer and a genuine discoverer is, that it takes notice of the influence which drugs exert upon the functions of the mind. Homœopathy thus practically recognizes a physical basis for psychical diseases; and it has been eminently successful in their treatment.

A Case of Mental Disease

A boy was brought to me on the 25th April 1869 with the following symptoms: Costiveness, no stool for 8 days; disposed to drowsiness; has not spoken a word for 5 days. Suspecting all this was probably due to the action of opium which the boy might have taken in some shape or other I prescribed *Nux v. 6.*

26th April. Had a stool this morning and seems to be more active.

In a day or two he became all right. He remained well till the 10th May.

11th May. As bad as when he was first brought to me. The bowels were not constipated this time; but he would not utter a word. I could not satisfactorily trace the cause of the relapse. All that I could gather from the guardian was that he had been long in the sun yesterday, flying kite. I therefore prescribed *Carbo v. 30.*

13th—No change for the better. I resumed *Nux v.* which had done so much good.

15th—No better. *Camphor* three times a day.

16th—No sign of improvement. He remains quite dumb and apathetic. Great difficulty in making him eat. *Puls. 6* thrice daily.

17th—Seems more rational.

In a day or two he was all right and has continued so. Has become a voracious eater.

Remarks

This case speaks for itself. Homœopathy has proved as much a boon to the unfortunate sufferers from diseases of the mind as the non-restraint system introduced by the great Finel.

A Case of Rheumatism

10th August 1869—Babu M. Chakravarti aged 18 was under Allopathic treatment for 12 days for rheumatism. Iodide of potassium was pushed to the extent of 60 grs. a day, but without the slightest impression upon the disease. The following were the prominent symptoms when he placed himself under Homœopathic treatment: Considerable inflammatory swelling of the knee, ankle, elbow, and wrist joints, and of some of the small joints of the feet and hands, great pain,

fever, sleeplessness, obstinate constipation, and inability to move. *Bryo. 3*, ½ drop thrice daily.

11th—No change. *Lach. 6*, ½ drop thrice daily.

12th—Had one clear stool yester-afternoon, after which he felt considerably relieved. Swelling reduced to nearly half. *Lach.* only one dose.

In the evening pain and swelling much less; fever very slight; able to walk with the help of a stick.

13th—Slept well last night. Swelling and pain of right leg and left hand have disappeared. *Lach.* ¼ drop only once. Much better in the evening; pain in the left leg less; no fever.

14th—Had eaten more food than he could digest last night, in consequence of which he felt somewhat uneasy in stomach in the morning, which disappeared by evening. Had only one dose of medicine. One clear stool; slept well; no fever.

15th—Very slight pain in one toe and two fingers of the right hand. *Lach.* one dose. One stool; quite easy in the evening; no fever; slept well.

16th—Doing well. No medicine.

17th—To prevent a relapse and to complete the cure as it is called, a dose of *Sulph. 12* was

given in the morning. Unfortunately a false step was made in the afternoon in consequence of which the right foot was sprained, which swelled a little and became painful. There was slight fever in the night.

18th—*Rhus tox. 3* to be taken thrice. Rhus lotion to be applied to the painful part. By evening the pain was less, and there was no fever.

19th—Rhus twice internally; the lotion was repeated.

20th—for the slight pain remaining *Lach.* was resumed and continued till the 24th, after which he was quite well.

A Case of Infantile Convulsion

(*Reported by an L. M. S.*)

A child aged 1 year 9 months had malarious fever in the month of October 1868, in the district of Burdwan. Since then he used to have fever off and on, but he had never undergone any systematic treatment for the same except occasional exhibitions of Homœopathic remedies when the fever used to be rather severe. About a fortnight previous to the present occurrence

the fever became rather obstinate .and at this time a slight enlargement of liver was noticed. About this time he had looseness of bowels too and used to pass from 6 to 9 stools a day, the stools becoming more numerous and urgent during the night; and he was ordered to have *Arn. 6.* This was continued 3 or 4 days and the looseness and fever abated a good deal, but owing to some irregularity in diet the child had again had the fever on the 19th August 1869; the fever was rather of a continued type and he was ordered to have *Silicea 6.*

21st August—The heat of skin rather great, pulse full, has got cough—no medicine.

22nd—No abatement of symptoms, *Aconite 6.*

23rd—The fever symptoms and cough much the same but they began to increase in severity till at 4 P. M. it was observed that the skin of the child was very hot, pulse 180, tongue coated, abdomen bloated, occasional starting and tremors of the hands, lying in a state of half-drowsiness, bowels not moved since the morning. Dr. Sircar was immediately sent for and in the meantime the child had *Bell. 6.*

At 6 P. M., the child had convulsion attended with foaming at the mouth; at this time he passed a large liquid stool about 10 to 12 ozs.

Dr. Sircar arrived at 7 P. M. and found the child insensible, with full bounding pulse, hoarse breathing and congestion of the lungs; ordered *Bryon. 6* every half hour for three doses.

At 10 P. M. had another convulsion, and the child's feet were placed in warm water and cold applied to the head for about three-fourth of an hour; the fit lasted for nearly half an hour, and the child became more sensible.

24th Aug. No fever in the morning—but the fever returned at 3 P. M. with precisely the same symptoms as on the previous day without only the convulsions; hot applications to the feet and cold to the head was had recourse to, but the child remained in a state of drowsiness till 5 P. M. At 9 P. M. the Doctor called in and changed the medicine to *Bell. 30*; bowels moved twice after the exhibition of the above.

25th—No more fever, bowels moved 3 times copiously—cont. *Bell. 30.*

26th—Well. *Bell. 30* one globule.

27th—A peculiar rose-coloured eruption was observed on the face which subsided of itself.

28th—Bowels not moved for 2 days; no medicine.

29th—Bowels moved—cured.

Remarks

I have been induced to bring forward this case to the notice of the profession simply for showing what advantages Homœopathy offers in such cases. Had the parents placed the child under the treatment of an old school physician, I dare say—the child would have been half dead by the application of at least 3 or 4 blisters, mustard plasters, not to speak of the administration of very strong and powerful remedies internally. The successful treatment of such severe cases by infinitesimal doses of medicine ought at least to induce our professional brethren to give Homœopathy a fair trial.

A Case of Mental Disorder brought on by using Siddhi or Hemp leaves

Woomesh Chunder Paul, aged about 22, student, residing at Garden Reach, became perfectly insane in the course of two or three days about the end of February 1867. On enquiry it was found that he had indulged himself for several days previous to this occurrence in large doses of siddhi (hemp leaves) both by drinking it in the shape of an infusion as in usually the case with all siddhi drinkers, as well as by smoking it in pipes. The result of this (as candidly confessed by himself after his recovery) was, that he felt strong giddiness and burning sensation in head. Sleep forsook him altogether and he grew very irritable in temper. He said he had to pass several nights

without being able to close his eyes for a moment in spite of his attempt to smooth his troubled spirits by sleep.

While in this state of mind, an event occurred which at once set fire as it were to the combustibles with which his brain was full and which were well-nigh ripe for explosion. There was a piece of land close by his dwelling house which he had a great longing to possess, whenever an opportunity would offer for sale. On hearing that a neighbour of his has privately tried to purchase it, he rushed forth from his house and raised a violent quarrel both with the purchaser and the seller with unusually loud vociferations. From that very day he began to lose consciousness, reason, memory, &c. On the following day he was found in a very melancholy mood, looking steadfastly on any one who would go near him, almost without the power of speech. He remained in this state for two or three days. The next distinguishing characteristic of his disease was, that he used to give vent to loud lamentations and cries, and when questioned as to the cause of his doing so, he expressed excessive fear as if some evil spirits were coming to crush him. He used to cry out at intervals "Lo, he is coming to catch me." In the course of two

succeeding days all the symptoms of perfect madness were manifest. He became so violent and ungovernable that his relatives were compelled to tie his hands and legs in order to prevent him from doing injury to others which he had actually done in two or three instances.

In this state of affairs he was removed to Calcutta and placed under my treatment. He nearly recovered his wonted condition of mind and body under *Nux vomica*; and in the course of a fortnight he was so well that he was taken back to his house at Garden Reach, which was about the end of March 1867. He remained quietly for nearly three weeks without exhibiting any evident sign of madness, except an unusual brilliancy of his eyes and a peculiar casting of his looks. At the end of this time the disease relapsed with great virulence and assumed a fearful aspect. He was now treated by his uncle Allopathically for nearly a fortnight, during which time he was blistered and physicked and used to be beaten so severely that his constitution was at once shattered and he was reduced to a starved skeleton. So feeble and prostrated he was that he could not even drink a drop of water. His life was despaired of. In this hopeless condition my advice was again sought for. I saw him at

his residence, at Garden Reach, in the beginning of May 1867, as the patient was not then in a fit condition to be removed to Calcutta. He began to revive gradually and in a week's time was able to take light food and so far improved as to be capable of being removed to Calcutta, which was done on the 15th of May. As he grew stronger his madness returned with full force. He grew boisterous and furious. His bowels were very costive, and he had no sleep either in the night or during the day. This condition gradually yielded to *Nux v.*, *Bell.*, and *Stram.* He became milder, could sleep, and his bowels became regular. But the state of his mind took a different turn. He was listless and indifferent. He would go out in the night and would not return till searched out and brought back. A great disposition to walk, to laugh, and sing songs, was now observed. *Nux moschata*, at first in the 3rd, and lastly in the 6th dil. in the course of a few (15) days, restored him to his normal state.

A Case of Inflammatory Suppuration of the Womb

B., a respectable Hindu lady, had premature labour in the 7th month, on the 3rd September,

1869; the child had lived 48 hours. After the lochial discharge was over, a neuralgic sort of pain settled in the uterus and in the right ovarium, for which she was under my treatment for sometime. Not being satisfied with the result of the treatment, and being under the impression, that I slight her ailment, she called in an Allopathic physician under whose treatment she remained for about 3 months. All this time she was kept under morphia, chloroform, sherry, and tincture of muriate of iron, with indifferent benefit. The fact is, that under the perpetual narcosis that was induced by these drugs, the patient could not much feel the pain, and hence believed she was recovering. The disease, however, was merely suppressed, and not radically cured, as was apparent from the discontinuance of the drugs, when the pain was felt as severely as at the commencement of the treatment. The Doctor, therefore, suspected ulceration of the cervix uteri, and advised examination per vaginum by a midwife. Unfortunately the midwife recommended was an ignoramus; the examination made was very rude, and the result was the lighting up of very severe inflammation of the womb. There was considerable swelling of the organ, and extreme tenderness on the slightest touch over the supra

pubic region. There was also inflammatory fever, costiveness, and most distressing sleeplessness.

On the 31st December 1869 she agreed to be placed under Homœopathic treatment, which the husband, though an amateur, undertook himself as the patient had contracted a dislike for me. The husband treated her for a week, with *Merc.*, *China*, and *Puls.*, but without being able to do her any good. Being the family physician I was obliged to attend, and finding her very bad, took up her case against her will. This was on or about the 8th January. At first I gave her *Merc.* again but without any avail. The fever increasing I gave her *Acon. 6*, which reduced the fever, but did not in the least abate the pain or the swelling. There was copious discharge of purulent matter from the womb, there seemed to be some dislocation forwards of the organ, extreme tenderness on pressure, the gums were spongy and swollen, empty eructations, the urine was high-coloured, but no burning during micturition. All these symptoms determined me to select *Canth. 6*, and it had the most remarkable effect, which was described by the patient as that of fire being quenched by water. In the course of a month she was perfectly restored to health. Only a few doses of the medicine were given in the beginning.

Latterly I used to give her unmedicated spirit for her satisfaction. She is now one of my best advocates, and looks upon me as a father.

A Case of Threatened Abortion from Gonorrhœa

(Reported by an L. M. S.)

A young Hindu lady of robust make, aged abour 15, in her first pregnancy, in the 8th month of her gestation, was noticed to discharge blood from the vagina on the 12th March 1870; as she had menstruated three or four times since conception, this circumstance did not excite any fear. The hæmorrhage, however, did not stop as on former occasions at the end of the 3rd day; but on the contrary became rather profuse, so that on the 15th instant apprehension of speedy discharge of the foetus was excited and she was removed on the 16th March to the house of her father early in the morning in a gharry. Dr. Sircar called about 12 noon and prescribed *Sabina 6.*

17th—Passed clots of blood in the morning with pain in the uterine region. Dr. Sircar called at 10 P. M. and ordered *Secale 30.*

18th—Passed clots. Continued medicine.

19th—No improvement in the symptoms. *Pulsatilla 30.*

20th—As the symptoms did not improve, Dr. Sircar began to suspect that there must be some secret cause of all these, and on close scrutiny she confessed to be suffering also from burning in making water, with discharge of purulent matter with the urine; she was therefore ordered to have *Cannabis indica 6*.

21st—Burning much less, feels better, discharge of blood less.

22nd—No medicine; slight bleeding.

23rd—No more bleeding. From this day to the 26th she remained under treatment taking occasionally a dose of *Cannabis*. From the latter date she was able to get up and walk about.

It will not be uninteresting to bring to the notice of the reader that after the completion of the cure of the wife, the husband was discovered to be suffering from Gonorrhœa, and from his statements it appeared that he had been suffering from it before his wife got ill.

A Case of Urethritis in a Child

(*Reported by an L. M. S.*)

On the morning of the 3rd April, a child aged about 6 years was observed ill with the following symptoms—the penis was found swollen, there was thick purulent discharge from the

urethra; the child complained of difficulty in making water, not from burning but from stoppage at intervals as if from spasm. No history of specific infection could be made out.

At 10 A. M. Dr. Sircar saw the child and prescribed *Cannabis 6*, a single dose of which was given to him at about 1 P. M.

In the course of the day the symptoms began to disappear and the child was considerably better on the day following. In the course of the next day the child was all right.

A Case of Neuralgia of the Musculo-Spiral (Radial) Nerve (right)

B. N. D. was playing on the harmonium when the right bellow gave way, in consequence of which he received a sudden jerk which darted from the right foot to the right side of the head. The pain became aggravated on resuming the playing of the instrument. A variety of remedies was tried for about a month, without being of much avail in extirpating the pain. The pain was of a neuralgic character traceable to the Musculo-Spiral (Radial) nerve, coming on in paroxysms, and inflicting the most distressing sufferings upon the patient.

On the 3rd January 1870 the pain became insufferable. The patient had become irritable in temper, so as to blaspheme even God Himself (though perfectly convinced of the sin); he had become exceedingly sensitive to all impressions. He was also suffering at the time from incarcerated flatulence. All these circumstances—complaint, semilateral, and in the right side, neuralgia in a sensitive person, together with the incarcerated flatulence, led to the selection of *Cantharis*, a dose or two of which in the 6th dil, removed the pain as if by magic. The cure was permanent.

A Case of Sloughing Ulcer in the Fauces

In the latter end of January last a person presented himself with a sloughing ulcer in the left side of the fauces, which seemed to have resulted from an abscess in the tonsil of that side. I prescribed *Sil. 6*, with injunction to use *Lach. 6*, in case the first should fail to do any good. The *Sil.* was used for a few days without any abatement of the symptoms. The patient therefore used *Lach.* and from the very first day, improvement commenced, and in the course of about ten days, he was all right.

A Case of Obstinate Sinus (Syphilitic) Cured by Iris

A young man, aged about 20, placed himself under my treatment on the 20th May, 1869, for a sinus in the left groin, the result of a bubo He had syphilis, had taken mercury, and was very cachectic. I gave him *Sulph. 6.* Instead of improving he got fever, which was very severe, and reduced him much. For this reason or what I do not know, he did not ask my advice again till the 1st August next, when finding him emaciated and bed-ridden and suffering from a regular hectic, and the discharge being ichorous, I gave him *Ars. 30.* This did him but little good, the fever abating only slightly, but the discharge from the sinus continuing as before. I therefore gave him on the 6th *Sil. 6.* The *Silicea* only irritated the walls of the sinus, without doing him any positive good, gradually a swelling formed, which extended from Poupart's ligament to nearly 3 inches above. This threatening to be an abscess, I gave him *Hepar sulph. 6* on the 27th. This had the effect of causing rapid suppuration, the pus getting exit through the old sinus. The swelling became considerably reduced, but the improvement remaining stationary I put him on *Sulph. 30.* On the 3rd Oct. diarrhœa and an evening fever

developing itself (probably under the influence of *Sulph.*). I gave him on the 7th *Puls. 6.* This medicine did him some good, in causing diminution of the fever and the diarrhœa. But the improvement soon became stationary, and the discharge from the sinus was unaffected. I therefore gave him *Iris 3* on the 23rd and from the time the improvement was rapid and steady, till in the course of a fortnight from the commencement of taking the *Iris* he was quite well.

A Case of Dysentery in a Calf cured successfully by Homœopathy

A calf, 2 months old, had a very severe attack of dysentery on the 18th April 1870.

19th April—*Merc. cor. 6*, 2 drops every 3 hours.

Blood almost disappeared after the 3rd dose. Stools mucous, but much less in number.

20th—*Merc. cor* contd., 3 doses during the day. Much better.

21st—Do. 2 doses, improving.

22nd—Do. 2 doses, stools neither bloody nor mucous but thin.

23rd—*Verat. 3*, 2 drops thrice during the day. Stools much thickened in the evening.

24th—Do. 3 doses. Much better.

25th—*Verat. 3,* 1 dose, stools almost natural.

26th—Do. 1 dose, ate half a pound of bran by stealth; passed loose stools.

27th—Do. 1 dose at 7 A.M.—passed loose mucous stools streaked with blood, at 10 A.M.—*Merc. cor.* 2 doses; blood disappeared in the evening.

28th—*Merc. cor.* 1 dose at 7-30 A.M. and another at 5 P.M.; stools thin and slightly mucous; no blood.

29th—No medicine. Cured.

A Case of Advanced Phthisis

This was a very interesting and instructive case, and although the termination was in death (no other result could be expected), it proved satisfactorily how beneficial is Homœopathy even in such desperate and moribund cases.

The history was that the patient Nilmani Pakrasi, aged about 21, was suffering for six months, previous to coming under my treatment on about the 29th July, 1870, from cough and fever, and latterly from dysenteric diarrhœa. On examination I found cavities, large and small, in both lungs. The patient was much emaciated—having been exhausted both by the expectoration from the lungs which was copious. and by the

alvine discharges. The expectoration was purulent as also the alvine discharges. In fact, there was very little difference between them, and sometimes it was impossible to distinguish between them unless previously told which was which. There was also hectic fever. As he had taken large quantities of Allopathic medicines, opium, astringents, etc., I gave him *Nux. v.* This however did not produce any perceptible effect. The stools continued to be numerous, and the cry was to stop them somehow or other. Considering the condition of the lungs as well as of the intestines I prescribed *Silicea 30;* this did some good but not much. The number of stools, though somewhat diminished, was still 2 and sometimes 3 in the hour. I therefore thought of *Silicea* lower and prescribed the 12th. This had at once the most remarkable effect of considerably reducing the number of stools and changing their character. In place of pure pus there were now consistent feculent stools and from having been 48 to 60 in 24 hours, they were diminished to about 10 to 15. On the 5th of the next month, (August), the patient was a great deal better, the stools were not more than 2 or 3 in 24 hours, consistent and quite healthy-looking. His appetite became so sharp that he could eat and digest

almost the quantity he used to take in health. This return of appetite was however his ruin. The cry for food was loud, and he began to eat stealthily more food than he could digest, so that by the end of the month the same symptoms returned, diarrhœa, increase of cough, and fever. From this time forth the effect of the medicines, although very prompt, was not lasting, and he sank by the end of September. I am almost persuaded that if this patient had not committed errors of diet he would have lived much longer.

A Case of Suppurations and Pyæmia Recovery under Silicea

The patient, Babu U. C. Banerjea, aged 24, native of Sibpur, told me that in the month of Jaistha last (which commenced on the 14th May, 1870) his meals consisted chiefly of bread, rice, milk, and the jack fruit. On the 26th or 27th of that month (i.e. 8th or 9th June) a boil made its appearance in the middle of the left thigh. Three or four days after its appearance, deeming it ripe for operation, he punctured it himself with a pen-knife, when only a few drops of matter came out. Next day, as he relates, "an abscess of a severe nature was visible about the wound." This must have been on the 12th or 13th June.

After about three or four days about 6 ounces of pus came out of the wound. The mouth of wound closing in a day or two, the thigh (left) became swollen and painful, as also the left shoulder-joint and arm, and the right side of the lower belly. This was accompanied by strong fever. He took a purgative draught of senna infusion twice in the course of a week, but without any benefit to the pain or fever. He then placed himself under a Kaviraj by whom he was treated for a fortnight without benefit. He therefore came over to Calcutta in the middle of July, and placed himself under my treatment. He as well as his father-in-law (a friend of mine) had no faith in Homœopathy, still they were anxious that I should treat him, but treat him Allopathically.

I found it difficult to refuse, and undertook the treatment on condition that should I find it absolutely necessary to change, I should be allowed to do so. To this they agreed. The fever was of the remittent character, with paroxysms of aggravation in the afternoon. There was a large abscess, deep-seated, in the left thigh, occupying about the middle third of the inner side, and there was a swelling about the left shoulder-joint which threatened to become an abscess. I opened the thigh abscess about a week

after his arrival in Calcutta and "supported him," as the phrase is, with quinine, iron, and stimulants. In spite of all this, however, the fever did not abate and the swelling about the left shoulder became an abscess and had to be opened on the thoracic side of the axilla. The patient did not improve, and gradually began to fall off on account of the profuse discharges from the thigh and the axilla. After about 40 days from the commencement of treatment I found it absolutely useless to continue the old system and plainly told the father-in-law that unless he would allow me to try Homœopathy I could not persuade myself to bear the responsibility of treatment any longer. Seeing that the patient was really going worse they had no other alternative than to submit to my proposal. It was on the 27th August that I began to treat him Homœopathically. I gave him *Silicea 12*. By the 3rd of the next month (September) the fever became considerably less, though the discharge continued as before. From this time forth improvement rapidly took place, the fever and the discharge gradually became less and less, till they altogether disappeared by the 20th. At the end of the month he was quite well. He had no other medicine than Silicea and I had not to change the dilution.

Remarks

The two preceding cases have been taken at random from a large number in my case book, illustrating the remarkable control which Silicea exerts over the suppurative process. I would here notice, with the object of inviting the opinion, and stimulating the observation of my professional brethren, that I have observed one very singular peculiarity with respect to the therapeutic action of the drug which, as far as I can remember, has not come across my reading, namely, that it is more useful in open than in closed suppurations, and, in fact, my experience of the drug in these cases has not been very favourable. Generally I have found it to cause considerable irritation and consequent extension of the suppurative process. I have never, for instance, found it to open an abscess, which Hepar Sulphuris and other drugs have very often done. But the moment the matter finds an exit, either through an operation or by the natural course, it is then that the curative action of Silicea manifests itself. It has seldom failed me in open ulcers, fistulae, and sinuses, irrespective of the nature of the discharge. Some time ago I cured a very bad case of sloughing Dysentery, where the sloughs were large, gangrenous, and pus-infiltrated, and which must have left large, open ulcers on the surface of the large intestine.

A Case of Strangulated Inguinal Hernia

Babu R. G., aged about 80, is subject to descent of a hernia through the left inguinal

canal, for which he uses a truss. On the 14th November 1870, he had taken out the truss before going to the privy, and the effort at stool brought out the hernia. He could not reduce it as usual. On being sent for I found the gut had considerably descended through the inguinal canal into the scrotum so as to give it the appearance of a pretty large scrotal tumor. There was a good deal of pain and tenderness over the ring. I tried the taxis but could not use it effectively on account of the pain. I therefore prescribed the hydrate of chloral in 15 grains doses. The first dose sent the old man to sleep, so that on my return after about 3 hours I could handle the hernial tumor without inflicting much pain. I could not succeed in effecting reduction, and, afraid of causing mischief by too much meddling, I left him alone directing another dose of the chloral hydrate to repeat if necessary.

15th Nov.—Another dose of the medicine was given as directed last night, and the patient was under its influence the whole of this day, but the attempt at reduction was as fruitless as on the previous day. I therefore did not meddle much but left him alone.

16th Nov.—Still under the influence of the medicine. But could not reduce the hernia. I

therefore ordered *Nux v. 30*, ¼ drop every 4 hours. After the 2nd dose the gut went up to itself.

Remarks

It may be asked why was not the Nux v. used at first and at once? The answer is, because in the few cases I had tried it before I did not succeed in effecting reduction with it alone. I had to use opium sometimes, and sometimes opium and chloroform, in massive doses to soothe the pain, to employ the taxis with advantage. I do not say that Nux v. alone or other suitable Homœopathic remedies may not have succeeded. I merely give my own slender experience. And I do not think that the course I pursued in this case and which was attended with such happy results, is inconsistent with true Homœopathy and unworthy of being adopted by any but the most stiff-necked and bigoted Homœopaths. In cases where the nervous system is engaged in considerable irritation, removal of that irritation by a palliative is not an irrational or an unscientific procedure. On the contrary to grope about in the dark, hunting after suitable remedies while our patient is writhing under torture, and when an obvious and a known reliable palliative is at hand, is, in my humble opinion, grossly culpable.

A Case of Idiopathic Tetanus treated successfully by Hydrate of Chloral

I was called to this case on the 13th Dec. 1879 (?) when I found the patient, a young girl

of between 13 and 14, suffering severely from tetanic convulsions. The whole body was engaged in tetanic rigidity and fits were troubling her at very short intervals. The mouth could only slightly be opened. Deglutition was very difficult. The history of the case was that she had menstruated on the first of the month, on which she had complained of pain in the whole body as from cold. From the 5th to the 9th instant the pain of the body gradually increased and with it there was some cough. On the 10th pain was felt in the root of the tongue, and in consequence during deglutition. There was also inability to open the mouth. The patient had fever, some swelling and painfulness of the submaxillary sublingual glands. She was unconscious and could not recognize persons. The Doctor, who was called to treat her, had ordered a foot-bath and continual fomentations and a dose of castor oil. The bowels had moved and consciousness was restored. On the 11th convulsive fits commenced from the morning. The constant water-brash suggested the possibility of worms being at the bottom of the disease. Accordingly castor oil and santonine were ordered. No worms were passed and the fits were not diminished. Consequently tincture of hemp and chloroform

were ordered with peppermint water. The fits, in spite of this treatment, became more and more violent, and more frequent, so that on the 12th they recurred every 5—10 minutes. Hence I was called on the next day as said above. The following daily report shows the improvement that rapidly took place.

13th Dec.—Hydrate of chloral in 15 grains doses. Slept after the 1st dose. On waking it was seen that the lock-jaw had almost disappeared. The fits had become much less intense and frequent. One stool at 4 A.M.

14th Dec.—Only one dose in the morning; fits were very moderate till afternoon, when symptoms of increase of intensity being seen another dose was given, with the usual good effect. A stool at night and with it a large round worm passed.

15th Dec.—Only two doses of medicine, and she was doing very well.

16th Dec.—Pain only in the back and neck. One stool.

19th Dec.—She had no medicine since the 16th. Fits increase a little. They were observed to become worse from noon afterwards. In the evening there was a sudden violent fit with lock-jaw. Weeping mood, sudden pain in the abdo-

men, very violent. Medicine repeated at night with the usual happy results. A stool at 2-30 A.M.

20th Dec.—Much better. A stool in the evening, with which a living round worm passed.

From this time forth she made a rapid recovery, so that by the end of the month she could sit up. The only symptom which still continues is slight stiffness of the spine and neck, but this is gradually disappearing under the assiduous rubbing in of lard.

Remarks

This is a very good case, and satisfactorily demonstrates the utility of the hydrate of chloral in one of the most severe forms of spasmodic diseases. In this case, chloroform in the crude state was administered without benefit, but the nascent chloroform disengaged from the decomposition of chloral hydrate in the blood and probably in the interior of the tissues did exert a powerful sedative action on the nerves and caused the final and complete extinction of the disease, without the aid of any other drug.

A Case of Gangrene from the bristles of the 'Shoah Poka' or the hairy Caterpillar

On the 1st of October 1870, the middle toe of the left foot of Dakshina Prasad Mukherjea, aged 28, native of Bankra near Sibpore, got

pricked by the bristles of the 'Shoah Poka'. This gave rise to inflammation which culminated in gangrene of the toe with suppuration of the foot close by. When we saw him first on the 19th Oct., we found the toe blackened and the foot swollen. We gave *Sil. 30.* But on the following day finding that an abscess was forming, we gave him *Hep. s. 30.* This was continued till the 29th when, finding the abscess brought to a head, we opened it. From the following day till his final recovery by the middle of December, he had *Sil. 12*, which had the effect of diminishing the discharge, reducing the swelling and healing up the sinuses. The first phalanx, which had mortified, dropped off of itself in the course of the treatment. Externally, we had used the *Calendula lotion* (ten drops of the mother tincture to an ounce of water) so long as the sloughs were not all separated, and the discharge continued foetid. We have invariably found the *Calendula* to be an excellent cleanser of such sores.

Remarks

We publish this case not only to illustrate the effect of Silicea in open suppurations, but also to point out the danger, which attends the penetration into the skin or other living tissues of the bristles of the insect known as 'Shoah Poka', the hairy or the spinose caterpillar, the pest of the

rainy season in Bengal. These bristles are very poisonous and we have known Panophthalmitis with sloughing of the cornea and even destruction of the eye-ball to result from the irritation caused by their contact with the conjunctiva. The best antidote we know of this insect, and the best remedy of the recent inflammation caused by it, is the juice of the leaves of the plant, called Dhola or Kanchira (Commelyna bengalensis). We have taken out the bristles from the living 'Shoah Poka' and, mixing them with this juice, we have rubbed them between our fingers, and we have found them literally to melt away. Would not a saturated tincture of the fresh leaves be equally useful? This is at least worth a trial in recent inflammations resulting from this cause. And why may it not be useful, even when the inflammation assumes a destructive character, as it did in our patient?

A Case of Traumatic Tetanus: Recovery

Radha Nath, a Hindu, aged 40, carpenter by profession, presented himself for treatment on the 8th March, 1871, with symptoms of Tetanus. He had the peculiar tetanic look, chiefly characterized by half-closed eyes and stiffness of the neck. There was partial lock-jaw, and rigidity and pain in the muscles of the back and the spine. He complained of not being able to masticate properly and of being unable to speak with usual

force and distinctness. He had a wound at the tip of the third right toe. This was caused by the wheel of a carriage running over the toe and cutting off the toe at the middle of the first phalanx. This had taken place 15 days before admission. The tetanic symptoms were first observed 9 days after the accident.

The soft parts of the toe were in a state of gangrene. We prescribed *Lach. 30.*

On the 10th the patient reported some increase of the tetanic symptoms, and extension of the rigidity to muscles of the abdomen. The progress of the case was, however, not unsatisfactory. The medicine in the same dilution was therefore continued.

On the 16th the patient was worse than he was on the 10th but still not so bad as such cases generally become. We therefore changed the dilution to the 6th. From this time forth improvement commenced in the wounded part as well as in the tetanic symptoms.

The sphacelus separated on the 24th and the patient was doing very well. The tetanic symptoms had considerably abated.

The same medicine in the same dilution was continued till his final recovery by the end of April following.

Remarks

This was not a severe case from the beginning. But there cannot be the slightest doubt that Lachesis exerted a considerable influence over the disease, arresting its progress and ultimately extinguishing it altogether. This is evident from the fact that the 30th dil. was not so efficacious as the 6th—which brought the case to a successful termination. What induced us to select the drug in preference to others was the traumatic origin of the disease and the gangrenous nature of the wound. It is a routine practice to try Arnica first, but we have never derived any benefit from it, no doubt for the obvious reason, that Arnica can never be Homœopathic to Tetanus.

A Case of Crocodile-bite: Recovery

Babu Srinath Mukherjea, the subject of the above accident, thus narrates it at my request:—"On Saturday, the 3rd June 1871, at about 9 P.M. as I was bathing in the river (at Khurdah) I felt as if something caught hold of the upper part of my right thigh. To ascertain what it was I placed hands over it, and it felt like a large piece of stone. I was at once convinced that I had fallen into the jaws of a crocodile. Of course I cried out loudly for help, but before anybody could come to my rescue I was dragged away to a

good distance from the ghat, and twice drowned and lifted up. Fortunately I did not lose presence of mind. I prayed to my God to save me, as I was past all human help and hope. Suddenly the idea flashed to my mind, or rather I recollected, that the only chance of extricating myself from the jaws of my monster-captor was to plunge my fingers into his eyes. No sooner conceived than the idea was carried into effect. My left thumb or finger was at once buried into one of the eyes of the beast who, no doubt from the pang it caused him, at once let go his hold, but not without taking away a piece of flesh from my thigh. I of course lost no time, and swam to the ghat with all my might. I reached the ghat, I suppose in about 3 or 4 minutes. As I sat down on one of the steps, knee-deep in water, a man came down to my assistance. He caught hold of me and dragged me up the ghat, as he perceived the disappointed beast was coming again for a second attack."

The wound was examined and dressed by a medical man who was called in from a neighbouring village.

On the following day, the 4th, hearing of this accident to our friend, I went to see him in company with Babu Rajendra Dutt. The wound

was a gaping, lacerated wound, situated in the upper and inner aspect of the right thigh about 2 inches below the groin. The wound was about 6 inches long and about 4 deep. There has been profuse hæmorrhage, but at the time we saw him (2 P.M.) it had stopped. To prevent all chances of further hæmorrhage we ordered *Arnica* in mother tincture to be applied as lotion (20 drops to an ounce of water) and the same drug in the 6th dil. to be given internally.

In a day or two the sore assuming a putrid character, Calendula instead of Arnica was applied externally. Internally *China 30.* He had no fever from the beginning. The wound healed up in about 2 months. He is now (28th Aug.) quite well. The cicatrix is about 4 inches long.

Remarks

The interest of this case lies not so much in the treatment which was simple enough, but in the fact of the gentleman having kept his presence of mind in the midst of danger of such unusual magnitude, and in the peculiar mode in which he extricated himself from the jaws of the monster. This is worth remembering, as it may stand in stead, should such danger ever arise.

A Case of Hysteria

The husband of the girl, subject to the above disease, came to me in the middle of May 1871, and gave me the following history of the case.

For 5 years previous to the commencement of the present disease the patient used to suffer from the following complaints: acidity of the stomach, burning of the skin generally and of the hands and feet in particular, pains in the chest, hemicrania. All these had come on after an attack of fever. In Bysakh 1277, that is, upwards of 13 months ago, she all on a sudden vomited a large quantity of blood, and was in consequence at once placed under Allopathic treatment. In spite of the continuance of this treatment for 3 months, the patient used to vomit blood, two, three times a day. The only improvement that was perceived was that the blood, which was thin and a mixture of dark and red blood, became thick and black and lost its fishy smell. After this the patient was placed under Kaviraji treatment. Under this treatment the vomiting of blood had stopped for 4 months, but the other complaints of the patient were not relieved. After this period, all on a sudden the patient vomited blood again, and again an Allopathic doctor was sent for. Immediately after the vomiting of blood had

ceased by the medicines he administered, the patient fell into a swoon followed by convulsions. This state of alternate stupor and convulsions lasted for five days. On the first day the most heroic Allopathic treatment failing to do any good, the patient was placed under a gentleman who had some knowledge of Homœopathy. On the 5th day, the fit disappeared. The patient continued under this gentleman's treatment for nearly 3 months. During this period, she had no fit, but used to vomit blood, commencing about 6 days before the menses and continuing about 3 or 4 days after, altogether about 13 or 14 days. In consequence of this the patient was brought to Calcutta. While coming by boat she had a fit of fainting and convulsions which lasted the whole time of the journey (1½ days) and about 12 hours after arrival in Calcutta.

On arrival in Calcutta, which was by the middle of January last, she was placed under Homœopathic treatment. She had at first Nux vomica 30th which continued for a month; the result of this was good sleep at night and less vomiting, but the hysteric fit and the hæmatemesis recurring as usual, Arn. 30th, Puls. 6th and Bryo. 18th were given in succession, without however any abatement of the formidable hysteric symptoms.

The symptoms, when I was called in to treat the case, were as follows:—

The hæmatemesis preceded by the fainting fit which lasts from 7 to 12 hours. The fainting fit is preceded by pains in the chest and stomach, which are relieved by the vomiting of blood. The blood thrown up is black and clotted. These fits of fainting and hæmatemesis generally commence 2 or 3 days before the menses and continue for 2 or 3 days after; sometimes they take place at other times. The menstrual blood used to be profuse before, but now it is scanty. The patient has white Leucorrhœa. During the menses she experiences nausea, pains in the uterine region and burning of the skin. The patient is subject to vertigo, which she feels especially on rising from a seat; she has occasional attacks of hemicrania; her vision is weak, being unable to distinguish objects at a distance. There is pain in the throat, and pains about the umbilicus. During the menses she feels as if there is a solid mass in the lower belly which rises up towards the chest. The patient has leucorrhœa for 4 years. In her childhood she was subject to attacks of fever, diarrhœa and worms. Worms used to come out of the mouth.

This case was evidently a complicated form

of hysteria, and although all the symptoms did not correspond, I prescribed (24th May) *Moschus 6*, having recently had experience of its remarkable influence over this disease in some cases. This had the desired effect. At the next course, she vomited blood only for a day, very small in quantity, and at the course after this, there is no hæmatemesis. After this the patient was well up to the 16th July, up to which date, *Moschus* was continued.

On the morning of the 17th, she had a fainting fit which lasted till 3 P.M., after which she vomited clots of blood. This was followed by strong fever. She had once more vomited blood and a large quantity of slime this day.

On the 18th the fever made its appearance again in the morning which lasted till after midnight, in spite of a dose of *Acon. 6*, in the morning. There was no more vomiting of blood to-day.

On the 21st I prescribed *Calc. c. 30*. This checked the vomiting of blood and slime and relieved some of the other symptoms, but did not check the fever. The fever used to come on at the same time in the morning, and on that account I gave her on the 23rd *Sabad. 3*, but without the least benefit. On the next day,

I gave her *Ars. 12*, on account of the excessive burning of the stomach and chest. Although it relieved the particular symptoms for which it was exhibited, it could not prevent the daily accession of the febrile paroxysms. Looking upon this as a fresh case of malarious fever, I gave her quinine in massive doses. The fever was at once checked, and she has remained all right since.

Remarks

This case demonstrates the utility of remedies whose pathogenesis, without corresponding to all the minutiæ, corresponds in a general way to the symptoms of a case. Under the pathogenesis of *Moschus* we do not meet with vomiting of blood, nevertheless the drug succeeded in checking it in this particular case by rectifying the hysteric cachexia, if we may so call it. The case proves also the utility of quinine in recent malarious fevers, and it is cruel, in our opinion to withhold it when the paroxysms are distinctly anguish and other remedies fail. Distinct periodicity of recurrence with distinct intermission ought to be sufficient similimum to warrant the exhibition of the drug. Besides, where with the return of the paroxysm, there is aggravation of all the symptoms, to withhold quinine has been in many cases to endanger the lives of patients.

A Case of Abscess in the Abdominal Parietes dispersed by Hepar Sulph.

On the 26th August last, I was called to see Babu Akshay Kumar Banerjee, who had come down from his native village Satgachia for treatment. He was laid up in bed with a huge swelling in the left Iliac region just above the Sigmoid flexure, which was exceedingly tender to the touch and which appeared to be an incipient abscess deep-seated in the abdominal wall at this place. The patient had hectic fever and was extremely prostrated in strength. He was 20 days under Allopathic treatment, but without deriving the slightest benefit from it. The swelling, the pain, the fever, and the prostration have been increasing day by day. He could not move from his bed at all. Having in several instances observed the remarkable powers of *Hep. s.* to open abscesses, I prescribed it at the 6th dil., three times a day. In less than a week the patient was nearly free from fever, the swelling considerably diminished, and the patient on the whole was so well as to be able to sit up and even walk a little. After a few days, the improvement became rather stationary, and I gave him *Rhus tox. 6.* From this time forth the improvement was rapid, the swelling,

pain, fever and debility all disappearing by the 20th September. By the end of the month he was all right.

A Case of Remittent Fever with Jaundice and a peculiar symptom, viz., severe vomiting after each draught of cold water

On the 11th Dec. 1868, I was first called to see Baboo P. K. D. for a peculiar and a most distressing symptom, namely severe vomiting after drinking the smallest quantity of cold water. On inquiry I found that the gentleman was laid up with fever for the last 22 days. The fever was at first of the intermittent character, but had latterly become remittent, and was day by day becoming more and more violent. I found him deeply jaundiced. There was some tenderness over the hepatic region. The abdomen was full and tympanitic; there was considerable griping always present, and very severe griping and tenesmus after stool for which he has to strain much. Passes fœtid flatulence with relief. Skin hot, pulse 120. For the last 3 or 4 days he was being troubled with the peculiar symptom mentioned above and which not yielding to any treatment, I was sent for. The patient described to me that on account of this distressing symptom he had a

horror for water although he had a burning thirst. He could take liquid medicines, even the most disgusting mixtures, without feeling the slightest nausea or tendency to vomiting, he could take milk, and anything else that is liquid, except cold water. Knowing that we prescribed medicines in cold water he requested me not to do so in his case. I however assured him, he will not vomit again. I gave him *Eupatorium perfoliatum 3*, $\frac{1}{4}$ drop in a little cold water, to be taken every hour for two or three doses.

12th—Called at about 11 A.M. and had the satisfaction of hearing that the patient could retain water after taking 3 doses of the medicine. In fact he described to me that he felt an attraction for water after the 3rd dose, immediately after which he passed a stool consisting of fœcal matter and a large quantity of bile. The stool was hot and much flatus escaped with it.

Temperature of the skin almost normal; pulse between 104 and 100. Has griping still of the bowels; has had no stool to-day. Tongue still as bad as before, being thickly coated white and having the impressions of the teeth on the margins; the conical papillæ much inflamed. Eyes jaundiced, perhaps slightly less than

yesterday. Appetite has improved somewhat after the stool last night.

The same medicine was ordered to be continued.

13th—No fever; no vomiting; says has a very sharp appetite; the tongue however is not yet quite clean; griping less but still continues; has had no stool. Was ordered chappatee (unleavened, hand-made bread) and gandal soup. To have *Eup.* one dose.

4 P.M.—could not take chappattee; says he does not seem to have much real appetite. No fever; jaundice somewhat less. Tongue still continues white. *Nux vom. 6.*

14th—Ravenous appetite, must have rice. Had one good stool, consistent and containing much bile; griping still continues. Rice was ordered. To continue *Nux vom.*

In a few days more he was perfectly well. *Nux vomica* completed the cure.

Remarks

In this case the "regular" practitioner with his powerful sedatives and anodynes and other nervines was left completely in the lurch. At the same time, therefore, that it proved the utter worthlessness of orthodox medicine, it thoroughly established the immense superiority of treatment by the law of similars. The patient, a highly intelligent gentleman,

was astonished at the action of our medicines. He is so convinced of the vast difference between the two systems that he now always honours me with charge of cases that occur in his family.

I have since had an opportunity of testing the efficacy of *Eupatorium* in reference to the peculiar symptom noticed above. This was in a case of cholera, where on the subsidence of the more urgent symptoms, this symptom developed itself and readily yielded to the *Eup. 6.*

A Case of Incipient Hysteria

I was called on the 17th instant, to see a girl of about 15 who, while dining, felt a constriction in the throat which prevented her eating. Immediately she was seized with a tendency to weep and she did weep often. She then lost all power of speech and informed us by writing that she felt as if something in the throat was preventing her from giving utterances to her thoughts and feelings. There was very great oppression and tightness of the chest, and a crampy pain in the stomach. She could not trace her ailment to any particular cause. All that she could say was that she had disturbed sleep in the night and that since then she was not feeling all right in her head, which was rather heavy. On inquiry we learnt that since her first

menstruation, the course had been irregular and rather scanty and not having the natural color. We gave her *Puls. 6* to inhale and immediately she felt the constriction in the throat removed. In a few minutes more the tightness and oppression of the chest were considerably relieved. She felt as if she could speak, made several attempts, succeeded in only uttering simple sounds, but could not utter articulate speech. We therefore gave the medicine *internally* as she could now swallow. In the course of an hour she was all right again.

Chronic Traumatic Inflammation of the left elbow-joint cured by Rhus tox.

A boy named Preo Nath Mukherjea aged 15 was brought to me from Ooterparah on the 28th February last for pain and swelling of left elbow-joint resulting from a violent sprain upwards of two months ago. The joint had remained in a semi-flexed condition, since the accident, incapable of both extension and flexion. Blisters, liniments, fomentation had been applied, but in vain. I ordered *Rhus tox. 6,* globules; in the course of a week the swelling had so far diminished as to allow the joint of full extension

and flexion. The slight pain that remained vanished in a week more. This is only one of many instances in which I have tested the efficacy of *Rhus tox.* in chronic inflammation of the articular structures, especially when resulting from blows, sprains, etc.

A Case of Puerperal Tetanus

Babu P. C. Banerjea's wife, aged about 34, was delivered of a male child on the 26th February 1869. This was her 8th child and the labor was natural and easy. The confinement was as usual in a native house, in a low, damp, ill-ventilated room. On the 28th instant, she had an attack of slight fever from which she was quite free by the 3rd of the next month, March. On the 7th March, the 10th day of confinement, she bathed for the first time after delivery. On that very day she felt slight stiffness of the jaws, but this was slighted and thought of as nothing but slight cold. On the 8th the lockjaw was distinct but still disregarded. On the 9th the lockjaw considerably increased. In the morning difficulty was experienced in swallowing solids, but by evening there was difficulty and pain in swallowing liquids as well.

PROGRESS AND TREATMENT

10th March—I was sent for, and of course there could be no mistake as to what the case was; it was a case of tetanus, and not of simple cold as the patient and her husband had thought. The patient was in the habit of taking opium daily (a habit which she had contracted for a chronic diarrhœa which she had suffered from long) and the husband had strong prejudices against Homœopathy. I therefore ordered—

Liq. Opii. Sedat. mviii. every 3 hours.

11th—The opium, having procured some relief, enabling her to swallow better and giving her snatches of sleep, was continued.

12th—Extension of the disease. The neck became involved for the first time. As yet the spasm was of the tonic character.

℞ Tinct. Cannabis ind. mv, every 3 hours.

℞ Chloroform ʒii

Lint. Sapon ʒii. Ft. Lt. Rub the affected parts with Chloroform inhalations.

13th—The tonic spasm invaded the muscles of the back. Same treatment continued, and the opium which was discontinued was resumed in addition. The patient having become weaker, broth was ordered.

14th—Clonic spasms commenced to-day, con-

vulsing at times the whole body, but more especially the neck. Thirst very great. Patient very weak. Brandy ordered to be given as frequently as she could take, in addition to hemp and opium.

In the afternoon the violence of the clonic spasms increasing, we gave *Nux v. 6* internally and *Nux v. 8* to inhale. The inhalation had the effect of diminishing the severity of the fits, and even of enabling her to open her mouth better so as to take in medicine and nourishment more easily than she could before.

The following liniment also did great service in keeping down the tonic spasms:—

℞ Sapo. Mollis ʒii.
Spt. Vin. Rect ʒii.
Chloroform ʒiv M. Ft. Lt.

15th—The convulsions very severe; abdomen distended, breathing difficult; spasms in the stomach. All previous medicines were stopped and *Nux vom. 100* was ordered to be given instead.

Very bad in the evening; distension of the abdomen. No stool since the commencement of the attack. An enema of castor-oil and turpentine was therefore ordered, but it brought away nothing, in fact nearly the whole of the liquid thrown in remained in the bowel.

In the middle of the night the fits became very frequent and severe. Groans and unintelligible speech. Pulse almost imperceptible. Body cold. This state was gradually recovered from, without anything being done.

16th—The patient continuing very bad, a Kaviraj was called in who ordered Makaradhwaja (a compound of gold, mercury, and sulphur) internally, and old ghee (clarified butter) to be rubbed over the body, and heat applied to it from the flame of palm leaves burning close by.

This day she had a stool at 2 P.M., whether the result of the Kaviraj's medicine, or the effect of the previous day's enema which was retained, it is impossible to say. However the patient felt much better to-day. The fits were fewer and rather less severe.

17th—The patient was well till 2 P.M., after which fits returned in a much more severe form. There was this peculiarity in the fits, that the right and left sides of the body were alternately convulsed and free from tetanic spasms. During the fits fœtid saliva spirted out of the mouth with force. During the intervals between the fits the countenance became much sunken, the eyes vacant, the voice plaintive and hoarse.

I was sent for again in the afternoon, and

remembering the case of the criminal upon whom Mathiolus had experimented, which seems to point to alternate affection of the sides of the body by the drug, though the particular affection developed in that case was paralysis, I prescribed *Acon. 6.* This did not seem to do any good. Fits of violent convulsion continued the whole night.

18th—The peculiarity observed yesterday of the sides of the body being alternately convulsed had disappeared, probably the result of the *Acon.*, but the whole body became rigid and was being violently convulsed so that there was impending danger of death by suffocation.

A dose (5 drops) of tincture of Tabacum was put into the mouth at 11 A.M., but without the slightest effect upon the spasms. On the other hand, it had a depressing influence upon the pulse and the abdomen becoming very tympanitic, the medicine was not repeated. In the evening the fits became so violent and the pulse so lowered that all hope was given up of her recovery. The following mixture was ordered:—Liq. Strychniæ (B.P.) mxv. Chloroform ℥i. Aq. Dist. ℥i, ℥iii M. Ft. Mist. One Drachm for a dose. Only one dose was given but the symptoms getting aggravated, Dr. Chapman's

ice-bag was applied over the spine. This had the remarkable effect of at once quietening the spasms for sometime, and the night was passed in comparative ease, though fits and violent ones too did return. After the application of the ice-bag the temperature of the chest became very high, it felt hot to the hands.

19th—The ice-bag ceased to have any effect. The fits became again violent and frequent. Difficulty of breathing was very great. Tympanitis continued. Chloroform and brandy were tried but without effect. In the afternoon we found the patient very bad and we thought of counteracting all the medicines she had taken. We therefore administered *Camphor* and with remarkable benefit. The fits became less frequent and less violent, the tympanitis diminished, dyspnœa became less.

20th—Same as on the previous day after *Camphor*. Thirst continued.

21st—Fits less in number but longer in duration than they were before. Body cold at intervals.

22nd—Passed a very bad day. She had nearly died in the night. Whole body was cold as ice; hardly any pulse. *Ars. 6* revived her.

23rd—Decided improvement. Had one good stool. No medicine. Broth was again ordered.

24th—Same as on the previous day. No medicine, except *Ars.* or *Carbo v.* when collapse was threatened.

25th—Fits became longer in duration. Same treatment continued.

26th—Duration of fits became very long, as long sometimes as 2½ hours. The opisthotonos was at times so great that the body was curved like a bow. *Hyoscyamus* (mother tinct.) was ordered in doses of 5 drops every 2 hours. This had the effect of at once quieting the spasms, and from this day the tetanic symptoms steadily diminished till there was no vestige of it except some rigidity of the body by the 30th. It is worthy of remark that the chloroform liniment having ceased to do any good, a lotion consisting of sulphuric ether and rose water was used, and with considerable benefit.

1st April—While we were congratulating ourselves on the improvement already effected, a new and a most troublesome symptom set in—grinding of the teeth. The noise made was so loud as to be audible from downstairs. And sometimes the jaws were so strongly pressed against each other that we were afraid they would be smashed to pieces. Fortunately we found in *Stramonium* an agent more potent than

the disease. We first prescribed the 6th and we had to descend to the 3rd to complete the cure in about 4 days.

On the 5th the patient was well enough to take rice.

Remarks

This was one of the most remarkable cases that we have had during the whole course of our ten years' practice. It points to a most common cause of tetanus in the puerperal state, namely confinement in a low, damp, ill-ventilated place. To some extent it seems to favour the prevalent idea of the 8th pregnancies being attended with more or less danger. It most emphatically demonstrated the power of the medicines, especially Homœopathically selected medicines over disease. It demonstrated likewise the utility of Dr. Chapman's ice-bag to the spine, and it proved as well the folly of continuing its application when it ceases to do good. There is a time for everything, during which alone it acts beneficially, and beyond which cannot fail to be injurious.

A Case of Colicodynia, terminating in severe Tympanitis, with impending Intussusception

(Reported by an L. M. S.)

The patient, a girl aged about 15 years, of respectable parents, came under treatment on the

30th December when Dr. Sircar saw her for the first time. On enquiry it was learned, that the disease first commenced as griping colic on the 27th instant, when it was confined to the lower part of the abdomen only. For sometime previous to this she had been suffering from costiveness and other dyspeptic symptoms which she did not think it necessary to report to any one in the family until the symptoms grew worse on the 27th. The father of the patient being apprised of this and thinking her to be suffering from worms gave a few doses of *Cina* during the day; but in the afternoon, on coming to learn that she had not menstruated since delivery (that is about 8 months), he administered a few doses of *Puls. 3* at short intervals after which the menses appeared though scantily and without the least abatement of the colicky pain which continued to trouble her day and night unremittingly up to the 29th. Up to this she had lived on spare diet and took every care to avoid cold bath or a heavy meal. But on the latter date being induced by the female members of the house, she took a cold bath unknown to her father, besides a meal consisting of rice, ghee and milk, rather unusually, with a view to removing her constipation from which she has

been suffering all along. After this she felt still more unwell, and within three hours after the above treatment, she vomited everything she took, with aggravation of the griping pain, which now extended over the whole abdomen and was soon followed by tympanitic distension of the bowels. It was at this crisis that a lay practitioner, a friend of the patient, was called in, who prescribed *Nux* and *Bryo.* in alternation. The medicines were continued throughout the night, but finding no sign of improvement in the morning Dr. Sircar was sent for. On arrival he found the patient to be suffering terribly from tympanitis and along with it colic, and ordered *Carbo v. 30* to be given immediately. After having 3 doses of the medicine, the patient threw up a lumbricus; the medicine was continued throughout the night at intervals, varied according to necessity, during which she had 4 motions, which were thin and scanty; beyond this she derived no other benefit from the medicine.

31st Dec.—Dr. Sircar saw her again this morning and finding the state of her pulse to be very rapid (160), and irregular, prescribed a stimulant mixture, conformably to the urgency of the symptoms, besides an anodyne liniment for application over the abdomen. As accessory to

these she was ordered fomentations and an enema of castor oil and turpentine in the evening to clear her bowels, as they were found confined since last night but all to no purpose.

Jan. 1st 1872, Morning—The patient was in the same precarious state as on the previous days, there was the same drum-like distension of the abdomen, with constant moanings owing to indefinite pains in the bowels, which the patient could not describe properly—the abdomen was resonant on percussion in all other parts excepting the sites of the lower part of the ascending and descending colon—the whole surface was extremely painful on pressure; there were, besides, hurried breathing with hiccough from time to time and obstinate constipation. Pulse 150. Thinking this to be a case of impending intussusception of the intestines, *Nux v. 30* was ordered to be given every hour or two, according to the requirements of the case, until the symptoms were somewhat relieved. The medicine was continued up to 6 P.M. with the only benefit that she slept for about half an hour, whenever she had a dose of it; further than this it produced no other change in the system, barring the hiccough which disappeared at once.

About 8 o'clock in the evening the patient's condition was still more precarious. Her whole condition pointed to *China 30* which was ordered to be given at once. It was not long before we had the satisfaction to see its wonderful beneficial effects; within an hour's time from this, and after two doses of the medicine administered, she passed 3 copious stools, thin and fœtid, much to her relief. The medicine was continued throughout the night, during which she had 3 other motions of the same character as described above.

2nd Jan.—The distension of the abdomen has been diminished by half; *China 30* was continued every two hours and the more she had of it the better she felt; she had altogether six motions during the 24 hours. As to diet she could take nothing besides orange and pomegranate juice. Pulse still 150.

3rd Jan.—Tympanitis less—had 3 motions in the morning, with which she passed some scybalæ. Took a little Decoction of Barley with soup made of Gandal leaves. Pulse 140. Medicines continued every 3 hours.

8 P.M.—Abdomen feels softer. Complains of pain on pressure over the Sigmoid flexure especially, had two more stools in the afternoon. Pulse as in the morning.

4th—Was feverish in the night—the pyrexia continues yet—she slept well in the first part of the night but was quite awake in the latter part, from gripings which were somewhat relieved after a motion—left Iliac region intensely painful on pressure—a chord-like body is distinctly traceable about this part by palpation. Pulse 136. *Merc. s. 30* every 4 hours. Diet as on the previous day.

8 P.M.—Complains of stitching pain in the left side about the region of the Sigmoid flexure—but the chord-like feel has disappeared.

5th—Had slept pretty well in the first part of the night, not so in the latter, when she passed a worm with stools and some scybalæ, with great relief of the pain on the left side. She feels as if something were moving in the intestines. Pulse still above 100. Diet Barley and fish soup. *Merc. s. 30* to be given once in the morning.

8 P.M.—She had several motions during the day, preceded and followed by griping, feeling of hardness and dullness on percussion over both the Iliac and Hypogastric regions; it is over this extent of surface that the pain extends; pain is also felt posteriorly over the region of the kidneys, the lower part of the abdomen feels hot as

compared with that of the upper; sometimes the pain on the left side makes her restless—she took a little more of Barley water in the evening; medicine repeated.

6th—Suffered much from pain in the lower part of the abdomen during the night, when she was also feverish—passed several stools this morning with scybalæ; pain in the abdomen less. Pulse 130; diet as yesterday. Omit medicine.

8 P.M.—Had two more motions since last report, nevertheless she complains of griping yet which are invariably relieved after a stool.

7th—Was somewhat restless during the night owing to griping; the stools are scanty and attended with tormina; the pain commences from either side of the umbilicus; pulse about 100. *Nux 30* to be repeated at interval of 6 hours, if necessary.

8 P.M.—No griping since 10 o'clock in the morning; stools are still scanty. Repeat *Nux.*

8th—Passed a good night in spite of the disturbance she felt in getting up for stool; the griping has lost its former sharpness though it continues to trouble her in a somewhat mitigated form; stools healthy; pulse 100. Omit medicine; allowed to take rice and fish soup in the morning.

Evening—she still complains of occasional

griping in the lower belly before a motion; ordered to take pulp of roasted Bael fruit.

9th—Had slept well till 2 A.M. in the morning when she had a stool, with which she passed another lumbricus, followed by severe griping; appetite good.

10th—She had a good night's rest; a tendency to diarrhœa still continues. But from this day she steadily improved and was gradually restored to her former condition.

Remarks

It is impossible by mere report to give a faithful idea, a true picture, of this remarkable case, remarkable both by the gravity of the symptoms it presented and by the illustration it afforded of the actions of the medicines generally and of China in particular. It is not often that a patient with a pulse above 150 recovers, and recovers from such a formidable disease which threatened to extinguish life every moment for upwards of 48 hours. The recovery of the patient depended as much on the utmost care with which she was watched as on the medicines which were selected with the greatest scrupulosity.—*M. L. S.*

A Case of Herpes Circinatus

The following case which I saw on the 21st March 1871 is interesting.

A girl of about 8 years had a patch of herpes

on the right temple. It had commenced upwards of a month previous to my seeing her as a single vesicle and was spreading by the circumference, leaving a furfuraceous patch bounded by it. There was itching and burning in the part. The repertory assisted me in the treatment of this case. Under the head of ring-shaped herpes, there were Calc., Caus., Nat., Natr. m., Sep., Sulph. Of these Nat., and Natr. m. had no itching in their herpetic eruptions and the character of spreading eliminated Caus. The drugs that remained to be further sifted were Calc., Sep., and Sulph. From this list I was able to eliminate Calc. and Sep., as they did not correspond to the characteristic bilious constitution of our little patient. I therefore prescribed *Sulph. 6*, 2 globules every 4th day. She had altogether to take 2 or 3 doses and she was all right. The patch, which from a point had already become larger than a rupee in size and was spreading every day, disappeared altogether.

A Case of Inflammation of the Uterus and Ovaries, with metrorrhagia

B. aged about 24 had a fall on the evening of the 29th February last. Next day at about evening she began to feel pain in the regions

of the ovaries. This was accompanied by fever. In consequence of this the family physician prescribed *Aco. 6* and *Arn. 6* in alternation. The fever and the pains increased considerably, the patient began to get spasms of the upper extremities, and was extremely prostrated. Suspecting that the patient was suffering from suppressed menses the said physician prescribed the following mixture on the evening of the 2nd March:—

℞ Tinct.	Cannabis ind.	ʒ ss
,,	Secale cor.	ʒ ss
,,	Aconite	m vi
Aq.	Pura	℥

M. Ft. Mist. 1 oz. every hour. This was continued till the 5th inst. There was some improvement and the menses did appear. On the 5th the following mixture was given:—

℞ Tinct.	Bell.	m vi
,,	Acon.	m vi
Aq.	Pura	℥ vi

M. Ft. Mist. 1 oz. every 4 hours. Considering that the patient was well, she was ordered to take Ogra (rice and dal boiled together). Whether owing to this, or to the altered prescription, or to other causes, the fever increased violently that very day. There was violent

metrorrhagia, and the region of the ovaries and uterus became very much swollen, hard, and exceedingly sensitive to touch.

I was sent for on the 7th and prescribed *Bell. 6* every 2 hours.

On the 8th I found no improvement. The tenderness and swelling of the uterus and the ovaries were as bad as yesterday. The metrorrhagia was continuing, but the discharge had become of a pale color, and there was much involuntary weeping. As far as recorded pathogenesis went, I found the following drugs had a direct influence in setting up inflammation in both the uterus and ovaries, viz., Acon., Bell., Canth., Chin., Lach., Merc. and Plat. Of these Canth., Lach., and Merc., had no metrorrhagia, and Acon. and Chin. had no discharge from the uterus of a pale character. Consequently the only remedies that were admissible in this case were *Bell.* and *Plat.* But as Bell. has already been used without effect (probably because it was prescribed in massive doses before), I prescribed *Plat. 6*, ¼ drop three times a day. On the 1st day of *Plat.* the patient was much relieved and on the 3rd day she was all right.

A Case of Scrofulous Corneitis: Recovery

Naphar Chandra Raya, a lad aged about 11, of dark complexion, thin make, with a head indicating the existence of hydrocephalus at an early age, came to me first on the 4th of December 1869 for periostitis of the right Tibia. He improved under *Rhus tox. 6* and then disappeared till the 23rd February 1870, when he came with fully developed synovitis of both knees. I gave him *Bryonia 6* under which the synovitis greatly improved. But the pains about the joints continuing I resumed *Rhus tox. 6* on the 4th March.

On the 8th March I noticed inflammation of both the corneæ. The corneæ had lost their transparency, having become nebulous from the deposit of lymph in the interstices of their tissue; and there was the well-marked sclerotic zone. Along with this there was considerable photophobia. I at once gave him *Sulph. 6*, as on inquiry I found he was born of syphilitic parents. On the 11th he seemed to me to be somewhat better, but he did not admit the improvement, and complained of greater pain in the eyes. I continued the *Sulph.* but in a higher dilution, *viz.*, the 30th. The patient however again disappeared and did not make his appearance till the 23rd,

when I found the eyes had become a great deal worse than they were ever before. There was now violent inflammation of the whole eyeball and a good deal of photophobia, so much so that the boy would not allow the eyelids to be opened for examination of the corneæ. Having in my previous experience derived benefit from Quinine, I prescribed that drug and continued it till the 27th when finding no improvement, I tried *Bell. 30,* but with the same unfortunate result—no benefit. On the following day, in despair, I gave Iodine of Potass, in grain doses with decoction of Cinchona. Finding not the least improvement, I again gave Quinine with port wine on the 30th. The eyes continued as bad as ever. I could not see the corneæ, as the eyelids were so spasmodically closed, and the least attempt to open them threw them into such spasms that the examination of the eyes was absolutely impossible. Even if I could succeed in forcibly opening out the eye-lids they would get so everted and the eyeballs would be so instinctively turned up, that only the lower portion of the sclerotic and just the lower margin of the corneæ could be seen. From this imperfect observation I could only make out that red blood-vessels had already passed from the sclerotic into the substance of

the corneæ, but the amount of mischief in the corneæ I could only infer and not see. I can now hardly describe the anxiety I then felt for the poor lad's eye-sight. I felt the awful responsibility of my position. I returned to Homœopathy on the 1st May, and up to the 28th prescribed in succession *Merc. s.*, *Sil.*, *Can. i.*, *Sulph.*, *Rhus tox.*, *Hep. s.*, *and Spigelia*, with what success, can only be imagined from the fact of my having to change them so often. In fact not a single medicine did seem to do even the slightest good even for a short time. On the 29th I thought of *Argentum met.* more for the rheumatic diathesis of the child than for his eyes. And it was astonishing to observe the marvellous effect the medicine had upon the Ophthalmitis. The disease seemed as it were to melt under its influence. The photophobia, the lachrymation, the spasmodic closure of the eyelids disappeared in the course of a few days. The dilution first used was the 6th and I had to complete the cure with a higher, the 30th.

A Case of Chronic Conjunctivitis : Recovery

The patient, named Gadadhar Patua, aged 20, was admitted in the Out-Door Dispensary on the 21st January 1872, with the following

symptoms:—The conjunctivæ of the eyelids, especially of the right eye, were inflamed and presented a granular appearance. Constant flow of tears. The lachrymation was almost always preceded by burning in the eyes. Agglutination of the eyelids at night. The disease invariably used to become aggravated in the cold season. The disease was of 9 years' duration. The patient at first had *Euphr. 6*, which he took for 4 days without benefit. He then had *Puls. 6*, which had the marvellous effect of bringing about a complete recovery in about a week. He was discharged cured on the 2nd February last.

A Case of Ulcerative Corneitis: Recovery

Srimanta, aged 26, was admitted on the 12th January 1872, with Corneitis of both eyes. The patient could not say how long he was suffering. Judging from the symptoms he must have been suffering for upwards of a month. The Corneæ had become nebulous and there were superficial ulcers, some of which seemed to have healed up. There was besides profuse lachrymation. The patient had *Arg. n. 6*, which he took till the 20th when he was nearly cured. After that he had no medicine, though

he was told to attend the Dispensary occasionally. On the 3rd March following he was all right, and was discharged cured.

A Case of Cystic Tumor

Kripamayi, a girl aged 5, was admitted in my out-door dispensary, on the 24th April 1871, for a cystic tumor in the right temple close to the external canthus. The tumor had been growing for 3 years, and at the date of admission was of the size of a betel-nut. It was perfectly moveable, unconnected with bone, and was evidently cystic in character. I prescribed *Bar. c. 6*, which was continued till the 26th May. The only benefit derived was that the growth of the tumor was arrested. No medicine was given till the 4th August, when finding that the tumor had continued in the same state, I prescribed *Calc. c. 30*. This was continued till about the 18th and then discontinued, no apparent benefit being seen. It was only the other day that the girl was brought to me for other complaints, and I was astonished to see her perfectly cured of the tumor. I was assured no other medicine was given to the girl, than what I had given her.

Remarks

The interesting question in reference to this case is, how was the cure, the total disappearance of the tumor, brought about? So long as she was taking Calc. no apparent improvement was seen in the tumor, but it began to diminish in size, till it disappeared altogether, after its discontinuance. Does not the case offer an instance of a medicine acting long after its cessation?

A Case of Scrofulous Ophthalmia: Recovery

Phelumani, a Hindu female child, about 10 years old, was brought to me on the 27th July last for disease of her right eye, from which she has been suffering for four years. The eye could scarcely be opened, both on account of swelling of the lids and the intense photophobia with which she was troubled. The conjunctivæ were injected, and beneath it, around the margin of the cornea, the sclerotic zone of inflammation was well seen. The cornea presented a nebulous aspect throughout its substance, patches of recent ulcers here and there, as well as, cicatrices of old ulcers. Red blood vessels were seen pervading its entire area, coming from both the sclerotic conjunctiva and the sclerotic zone. On inquiry I learned that there was intolerance of light of the Sun as well as of

the candle. The general health of the patient was somewhat impaired but there was no particular symptom. I prescribed *Calc. c. 30.* This was continued till the 30th when perceiving no tangible improvement I gave *Arg. n. 6,* having found it so eminently serviceable in ulcerations of the cornea. This was used for 6 days, but finding no benefit from it. I ordered *Euphrasia 6* on the 6th August. No improvement; *Ars. 30* on the 11th. No improvement; *Sulph. 30* on the 15th. No improvement. Stopped medicine from the 20th for 3 days, after which on the 23rd prescribed *Bell. 30.* From this day the patient began to improve rapidly. The inflammation of the whole eye became less, the photophobia diminished, the cornea began to clear off, its ulcers began to heal. By the 16th of the next month (September) the patient was nearly all right, the photophobia and the vascularity of the cornea having disappeared. Only slight nebulous and leucomatous specks here and there.

Remarks

The great difficulty experienced in the treatment of this case was in the selection of the remedy. The symptoms were so few that the process of elimination could hardly be of any avail in the determination of the remedial agent that

would be in exact Homœopathic rapport with them. Moreover, in cases where such destructive changes have already taken place in the cornea, we have chiefly to depend upon clinical experience. In the case under consideration these destructive changes had advanced so far and were progressing so rapidly that, I was in constant dread of seeing the cornea perforated with holes and the consequent closure of the pupil from the protrusion of the iris, before I could fix upon the right remedy. This is the reason why I was obliged to try approved remedies in rather rapid succession, till at last I succeeded, unexpectedly I must say, according to my previous experience, in alighting upon one which arrested and finally cured the disease.

Dyspepsia (hysteric); Hæmoptysis (probably sympathetic of portal derangement)

HISTORY

Patient named D———aged 20. When one year old she had a whitish discharge from the genital passages, which was of very offensive smell and which had continued till her 7th year. It was observed that this discharge used to become copious when she would get fever. Upwards of 2 years ago, in August or September 1866, she had gonorrhœa attended with fever, and afterwards rheumatism. The fever was of the aguish character and would make its appear-

ance at full and new moon. Since May or June, 1867, she began to have prickings of the chest (stomach) which is the first commencement of fits from which she is now most intensely suffering.

PRESENT SYMPTOMS

The fit is ushered in by a pain which commences as pricking first in the left hypochondrium. Then she experiences as if something presses against the chest (diaphragm). The upper part of the abdomen (epigastrium) becomes tense and tympanitic, in consequence of which she feels as if suffocated; she then experiences cramps in the extremities which become very troublesome; cramps are also felt in the neck, shoulders, and over the spine. When the fit is over she feels the limbs very painful. She does not become unconscious during the fit, remembers whatever happens at the time. Headache during the fit. Before the fit she has nausea and occasionally vomiting, which sometimes, but not always, relieves the pain. After the fit is over she feels prostrated, remains quiet, almost speechless. After the fit is over, she does not feel inclined to make water or to go to stool. There is no regularity in the appearance of these fits. They have evidently become more frequent and more intense.

Besides the fits there are other general symptoms which are constant. These are—Pain on pressure over the right ovarium; vertigo, after waking from sleep, on turning the head round, on the bed being moved, on standing more than when sitting, on sitting more than when lying; heart-burn, nausea, sometimes vomiting of acid matters, especially after taking rice, likes milk and it agrees with her; the last monthly course was earlier than usual, and generally her menses are earlier in making their appearance.

Since Sunday before last she is expectorating blood in small quantities. At first there was no cough, nor phlegm; but cough has since made its appearance, and the blood is expectorated with the cough but not always. The blood is expectorated more frequently while she has burning of the stomach; it is believed that this expectoration of blood has commenced after taking some quack medicine for her fits.

She does not get sound sleep; it is disturbed by dreams; says she dreams of dead persons, of fire and murder by cutting instruments, of snakes and of their running to bite her, of falling from the terrace, of thieves pursuing her; she weeps during sleep.

6th July, 1868—The foregoing history and

ance at full and new moon. Since May or June, 1867, she began to have prickings of the chest (stomach) which is the first commencement of fits from which she is now most intensely suffering.

PRESENT SYMPTOMS

The fit is ushered in by a pain which commences as pricking first in the left hypochondrium. Then she experiences as if something presses against the chest (diaphragm). The upper part of the abdomen (epigastrium) becomes tense and tympanitic, in consequence of which she feels as if suffocated; she then experiences cramps in the extremities which become very troublesome; cramps are also felt in the neck, shoulders, and over the spine. When the fit is over she feels the limbs very painful. She does not become unconscious during the fit, remembers whatever happens at the time. Headache during the fit. Before the fit she has nausea and occasionally vomiting, which sometimes, but not always, relieves the pain. After the fit is over she feels prostrated, remains quiet, almost speechless. After the fit is over, she does not feel inclined to make water or to go to stool. There is no regularity in the appearance of these fits. They have evidently become more frequent and more intense.

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6th July, 1868—The foregoing history and

symptoms were taken down. Ordered *Calc. c. 30.* ½ drop twice daily.

7th, 10-20 A.M.—Pulse 92, intermittent, intermits from after the 8th to the 10th beat. Respiration over the right scapular region very feeble, almost inaudible; percussion note duller than on the left. In the right axillary and infra-axillary regions the respiration is feebler than in the left but not so much as in the scapular region of the same side. Percussion over both subscapular regions is somewhat painful. Expectoration thin, bloody, darkish, with few lumps of mucus floating in the bloody fluid.

Cont. medicine.

8-20 P.M.—Pulse 80, intermittent as in the morning. Character of respiration same as in the morning. Says she feels easier; eructates better; no fit up to this hour; had prickings in the hypochondrium as usual from 1 to 6 P.M. but much less in intensity than before. These sensations disappeared after vomiting at 6 P.M. The vomited matters consisted of sour fluid, and with 2nd and last vomiting, which took place an hour after the first, a minute clot of blood was observed. The pain in the ovarium continues. Headache slightly increased after the vomiting. The right upper extremity feels heavier, aches and becomes

numb alternately. Feels appetite which she never felt since the commencement of the hæmoptysis. Had a free stool.

8th, 1-15 P.M.—Pulse 84, less intermittent. Respiration in the right lung, not so feeble as yesterday, decidedly clearer; appetite same as yesterday morning, that is less than it had become last evening; feels some heaviness in the stomach, nausea greater than up to this hour yesterday; vomited at 11-15 A.M., the vomited matter is glairy, watery fluid, with frothy and tough mucus, tinged here and there with blood; has expectorated blood twice, once at 7-30 and again at 10-30 A.M. The expectoration is preceded by itching and burning in the throat and slight cough; says the cough is less than yesterday; headache, aching of the limbs especially of the joints more. The only thing less is prickings in the stomach. The hands and feet are colder to my touch than they were yesterday. Had one good stool in the morning. The urine is as yellow and attended with as much burning as before. The leucorrhœal discharge is the same, whitish, thin and so copious as to stain the cloth. The pain in the sternum is almost gone. *Sepia 6.*

9th, 1 P.M.—Burning with urine less; leucorrhœa no better. Aching of the limbs and

joints less generally. The hands and feet less cold. Felt better appetite this morning. Headache and vertigo much less. Feels stronger, had not to be supported in sitting or standing. Heart-burn slightly greater but less than what it would have been after taking rice on other days. No prickings in the stomach. Cough much less; yesterday she did not expectorate any blood after my visit; has expectorated blood only once to-day. Pain in throat less. Cont. medicine.

10th, 12 noon—No pain in throat; no headache; no nausea; no heart-burn; no prickings of the stomach. Appetite improving. Burning with the urine much less. No coldness of hands and feet. No expectoration of blood since last visit. Cough less. The limbs and joints are aching more than yesterday, probably owing to the weather (incessant rain since morning). Cont. medicine.

11th, 11-30 A.M.—Had a fit yesterday commencing at 5 P.M. and continuing till 7 P.M. ushered in as usual by heart-burn and prickings in the stomach. The fit was much less in severity, she could lie on the side during it, which she could not do before. It was probably due to her having taken some milk at 2 P.M. The leucorrhœal discharge increased after my visit.

Cough less, and has not expectorated any blood. In fact she does not feel particularly weak after the fit as she used to do before. Respiration nearly the same in both lungs. Pulse 86, less irregular. Tongue cleaner. Countenance brighter. Burning with the urine slightly greater, as also the pain in the left ovary. Sleep disturbed by dreams of fighting with cutting instruments. Discontinue *Sepia*. Resume *Calc. c.*

12th, 5 P.M.—Pulse 94. Respiration in the right lung not perceptibly different from that in the left; no headache since last evening. Tongue clean, moist; none of the gastric symptoms present, appetite better. Urine less high-coloured and burning during micturition less. Sleep sound, undisturbed with dreams. No cramps since yesterday, expectorated blood twice after 10 A.M. Some burning of the hands and feet, which had commenced just before the expectoration. To have medicine only once a day.

18th, 11-15 A.M.—Expectorated blood yesterday at 2 P.M. Has expectorated again at 7 A.M. to-day. Every time this was preceded by burning in throat and stomach. Had no fit yesterday. No stool yesterday, none to-day as yet. Pain in lower belly less, no burning in the genitals yesterday, but some to-day; the leucorrhœal

discharge is somewhat less and thicker. Appetite better in the evening than in the morning. *Nux vom. 30*, ½ drop at 3 P.M.

19th, 2-25 P.M.—Feels much stronger. Vertigo considerably less. Heaviness of the stomach after the morning meal is entirely gone. Leucorrhœal discharge continues but less; pain in lower belly (left ovary) less; burning in genitals less. Bowels continue costive. Cont. *Nux vom.*

26th, 2-40 P.M.—The last course which had commenced about 8 days ago was quite normal. Appetite much better; but bowels continue costive, sometimes they do not move for 2 or 3 days. Some heaviness of the right chest, felt particularly in the morning. The spittle is of rosy hue for the last 3 days. One point in the history of her case which was omitted to be mentioned before is that the pain in the lower belly has increased since she fell from a staircase last March since which she is unable to move about without pain. To have *Rhus tox. 12.*

2nd August, 3 P.M.—The heaviness of the right chest as well as the rosy spittle disappeared on the 3rd day after taking *Rhus*. Slight headache since day before yesterday. Sleep sound; appetite much improved; bowels less costive, but still do not open every day. Cont. *Rhus tox.*

6th to 10th—No medicine.

11th—The only complaint now remaining is the continuance of the leucorrhœal discharge. *Sepia 30.*

16th—Pain in lower belly has increased; she feels it on sitting for stool, in making water, and even on coughing. This is probably an aggravation brought on by Sepia. To have no medicine.

22nd Saturday—Fever since last night. No fever now (9 P.M.). Had menses which commenced on Sunday night and had continued till this morning. Pain in lower belly continues. *Nux vom. 30.*

25th, 11-45 P.M.—Fever every day, comes on at night at about 11 P.M. and continues till morning up to 7 or 8 A.M. Vesicles on the tongue and other parts of the mouth and probably along the œsophagus and trachea. Difficulty and pain in speaking and swallowing; some of these vesicles have broken into ulcers. Unequal pulse, intermits after every 3rd or 4th beat, now 88. *Acid nitric 6.* ¼ drop thrice daily.

26th, 7-30 P.M.—Had fever last night about half an hour after 12, somewhat less in intensity, lasted as usual till morning, profuse salivation, the fluid is tinged red and contains minute clots of

blood. The vesicles have all burst and formed ulcers; complains of pain in the chest evidently in the course of the bronchi and their ramifications. Cont. *Nitric acid.*

28th, 8 P.M.—Better in every respect. Fever was less last night. Salivation and exudation of blood much less. Appetite better. Ulcers in the mouth looking healthier. The throat is less swollen. Cont. medicine.

30th, 8 P.M.—The ulcers much better. No fever last night. Pain in lower belly less, but swelling of external genitals (only reported to-day) continues. Feels much better to-day. Cont. medicine.

She continued steadily to improve under *Nitric acid* and she was all right by the middle of this month (September).

Remarks

This was one of our "given up" cases. The prostration of the patient, at the time of our first visit, was so alarming, that we had not the least hope of ever being able to do her any good. Nevertheless under the alternate use of Calcarea and Sepia, in infinitesimal doses, she was brought over as it were from the verge of death, at least, cured of a disease that was pronounced and believed to be incurable. Nothing but culpable scepticism would speak of the recovery of the patient

as one effected by unaided nature. We believe this case satisfactorily proves that weakness caused by disease is better combated by remedies directed against the very springs of the disease, than by the so-called "stimulants" and "tonics" and "generous diet". These have, of course, their uses in appropriate cases and in particular conditions; but the true curative agents are those which can influence the ultimate nutrition of tissues through their controlling nervous centres.

Inflammation of the right Parotid Gland, threatening suppuration, dispersed by Hepar Sulph

The patient, a young child, 3½ years old, was first seen on the 7th instant, presenting acute inflammation of the right parotid gland; there was erysipelatous blush in the adjacent skin extending over the eyelid and even the nose. There was slight fever also. *Bell. 30* was ordered.

8th Aug.—Inflammation seems diminishing, and the tenseness of the skin less.

11th—The child had no sleep, swelling again increased since last night, probably owing to the foulness of the weather. The same medicine was continued.

12th—The swelling has increased and exten-

ded over the right eyelids so as to close the eye altogether. Medicine discontinued.

13th—Swelling of the eyelids a little less. In other respects the same.

14th—No better. *Sulph. 30.*

17th—No better. On the contrary there was every indication of suppuration taking place in a day or two. A few pimples have made their appearance in the face. *Hep. s. 6.* ¼ drop twice a day.

18th—Swelling less. *Hep.* continued.

19th—Swelling considerably diminished.

Hepar discontinued.

From this day the inflammation got less day by day till on the 26th there was no vestige of it remaining.

In this case there could be no doubt that *Hepar* effected the discussion of the inflammation.

Acute Rheumatism

Basanta Kumari, aged 6⅓ years, was first seen on the 5th September, 1868, when she was found suffering from the following cōmplaints:—

Ardent, inflammatory fever, with burning heat of the skin and a full, bounding pulse, 120; swelling and pain of all the joints of the upper

and lower extremities from the shoulder and the hip to the last joints of the fingers and the toes, the smaller joints being less affected than the larger; tenderness of the abdomen on pressure so great as to lead to the belief that the peritoneal as well as the mucous lining of the intestines were probably involved in the inflammatory action; the salivary and inguinal glands were considerably swollen and painful. Tongue white, thickly coated. Urine high-colored. No stool since day before yesterday. The history of the case is, that on Tuesday last (Sept. 1) she took acid fruits, got fever on the next day and pains in the limbs, joints and glands on the day following. Ordered *Merc. sol. 30*, ¼ drop every 4 hours.

6th Sept., 5 P.M.—Tenderness of the abdomen somewhat less. But fever continues. The joints as bad as before. Palpitation of the heart, but no murmur with the sounds. No stool. *Bryonia 6.* The joints to be wrapped with cotton wool.

7th, 2 P.M.—Fever continues, but perspires occasionally. Had no fresh accession of fever as she used to have; the joints continue still painful; those of the right upper extremity are more painful than yesterday, but those of the

left lower less so. Passes urine freely. *Bryonia* continued.

9 P.M.—Fever considerably less, but they say the pain in the joints of the upper extremities have somewhat increased. Fast asleep just now. Medicine to be discontinued.

8th, 1 P.M.—Quite free from fever; the pains of the joints much less; almost no pain in the hips; no stool. No medicine.

10 P.M.—Slight accession of fever. Pains in the left upper extremity slightly increased; no stool. Pain on pressure in the abdomen much less. The tongue still thickly coated, the conical and the filiform papillæ both enlarged. No medicine.

9th, 1 P.M.—No stool, free from fever. Tongue still bad. Pain and swelling of the joints much less; pain in the abdomen continues, though less than before. No medicine.

8 P.M.—Slight excitement. Itching and sudamina throughout the whole body; no stool. No medicine.

10th, 4 P.M.—No fever; no stool; pains almost gone. Has been able to come out to the outer room where she is now sitting; tongue much cleaner. No medicine.

11th, 8-30 P.M.—Had one free stool in the morning at 10 A.M. No fever; could walk

to-day. Sleeping soundly now since 5-30 P.M. No medicine.

13th, 2-30 P.M.—Quite well. Free from fever and pains. The swellings have disappeared. Walking about freely.

Remarks

This is one of the most severe cases of acute rheumatism I have seen, and never have I met with a more satisfactory result in the treatment of this disease than in the present case. I have had success from the employment of the bicarbonate of potash, lemon juice and large doses of quinine, perhaps the best result from the first named remedy, but the issue of this case has outstripped my most sanguine expectations. One important feature in the treatment of acute rheumatism to which I would draw particular attention is the wrapping of the joints with a thick layer of cotton wool, well-carded. This has the effect not only of protecting the joints from the influence of the external air, but maintains an equable temperature of the parts which favours the absorption of the effused products of inflammation. I had before this treated several cases with Homœopathic Remedies, without this auxiliary. They terminated more rapidly than I could ever succeed in doing with the old school drugs, but not so rapidly as the present case did.

In acute rheumatism I cannot too strongly condemn the use of purgatives, in as much as they needlessly necessitate the patient to move about which prove very prejudicial to the affected joints.

A Case of very severe general Enteritis involving the Colon

Akshya Kumar Chattopadhya, aged 20, naturally of mild disposition, student, Presidency College, was first seen on July 24th, while he was suffering from extreme tenderness of the abdomen, considerable tympanitis, and extreme weakness. The following is the history of the case according to the patient and his guardians:—

On the morning of Friday, July 17th, his bowels were rather costive and his appetite was rather dull. He took his morning meal as usual and went to College. In the afternoon he felt a pain in the stomach and took an effervescing draught of soda and tartaric acid. He felt very uneasy during the whole of the night and the pain increased. The following morning he took Seidlitz's powder, from which he had only one or two stools, but the pain did not diminish. On the morning of the 19th he took a dose of castor oil, but immediately after threw it up. An Allopathic native doctor gave him therefore a few doses of Gregory's powder and he had 4 or 5 motions, and the pain, which had during the previous day extended to the abdomen, diminished considerably so much so that he felt quite easy in the evening. At night a third of a grain of morphia

was given him and he had sound sleep. The following morning (20th July) he felt easy and there was only a little pain in the abdomen. But at about 7-30 A.M. while lying in his bed he felt, of a sudden, a burning pain in the urinary organ, which was followed by a troublesome pain extending over the whole abdomen. The abdomen was very much distended and could not bear the slightest touch. The pain was so very great that he felt great difficulty in breathing and moving. The Sub-Assistant Surgeon of Utturpara was sent for, and he at once pronounced the disease to be Enteritis. Bran-poultices were applied over the abdomen every hour, and the following medicines were prescribed and used:—

℞ Hyd. Chlorid gr. ij
Ext. Opii gr. j
M. ft. pill vj—one every 3 hours.

℞ Ext. Belladonna iv
Glycerine
Liniment Saponis aa ij
M. ft. Liniment. To be rubbed over the abdomen.

There was fever also. Another doctor administered a tonic mixture and directed that after three of the above pills shall have been taken the following should be taken instead:

℞ Hyd. Chlorid gr. j

Ext. Hyoscyamus gr. ij to form one pill.

Two of these latter pills were taken at night and the pain abated much.

21st, Tuesday—The pain again increased and the distension of the abdomen remained the same as before. The 1st pills were repeated but the symptoms did not change in the least. He had nausea the whole day and vomited thrice, once in the morning, once in the evening, once at night. He had several stools at night, especially towards the latter part. Was very uneasy the whole night, and had no sleep.

22nd—Had several stools, thin and fœtid, of a greenish colour, having bloody mucus in them. One opium pill was again given; so that he had altogether 7 of these pills (14 gr. of mercury and 7 of opium). This day a medical man from Calcutta was brought in who applied a mustard plaster over the abdomen, and ordered a few doses of Dover's powder of which one only was taken. He said the pulse was weak and flickering, and the patient was becoming exhausted on account of the diarrhœa. He declared the case to be very dangerous. In the afternoon of this day (22nd July) it was thought advisable to try Homœopathy and accordingly a Homœo-

pathic physician was called, who prescribed *Mercurius 6*, of which two doses were taken. The patient however was uneasy and restless for the whole night and had fever towards the morning.

23rd—*Aconite 6*; pain in the abdomen less. Had several stools, having mucus in them but no blood. Was drowsy the whole day, and had nausea. *Nux vomica 6* at about 5 P.M. Slept at night, involuntary stools during sleep; not so uneasy as on the previous night. Fever towards morning.

24th—Much better generally; *Arsenic 6*. Had stools but not so frequently as on the preceding days, and less in quantity.

This day in company with Babu Rajendra Dutt I visited him and applied a wet sheet over the abdomen, after which he felt much easier and the pain in the abdomen became much less.

25th—Burning all over the body, especially in the right hand and palm. Drowsiness, slept with eyes half-open, great thirst. Fever. Several stools. *Arsenic* continued.

26th—Pain much less, almost imperceptible but burning continues, that in the right palm much greater than in the left. Very great thirst.

Urine not so high coloured as before. Drowsy. Fever rather slight but of longer duration than on the previous day. Abdomen a little more distended. *Arsenic* continued.

27th—In the morning much easier, but burning continues, especially in the right hand and palm. Had fever at about 4 P.M.—Remission after 3 or 4 hours. Thirst. *Sulphur 6.*

28th—Easy in the morning, pain diminishing. This day visited him the second time, and gave him *Camphor.* It was reported that after *Camphor* he had much less fever than in the previous day.

29th—Very easy in the morning. Removed to Calcutta. Had no fever and no burning. Stools less in numbers, a little distension still remains. *Camphor* continued.

30th—Very easy, almost no complaint, only a little distension continues. One dose of *Camphor.*

31st—Takes soup of shells and Gandal* leaves. Rubbing of oil over the abdomen lessens the distension. No medicine.

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* A rubiaceous creeper (Paderia fœtida) very common in Bengal. The soup of its leaves is an excellent cooling (and perhaps slightly astringent) beverage and food in bowel complaints. especially diarrhœa.

1st August—Took rice for the first time. Stools of a reddish colour. *Carbo veg. 6*; distension almost gone.

2nd—Took 2 tolas of rice. No distension. Sleep not sound.

3rd—The body was sponged with warm water; two and half tolas of rice. 1st appearance of blood with the stools. *Nux vom. 30.*

4th—Very good stool; Bathed; takes 3 tolas of rice. No appetite in the afternoon; distension. *Nux vom. 30.*

5th—Only one tola of rice. Blood with stool; appetite not strong. *Ipecac 3.*

6th—Blood continues; no distension. Has appetite. Feels comfortable in other respects. Rice stopped; only Barley water given as food.

7th—1st appearance of slough with the stools. Two pieces, each about 1 inch square. 2 tolas of rice. *Silicea 30.*

8th—Pus with stools, no slough this day. Appetite improving. Broth given. *Silicea* continued.

9th—Feels rather weak and thirsty in the morning. Blood and pus with the stools. *China 12.*

10th—Not so weak as on the day previous. Blood and pus continued. *China* continued.

11th—No other complaint except the blood

and pus with the stools. *Arnica 6.* Stool much better in the afternoon after *Arnica.*

12th—Blood and pus. Discharge of scybala. *Arnica* repeated.

13th—Stool same as before. Blood continued. Appetite increasing. No medicine.

14th—Blood and pus continued, rather increased in quantity. *Mercurius corrosivus 30.* Blood and pus much less.

15th—Blood and pus much less. Appetite increasing and food was increased with the increase of appetite. *Merc. 30.*

16th—Streaks of blood and very little pus. No medicine.

18th—No medicine. Discharge of several scybalæ. Blood and pus continued but much less than before.

19th—Discharge of scybalæ, but not so many as on the day before. *Nux vom. 6.*

20th—Discharge of scybalæ. Very little blood and pus. No medicine.

21st—No medicine. Very good stool. Several scybalæ and almost no blood.

22nd—Appearance of blood again; scybalæ. *Nux vom. 6.*

23rd—Blood and pus with stools. *Plumb. acet. 3.* Discharge of scybalæ in the afternoon of

larger size than before with the streaks of blood and a little pus in them.

24th—*Plumb. acet. 3* repeated. Scybalæ very large with streaks of blood.

25th—Thin stool with blood in the morning. In the afternoon very healthy stool with streaks of blood. No medicine.

26th—Very healthy stool, almost ordinary, with neither blood nor pus in it. No medicine.

27th—Bowels rather costive. Had only one stool in the afternoon consisting of 2 scybalæ, no blood. No complaint; no medicine. Bathed. Had very sound sleep at night.

28th—Bowels rather costive. Had no stool in the morning. In the afternoon felt very great difficulty in passing stool. The stool passed was very healthy. No complaint whatever. Feels much stronger than before. No medicine.

Dyspepsia (nocturnal aggravation); with Amenorrhœa. Cure effected by Pulsatilla

Last autumn I was consulted by a gentleman about the case of his sister, who was suffering as he said from indigestion. The symptoms were want of proper appetite especially in the night, tympanitis with rumbling of the abdomen

commencing in the evening and increasing in the night, thin stools three or four in number, sometimes containing even the ingesta, only in the night. Consequent upon this there was proportionate weakness and anæmia. On particular inquiry I found that the indigestion has resulted since the patient has ceased to have the regular course. The patient was a young girl of 15. *Pulsatilla 6*, in doses of 3 globules three times a day, was ordered. At the end of upwards of a week, the report was that there has been no improvement, in fact, there has been no change either for the better or the worse. *Pulsatilla* being still indicated I gave it in the same attenuation again, but in the form of tincture instead of globules. The improvement at the end of a week was so slight as not worth reckoning. The drug was in consequence ordered at the third dilution in tincture, and from the day this was done, decided improvement in the symptoms commenced. The tympanitis became less, the stools became thicker in consistency and diminished in number, the appetite returned gradually, till all the dyspeptic symptoms were finally and permanently removed. The patient began to have her course regularly, but sometime after the improvement in the digestive functions.

Remarks

We have selected this case out of many to show that the appropriate drug being selected, it is not a matter of indifference to administer it in any dilution and in any form. There is an appropriateness of the drug as well as of the state of attenuation in which it ought to be exhibited. Again, the dilution being selected it is not a matter of indifference to prescribe it in any quantity. We have found that where globules are useful, tinctures prove too much, and where tinctures are useful, globules are useless. We would here enjoin extreme caution in recommending to inquiring Allopathic brethren the use of their drugs after the law of similars, as for instance the liquor arsenicalis, tinct. aconite, tinct. nux vom., etc. In however minute doses these drugs may be used, they can never approach the Hahnemannian dilutions, and consequently may be more mischievous than useful in the majority of cases.

Suppurative Inflammation (traumatic) of the foot, Threatening Gangrene, Cure effected by Silicea

An old woman, aged about 80, slipped her right foot and sprained the toes on the night of 24th July last. On the following day there was pain and swelling of the toes. *Rhus tox.* externally and internally was used, but to no effect. The pain and the swelling increased till the whole foot was

involved in the inflammatory process. Signs of abscess here and there were visible but on opening one of them blood and sanious fluid oozed out. The woman, old as she was, was greatly prostrated by fever and the pain in the affected parts. Blisters formed on the skin of the dorsum of the foot and there was every indication of impending gangrene. *Hepar sulph.* was now used and in the course of a few days distinct fluctuations were noticed in places where the formation of abscess was suspected. These were opened one after another, and purulent matter came out. All these openings formed the mouths of long sinuses and the use of *Hepar s.* did not succeed in causing them to heal. It was therefore discontinued, and the Tinct. Fer. mur. substituted in its place. Nor was this of any use in promoting the healing of the sores. They continued as bad as ever. *Silicea 30* was now used. It did some good, but the improvement was stationary. *Silicea 12* was next used and it effected the final cure in about a month. By the end of September last she was well enough to walk about.

Remarks

The daily report of this case was not taken under the impression that the patient will not live. It is a pity this was not done. For it is impossible, otherwise, to convey even a

faint picture of the gravity of the case, and of the intensity of the poor woman's sufferings. The cure of the case has been remarked by all, who watched its progress, as a marvel achieved by the new system. The circumstances under which the treatment was pursued were the most adverse imaginable —in the rainy season, and the patient being obliged to remain in a low damp place, on a bed which was continually wet and filthy from her excretions.

Acute Anasarca following an attack of Intermittent Fever. Cure effected by Pulsatilla

Bhabani Charan, aged 4½ years, was brought to me in the beginning of November, 1867, with general anasarca. On enquiring into the history of the case it was found out that upwards of fifteen days ago while with his grand-mother at her house at Nimtah, one of the epidemic stricken villages, the child was attacked with fever of the intermittent type, which was not however of a very severe character. Very little restriction however was made in his food and he was allowed to indulge himself in the ordinary sweetmeats fried in ghee (clarified butter) which disturbed his digestion, and in the course of a few days the abdomen was found to swell and in a few days more general dropsy invaded the whole body. When the child was brought to me the dropsy

was of a frightful nature; the face, especially the eyelids, were so swollen as to cover the eyes. The hands, abdomen, scrotum, and the lower extremities were so swollen as to pit deeply on pressure. There was no pain anywhere. The child was free from fever, the bowels costive and the urine scanty. *Pulsatilla 30* and dry regimen were ordered. In the course of ten days the recovery was complete.

Remarks

The above case offers an instance of therapeutic success with remedies selected according to the indications presented by the immediate exciting causes of diseases. Upwards of a year ago I cured a case of epilepsy after childbirth which was evidently brought on by a fall immediately before delivery by Rhus toxicodendron. Cases of fever, diarrhœa, congestion of the brain, or of any other internal organ have been cured by Dulcamara, wherever we have been able to trace their origin to wetting. And so on.

A Case of Condylomata around the Anus

Trailakya, a girl, aged 14, was admitted in my Out-Door Dispensary, on the 12 November last, for condylomata, or flat mucous tubercles around the anus. They were as usual whitish in appearance, slightly raised above the skin, continually secreting a mucus-like fluid. There was a good

deal of burning and aching in the parts especially during and after stool. There was also much bleeding during stool. The patient had no syphilis nor gonorrhœa, but her husband had both. Her father also had syphilis. Prescribed *Thuja 6.* This was continued till the 29th but no improvement having set in, gave her *Acid nitric 6.* This was continued till the 15th Dec., without the slightest result. On the contrary the condylomata spread more and more on all sides. Thinking the girl might have been infected by the husband, without there having been any local sore, I gave her *Merc. s. 6,* and continued it till the 6th January, but without doing her the least good. Suspecting the disease might be purely local, I abandoned all constitutional treatment, and ordered a strong solution of Nitrate of Silver (20 grs. to the oz.) to be applied to the excrescences. From the day of the application, the discharge and the pains became less, the bleeding stopped, and the elevations began to be reduced in size. In about a fortnight the patient was all right.

Remarks

This case well illustrates the utility of local remedies and the utter uselessness of constitutional treatment in cases where the disease is purely local, and the constitution unaffected.

A Case of Hysteria: Recovery

Babu R. D. M. placed his wife (then aged 31 and mother of seven children, the age of the eldest 18½, of the youngest 3½) under my treatment in May 1870. Her symptoms were: Hysteric fits every day in the afternoon or towards evening. The fits were characterised by loss of consciousness, violent convulsions, and involuntary loud cries alternating with loud laughter. The duration of the fits varied, being sometimes as short as five minutes, sometimes as long as half an hour; generally they used to last from twenty to thirty minutes. Just before the fits she would complain of her jaws being compressed with great force, which caused inability to open her mouth; this lock-jaw continued throughout the fit, except when involuntarily opened by cries and laughter. She also felt as if something were moving below her throat, and as if a millstone were pressing against her chest. She also fancied that she saw figures of demons with numerous heads and large teeth, who seemed to converse with her. When not in the fits, the following symptoms were continually present:—giddiness; rumbling in the bowels; incarceration of flatulence, escaping neither upwards nor downwards, and causing her much uneasiness;

shuddering and shivering at times of bathing, though she could endure every possible amount of cold; in fact she was obliged to keep constantly a towel dipped in iced water over the head to allay the burning there; dulness and perversion of the senses generally, she would see figures, hear sounds, smell odours, alternately agreeable and disagreeable, without any objective reality; gloomy countenance; eyes swollen and fixed to the ground, as if wrapt in contemplation; forgetfulness; and fearfulness, fearing chiefly ghosts and demons, which she would request her relatives to have exorcised. Her bowels were very costive, her stools being always scanty. The menses were very scanty.

The disease in this form had first declared itself in December 1869. Previous to this she had been suffering from dyspepsia for sixteen years. This arose immediately after the death of her second child. The chief symptoms of this dyspepsia were—acidity, burning of the crown of the head, of the eyes, chest, hands and feet, with tightness of the chest. She could not derive relief from these troublesome and painful symptoms, excepting from vomiting of a large quantity of acid stuff from the stomach. For a year previous to her present complaints, the dyspeptic

symptoms had become very severe. Every morning she had very copious vomiting, after which she used to become so weak and languid as to feel her own body was not her own. The menstrual function had been irregular since 1864, previous to which for four years it was suppressed. A few days previous to the bursting out of the hysteria the daily vomiting stopped of itself and could not be induced even by voluntary efforts. This circumstance, with the privation she had to undergo on the occasion of her son's wedding, was probably the immediate exciting cause of the complaint for which she came under my treatment.

The disease at first was mild in character, the fits being much less severe and few and far between. There were acidity, burning of the whole body, especially of the crown of the head, loss of appetite, costiveness, with scanty stools shivering at times of bathing, melancholia and forgetfulness. She was placed under Kaviraji treatment, under which she was kept for three months. Inunction of various oils, and numberless internal remedies were prescribed, but without the slightest improvement. She was therefore placed under what is called English treatment (Allopathic) and in the course of a

month her disease became so much aggravated, that even the doctor pronounced the case to be incurable, and could think of no better treatment than the application of the seton to the nape of the neck, and removal to a better climate. This alarmed the husband and compelled him to think of Homœopathy.

The following is a summarised account of the treatment pursued:—

I began her treatment on the 7th May 1870. Gave *Aco. 30.* This had at once the remarkable effect of quieting and soothing her considerably, and though the fits were not altogether checked, their intensity and duration were much lessened. On the stopping of it on the 9th she became slightly worse again. Gave it again on the 10th with the same effect as before.

13th May—Fits, though less in intensity and duration still were occurring every day. Gave *Puls. 6.* This was continued till the 2nd June, with occasional intermissions. The fits had now become less frequent, coming on at intervals of 5, 6, or even 8 days.

3rd to 6th June—*Nux v. 30* for costiveness and acidity which were relieved.

8th to 24th—No medicine.

25th—Had been complaining since the 21st

of heaviness in the stomach, heat in the head and acrid sensation in the throat. *Puls. 30*, which was continued till the 20th July.

21st July.—Great disposition to weep. Loathing of life. Thoughts of committing suicide. *Am. c. 6.*

24th—Better. Cont. *Am. c.*

28th—Shivering again at times of bathing and also towards evening, since the 25th. Fits had not disappeared yet; they came on, though at long intervals. Alternate weeping and laughter. Thoughts of committing suicide stronger. *Aur. 6.*

31st—Better. Cont. *Aur.*

3rd Aug.—Course had commenced since yesterday. No medicine.

16th—Somewhat bad again, with thoughts of suicide. *Aur. 6.*

19th—No better,' *Aur. 30.*

20th to 31st—Again talking of demons and evil spirits and also much of other meaningless things. No fits for a long time, but flushes of heat towards afternoon in place of the fits. *Puls. 30.* which was continued till the 31st with the most beneficial results.

1st to 23rd—No medicine.

24th—One dose of *Puls. 30* for the return of some of her complaints, such as, heat in the head,

heaviness in the chest, loss of appetite, internal shivering, sensation as if something warm were rising from the stomach to the head. She was all right till the 30th Oct. when she complained of extreme debility; pain in the head, waist and joints; great burning of the skin throughout. *Ars. 30.*

6th Nov.—The menses, which should have appeared two or three days ago, had not yet appeared, on account of which she was uneasy again, the burning sensation in the stomach, nausea, fear of demons at night, &c., having returned. *Puls. 30*, one dose.

All right till the 14th Jan. 1871, when she was slightly bad again. One dose of *Puls. 30* and she was relieved.

On the 15th Feb. I had to give her a dose of *Puls. 30* for similar complaints with the same result.

16th Sep. 1871—All right till two or three days ago, since when she was complaining of temporal headache, a sensation of a lump in the throat, causing nausea and a desire to vomit, burning of the skin, flat taste in the mouth, achings and tinglings in the tips of the fingers, aversion to work, palpitations, fearfulness, evil spirits speaking to her. *Cupr. 6.*

All right till the 12th Nov., when she got fever which was very foolishly attempted to be cured Allopathically. Enemas of castor oil, Belladonna plasters to the temples, &c., were had recourse to with the only effect of aggravating the disease. Under our treatment the fever rapidly yielded to *Ars.* and *Puls.* and she has been all right since.

A Case of Diarrhœa: Recovery

Jogendranath Mookerjee, aged 15, who has been suffering from malarious fever and enlarged spleen for nearly a year, complained of heaviness of the stomach on Wednesday evening, the 2nd July, in consequence of having taken his meal unusually late. During the night he had three copious diarrhœaic stools of a whitish grey colour and mixed with undigested food. In the morning he still complained of frequent rumbling in the bowels, and there was much flatulent distension of the abdomen. *China 30* was prescribed at 10 A.M. He took four doses of the medicine, a dose after each stool up to 1 P.M. But in spite of that, the diarrhœa continued without the slightest change for the better, the stools becoming more and more copious each time. The last 3 stools

were very copious, not less than a seer each time. *China* was stopped and in its place *Ac. phos. 6* was given, as it precisely covered the symptom, "gurgling in the abdomen, when bending forwards, also when touching the abdomen". There was no return of Diarrhœa even after the first dose.

Remarks

The above case shows most clearly how a medicine, seemingly Homœopathic to a disease fails to make the slightest impression upon it, when a truly Homœopathic medicine arrests its progress and cures it like a charm.

A Case of Jaundice: Recovery

Babu S. Mukerjea, a young man aged about 20, who placed himself under my treatment on the 16th June last, gave me the following history of his case:—"A week after I had kept up two consecutive nights in the latter end of April, my whole body began to itch. In the course of the week my eyes changed their usual colour and turned yellow, and two or three days afterwards my urine became yellow also, whereas my stools became white. I was placed under the treatment of Drs.—under whose care I remained for three weeks or a month without the least improvement.

I was then placed under Kavirajs, and although I remained under their treatment for a fortnight or three weeks, I did not derive the slightest benefit, notwithstanding their promise to cure me in a week. I then let off regular treatment for a week or ten days, and without taking any medicine internally, went on applying externally medicines from quacks. The result was the same, that is, no improvement."

When on the 16th June I took him under my care, there were the following symptoms:—Deep yellow colour of the conjunctiva and though the skin was dark-coloured, the jaundice was well seen in it too. Slight enlargement of the liver. Some feverishness in the afternoon. Gave *Nux v. 6.*

19th June—Has been taking *Nux v.* but without any tangible improvement. The medicine was continued in the belief that its trial has not been sufficient.

21st—Not the slightest improvement being reported, discontinued *Nux v.* and gave instead *Bryo. 6.* The improvement was rapid from this date and by the end of the first week of the next month, he was nearly well, and at the end of the second week there was not a vestige of the disease.

Remarks

There were very few symptoms in the above case to enable one to select the appropriate remedy. We were entirely guided by clinical experience, which, in absense of numerous symptoms, is not to be neglected.

A Case of Caries of the 8th Rib (left): Recovery

Babu P. C. B., aged 33, school-master by profession, came to me on the 12th March, for the following complaints:—

A sinus on the back 2 inches to the left of the median line and 3½ inches below the inferior angle of the scapula. There was an ichorous discharge from the sinus. The skin around it was dirty red and adherent to the subjacent tissues which again were adherent to the bone beneath (8th rib). The part was painful. The patient could not lie on his back, especially on the left side, without feeling a good deal of pain. There was a tendency to diarrhœa.

The history of the case is as follows:—

The patient is of scrofulous constitution. Several cicatrices in the neck, indicative of previously existing suppuration of the glands. In November 1872, when at Baruipur patient felt pain at the spot of the back defined above. This pain

was at first felt only when lying on back; after sometime it was felt in all positions. The part was painted with tincture of iodine; when he came to his native village Baraset he had it examined by the doctor in charge of the station, according to whose advice compound iodine ointment was applied for sometime. This producing no beneficial effect, he took *Hep. s. 6* which seemed to relieve the pain for a short time, but the pain returned in an aggravated form and a deep-seated abscess was diagnosed. The abscess was opened on the 20th January of this year. A quantity of thick, apparently healthy pus came away. There was some bleeding. The ulcer was treated at first with warm water injection and application of lint, but, showing no tendency to heal, iodine with water, instead of simple water, was used as injection, and iodide of potassium was given internally. Still there being no tendency to heal, carbolic acid was substituted for the iodine in the injection. No improvement following, the doctor made a careful examination on the 10th March, and discovered caries of the rib. The patient, taking fright at this diagnosis, came to me on the 12th. I gave him *Sil. 12* and from that day improvement commenced. Discharge gradually diminished, and there was marked relief in the

pain. In less than a month the sinus closed and the patient could lie on his back without feeling any pain. After the closure of the sinus, there was once or twice some oozing of humor from the part, owing to some indiscretion on the part of the patient. He is now however quite well for upwards of two months.

Remarks

Any comment on this case is superfluous. It clearly demonstrated the wonderful curative influence Silicea exerts in caries of bones and the utter uselessness, to say the least of them, of irritating lotions, and injections. Without the proper internal remedies, they are not only useless, but prove, as we have often found, very injurious by keeping up a continual irritation in the affected parts, which, to return to their normal condition, require rest, and sometimes absolute rest.

A Case of severe Remittent Fever with Coma, Delirium and Jaundice: Recovery

Babu G. C. D. aged about 60, and resident of Chakraber, Bhownipore, was attacked with fever on the 1st August of the current year. The immediate cause of the fever could not be ascertained. For sometime previously he was subject to occasional indigestion, and his health was in consequence somewhat impaired. During the

day on the first day of the fever he was quite well. He began to feel somewhat uneasy in the evening but, being an opium-eater, took his usual quantum of milk. On going to bed at about 10 P.M. he got strong fever, which continued unabated the whole night. In the night he had to go to stool twice, and as it was raining that day he got wetted. On the following morning (2nd August) the fever somewhat remitted, but only to come on with greater intensity. The fever was accompanied by excessive thirst. From evening of this day the patient began to be unconscious and delirious. On the 3rd day the stupor and the delirium increased. This alarmed the family, and I was sent for on the 4th day. I saw him in the evening of Aug. 4. The patient did not appear to recognize me, though he knew me well.

I noted the following symptoms:—

Delirium, considerable depression, pulse very frequent, heat not considerable, tongue dry, and as far as could be made out by candle-light, yellow tinge of the conjunctiva. Prescribed *Rhus t. 6*, ½ drop every 4 hours. Saw him again at 10½ A.M. of the following day (5th August). Found him much improved; he could recognize me, and there was hardly any delirium, the pulse was better. The jaundice was deep. Gave *Bryo. 6*, ½ drop every 4

hours. In the evening report was brought to me that he was better in every respect, except that there was some tympanitic distension of the abdomen; I therefore stopped all medicine for the night. On the 6th the report was that he was considerably better, so much so that it was not deemed necessary for me to see him. As he has had no stool for 6 days, I gave him *Nux v. 6.* On the 7th he was better still, though he had no stool as yet. On the night of the 9th the patient having had no stool for upwards of eight days, the family, under the advice of a neighbouring doctor, gave an injection of tepid water with some castor oil, which had the effect of bringing out scyballæ and thus clearing the rectum. The patient gradually recovered, and on the 15th day had his usual rice.

Remarks

I have very seldom seen patients, especially at the age of this gentleman, recover from such a severe form of Remittent Fever, in which delirium and rapid prostration had set in from the second day of the disease. It was not simply the recovery, but the rapidity of the recovery, which astonished not only me but everybody who saw the patient. The case demonstrated the powers of Rhus toxicodendron and of Bryonia alba in fevers of the low type which have become so prevalent of late in Bengal.

We may, in passing, make one observation in connection

with this case, and this is, in reference to the much vexed question of "Auxiliaries". In the case under notice, the professional reader no doubt has noticed the administration of the injection of tepid water with castor oil followed by relief to the patient, and as far as could be judged, this procedure did not stand in the way of recovery, if, indeed, it did not accelerate it. The injection was given without my advice, and probably, if I had been asked, I would not have advised it. In many instances patients have recovered, though they did not pass any stool for such a length of time as from a week to three weeks. In some instances where the patients had become impatient to have a stool, I have seen the use of what are called "mild aperients" and even of simple tepid water enema followed by unpleasant disturbances, such as aggravation of the fever, diarrhœa, &c. I say in some instances and not in all. Sometimes, though very rarely, the artificial evacuation of the bowels had led to the removal of the residue of the disease, if we may so call it, and thus has helped the progress of recovery. Under these circumstances it is not easy to decide this question of auxiliaries. All that we can lay down on the point is that they should never be had recourse to except under the most urgent circumstances.

A Case of Cholera: Recovery

Mahesh, a boy of the weaver caste, aged 15, was admitted in my Out-Door Dispensary, on the morning of the 6th May, for diarrhœa, vomiting and gripes which had commenced at about 5 A.M.

According to the mother's statement, he had come to Calcutta only four days, walking all the way from Radhanagar, his native village (32 miles distance from Calcutta). He had indulged much in indigestible food the day before. At the time he was brought to me his chief complaint, which made him restless beyond measure, and utter loud and most distressing cries, was griping. Neither the diarrhœa nor the vomiting was at all severe, far less alarming. The pulse was good and the body warm. I therefore at 10-30 A.M. gave *Coloc. 6.* Took two doses at intervals of 15 minutes; griping as bad as before; passed a stool watery, not very profuse, but containing some undigested food. After this he had two more doses of *Coloc.;* griping no better if not worse; began to purge more, and in addition had one watery vomiting.

After this he began to collapse, pulse sank, the body became cold. *Ars. 6,* one dose; the body became warmer, but the gripes continued.

The stool, instead of watery, became slimy, with a rosy tint. Another dose of *Ars.;* body warmer still, almost feverish; the patient became from this time very thirsty; stools scantier and slimy. *Aco. 6,* of which he took 2 doses; stools became bilious but were still mucous and bloody

and the pains in the abdomen as bad as before. *Merc. c. 6*, one dose. After this he again passed a copious watery stool and became collapsed; thirst so violent that he loudly called for water, ran to the street-pipe and drank water out of the hydrant. On being restrained he ran away from the house and drank water from a distant hydrant; was brought back by the mother in a state of perfect collapse.

5-30 P.M.—Pulse hardly perceptible, eyes sunk and without lustre; complains of severe pain in the stomach; rolling on the floor and screaming in agony. *Ars. 12*, every ½ hour.

7 P.M.—Pulse very small and thrilling; other symptoms continue unabated; passed one scanty stool consisting of mucus and water.

9 P.M.—Pulse a little better; pain, which is at times burning, continues, empty eructations; cold all over, especially at the extremities. *Carbo v. 30.*

10-30 P.M.—Pulse improving. No amelioration of either the pain, or the restlessness, or thirst, but cannot drink largely at a time. *Ars. 12* and *Carbo v. 30*, alternately at intervals of 2 hours.

2 A.M.—Cold still, the region of the heart only appears a little warm; more quiet, but on

being asked, he says the pain has not abated; eyes injected, had more scanty stools, the last watery and of a yellowish colour; no urine; no more medicine.

May 7th, 6 A.M.—Pulse quick and small, but countable; eyes dull and injected; spasmodic pain in the stomach continues; empty eructations now and then; reaction very imperfect. *Cuprum 30*, no urine.

9-15 A.M.—After taking a little sugar-candy and water, he vomited a large quantity of bitter watery fluid of a greenish colour.

4 P.M.—Pulse much better; no urine; eyes dull and injected; speaking incoherently now and then; body warmer, extremities still cold. *Bell. 30.*

10 P.M.—Delirium much less, eyes red; pain in the stomach decidedly less. Repeat *Bell. 30.*

2 A.M.—Conjunctiva less injected, no more stools, no urine; retching now and then with scanty vomit; appears perfectly in his senses; extremities warmer. Stop medicine.

May 8th, 6 A.M.—No more pain in the stomach; no stool, no urine, no delirium; pulse regular but accelerated; eyes more healthy-looking. Ordered to have a little sago-water.

7 A.M.—Could not take sago, as it produces vomiting; complains of slight pain again. *Bell. 30* another dose. Half an hour after this, he experienced relief and passed a few drops of a very high coloured urine.

11 A.M.—Passed urine about ½ a poah. Cannot take any beverage, although he feels very thirsty, complains of burning in the stomach again.

1 P.M.—The mother stated that the patient was not able to retain water which he throws up immediately after drinking. *Eupat. 6.*

6 P.M.—The mother's statement appeared wrong on further examination. The patient could retain water but would vomit only sago, which he says had a peculiar nauseating taste, although prepared with care. Feels very languid after vomiting. No medicine.

10 P.M.—Retching and vomiting continuing; no more stool. There was this singularity in this case, that the vomiting and retching alternated with the purging. *Tart. emet. 30.*

May 9th, 6 A.M.—Passed a rather peaceful night; vomiting much less; no retching; sago or arrow-root still causes vomiting. Allowed (চিড়ার কাথ). From this time forward, he continued to improve, without any untoward symptom being

complained of, and on the 12th May he took his usual meal with good appetite.

Remarks

This was one of the most dreadful cases of cholera we have ever had, but of which the gravity is impossible in words to impress upon the reader. Commencing as simple indigestion from indulgence in indigestible food, it rapidly passed on to cholera of such formidable character that we had no hope of the patient for sometime. The almost perverse obstinacy of the patient was very annoying and was a serious bar to his treatment, but much of that perverseness was due to the intolerable griping from which he suffered, and which we failed to relieve till the next day when Cuprum removed it altogether. We had not prescribed this drug at first as there were no cramps of the extremities, and we were at last driven to it under the idea that the gripes might after all be nothing but spasms of the intestinal muscular fibres. The relief that followed the exhibition of the drug confirmed the idea. It is more than we can say if Cuprum would have cut short the disease if exhibited in the beginning. The case illustrated the efficacy of Bell. in cases where along with suppression of the urine there is affection of the brain, or more properly where there is congestion both of the kidneys and of the brain. The case further illustrated the utility of Tart. emet. when the vomiting alternates with the purging, ceasing when the purging appears, and re-appearing when the latter ceases.

A Case of Cholera

(*Reported by Dr. B. N. Dutt*)

Basanta Kumar, aged 15 months (son of Babu Amrita Lal Paul of Shibpore) suffering from a chronic diarrhœa for 3 months, was attacked with cholera on the 31st Oct. 1874, at about 1 P.M. After about one hour from the breaking out of the disease I was sent for, and I found the child with the following symptoms—pulse quick and feeble; extremities rather cold; eyes sunk; restlessness; thirst and prostration. Before my arrival, had one copious watery stool and vomited once. I gave a dose of *Ars. 3*, which quieted the child, and for the next 6 hours he neither purged nor vomited. At 9 P.M. I again saw the child when I found the pulse improved, extremities hot, but he was now passing watery stools of a whitish colour, the discharges being preceded by rumbling and slight distension of the abdomen. Guided by these symptoms, I prescribed *Acid phos. 2* with direction to repeat the medicine after every stool.

1st Nov.—Patient seems better; distensions of the abdomen less; no rumbling; stools yellowish; passed no urine since the breaking out of the disease. I prescribed *Canth. 6.*

2nd—Passed urine once (when not mentioned).

Occasional discharge of loose stools at long intervals. Prescribed *China 3.* At 4 P.M. the father gave me report, that the child was sleepy and did not open his eyes. On examination I found the pupils extremely dilated. Prescribed *Bell. 12.* As night advanced, the child began to grind its teeth constantly.

3rd, 6 A.M.—Dr. Sircar was called in and prescribed *Stram. 30.*

At 1 P.M.—Pupils dilated as before; constant grinding of the teeth with occasional protrusion of the tongue; constant raising of the left hand; gloomy and drowsy; a semi-transparent glutinous substance floating on the inner canthus of the right eye; had 2 scanty yellowish fœtid stools; made water once, the urine having an orange-coloured sediment at the bottom; abdomen distended. *Stram. 30.*

At 8 P.M.—Eyes glistening, and the pupils dilated; spasmodic rigidity and clenching of the fingers; stupor and grinding of the teeth; had 4 scanty, brown, fœtid stools since 1 P.M. At the suggestion of Dr. Sircar I prescribed *Secale 30*, 3 globules.

4th, 6 A.M.—Pulse 106; skin hot; fever has not yet subsided. After the administration of *Secale* the child slept quietly for sometime. No

rigidity of the hands at present; had 7 scanty, watery, fœtid stools during last night; passed urine twice. When the child lies on his back, he feels a slight difficulty on deglutition.

4 P.M.—At the suggestion of Dr. Sircar I had given 3 doses of *Chininum sulph 1*, during the intermission, but the medicine could not keep off the fever paroxysm which came as usual at 5 P.M.

The following report was sent to Dr. Sircar.

5th—Had several fœtid stools at night; abdomen distended; pulse 108 and regular.

He sent *Chin. 30.*

Evening—Dilatation of the pupils less; still drowsy; had 2 scanty stools; passed water once at 11 A.M.; pulse 108; skin hot; fever came at 3 P.M. Dr. Sircar sent the following directions: "I should do nothing during the fever, but would resume *China* after its subsidence."

6th Morning—Difficulty of opening the jaws. Had to give a dose of *Bell.* at 9 P.M. At 2 A.M. the dilation of the pupils was found much less; spasmodic closing of the jaws; pulse 96; skin slightly hot. At 3 A.M. gave a dose of *Cupr. ac. 3;* had 3 scanty stools of the same colour and consistence as before stated; micturited once; abdomen distended. After the administration of *Cupr.* the symptoms suddenly changed for the

worse. Dr. Sircar was accordingly sent for and he found the patient with the following symptoms of threatening collapse. Coldness of the upper and lower extremities; tympanitic distension of the abdomen; pulse feeble; eyes dull and without lustre. He prescribed *Carbo v. 30*, to be continued every 4 hours until the temperature rises. Diet—barley-water.

7th—Trunk rather hot; extremities of a normal temperature; had 2 scanty stools of a thicker consistence; passed urine twice, the last with the stools; no distension of the abdomen; no medicine. Diet—light broth and barley-water.

8th—Same as reported yesterday; only more sleepy; no medicine. Diet—light broth and barley as before.

9th—Pulse 108; skin slightly hot; lower extremities of ordinary temperature; no stool; no distension of the abdomen; eyes glistening; glutinous substance floating here and there over the cornea; very sleepy; no medicine. Diet—as before.

10th—Pulse 108; skin slightly hot; the whitish spot over the cornea has disappeared; less sleepy; constant moving of the head; had one almost normal stool; made water twice. No medicine.

11th—Pulse 102; skin very slightly hot; no stool; micturited twice; whitish deposit in the urine; no medicine. Diet—boiled rice.

12th—Fever came at 8 P.M. last night; skin still hot; pulse 120; no stool; micturited twice. As directed by Dr. Sircar, I gave *Nux v. 6* in *globules*.

13th—Pulse 126; skin hot; the temperature of the right leg is higher than that of the left; one yellowish stool at 4 P.M.; tongue red and hot; protrusion of the tongue; twitching of the facial muscles; constant rolling of the eye-balls, attended with movements of the head; pupils slightly dilated; occasional moaning; less desire for food. *Bell. 30* which, however, not having done any good, *Hyoscy.* was given at the suggestion of Dr. Sircar.

14th—Pulse 120; skin slightly hot; no stool; micturited once; tongue red; rolling of the eyes less; movements of the head less; no moaning; taking food with avidity. *Hyoscy.*

15th—Pulse 128; skin hot; had a scanty yellowish stool, after about 40 hours; severe thirst; tongue red; protrusion of the tongue less frequent; moving the mouth as if chewing; occasional grinding of the teeth; sleep disturbed. *Ars. 12.*

16th—Pulse 126; skin hot; occasional staring

of the eyes; constant chewing motions of the mouth. *Ars. 12.*

16th, 5 P.M.—Chewing motion of the mouth less; moving his left hand and leg at intervals.

17th—Pulse 126; skin hot; had one yellow-coloured thick stool; micturited twice, the last was passed with the stool; movements of the head, hands and legs less; fever persisting without remission for the last 3 days. As directed by Dr. Sircar, all medicines were stopped.

18th morning—Fever abated at 8 P.M. last night when the pulse was 108. The remission however did not last long, for at 6 A.M., the skin was found hot, and the pulse 114; tongue red at the tip with a brownish coating in the centre; had a very scanty stool; movements of the hands and feet constant again, accompanied at intervals by rigidity of the feet; dislike for both food and drink. No medicine.

19th—Pulse 120; skin hot; chewing motions and opening of the mouth constant; constant involuntary motions of both hands attended with rigidity and clenching of the fingers. The child is crying loudly since 5 A.M. From the above report Dr. Sircar prescribed *Cham. 12* in *globules*, under the supposition, as he wrote, that the child was suffering from colic.

19th, 5 P.M.—Pulse could not be counted on account of incessant convulsions; spasms of the whole body, especially of the hands and legs, with rigidity of the neck; stiffness of the sterno-mastoid muscles; constant, loud crying; distortions of the facial muscles; coldness of the feet. *Nux v. 30.*

20th—Pulse 114; skin slightly hot; no stool for 2 days; neck rigid, but the sterno-mastoids less so; inability to open the mouth; convulsive movements of the hands less. The loud crying has changed into weeping. *Nux v. 30.*

20th, 3-30 P.M.—The sterno-mastoid muscles are soft; the neck bent backward; the spasms have again become very violent. After giving 2 doses of *Nux 200*, I tried *Colocy. 6*, with the same unsuccessful result. Incessant loud crying; eyes upturned with rolling of the eye-balls. Prescribed *Bell. 12.*

21st—After the 2nd dose of *Bell.* the child slept for about an hour, and on waking a third dose was given, this was succeeded by a quiet sleep for more than two hours; the frequency and the severity of the spasms were also less; had 3 very scanty stools, and passed urine twice; skin hot; pulse 120.

3 P.M.—After a temporary lull, the spasms

reappeared although in a modified and a shade less severe form; with the spasms the child commenced to cry loudly and shake his hands. From the above report Dr. Sircar prescribed *Cina 30* (which not being at hand, *Cina 12* was substituted).

22nd—Skin slightly hot; tongue coated white in the centre and red at the tip and edges; neck still bent backwards, but the rigidity less; the right hand slightly stiff; slept quietly for 3 hours; chewing motion of the mouth now and then.

23rd—After the administration of *Cina*, the child commenced to bore at the nose; the spasms appeared somewhat less; weeping continued unmodified. From the above report Dr. Sircar prescribed *Cina 200.*

23rd—The spasms appear less, but the crying continues; swelling of the lower lid of the left eye with lachrymation; the spasms commence at 7 A.M. and go on increasing till 3 P.M. when they decrease again; slight coldness of the extremities; pulse 120. *Caust. 30.*

24th—Swelling of the lids almost gone; other symptoms continue without change. *Hep. s. 6,* and lime-water with milk as diet.

25th—Spasms rather severe again; picking of

the nose at intervals; crying. For the above symptoms Dr. Sircar directed to resume *Cina 200.*

26th—Spasms much less; crying less; no more rigidity of the neck and limbs. From this time the child made steady progress towards improvement, and in about a week, all the untoward symptoms entirely disappeared, although they left the child severely prostrated.

A Case of Elephantiasis of the Left Leg

Biswanath, aged 50, was first seen at the Out-Door Dispensary on the 14th June, 1879.

Previous History—He had inflammation of the lymphatics of the left leg about 25 years ago, accompanied with fortnightly attacks of lunar fever, and suffered from several such periodical attacks for a long time, followed by an interval of comparative freedom from the fever, which used to come on every 2 or 3 years. The attacks resulted in slight increase in the bulk of the left leg. Since the last 10 months the fever has been reappearing with its former violence and periodicity. With each attack of the fever there was some increase in the elephantiasis, upon which at last appeared several large nodular prominences.

Present Symptoms—The elephantiasis was confined to the lower part of the left leg from

about 4 or 5 inches above the ankle-joint, extending over whole of the left foot, mottled with black discoloration. Nodular prominences of various sizes were distributed throughout the out-growth, with itching sensation and slight exudation from the surface. He was getting fever every fortnight.

Treatment—From the day of his admission, June 14 to July 13, a full month, he had *Sil. 12*, with no other effect than slight diminution of the fever.

From the 14th to the 19th July, *Hydrocot. asiat. 3*, without effect.

20th July to 2nd August, *Ars. 12*, but no improvement followed.

3rd August—Patient complained that for some days past he was getting fever every day, and that it comes on in the early morning. *Spig. 6* was prescribed, and was followed by complete subsidence of the fever, disappearance of many of the nodular growths, of the exudation and the itching sensation. The *Spigelia* was continued till the 20th. No further progress being observable, *Sil. 12* was again given, and it completed the cure in two months.

Remarks

The great interest of this case consists in the complete recovery from a disease, which is very seldom amenable to

medicinal treatment, and is therefore looked upon as one of the opprobria of medicine. Under Homœopathic treatment we have found the disease kept in check, but not cured. This is the first case, in our hands, which has resulted in the most satisfactory cure. Arsenicum, and Hydrocotyle Asiatica (so much vaunted in elephantiasis) did no good whatever. Spigelia, which was selected for the peculiarity in the time of appearance of the fever, not only removed the fever, but with it nearly half of the skin affection. Silicea, which scarcely did any good in the beginning, completed the cure, after Spigelia.

A Case of Hæmaturia

R. L. M., aged 45, came on the 7th of May 1881, to the Out-Door Dispensary for treatment of bloody urine, which he was passing for about a week.

Previous History—He had gonorrhœa in his 19th year; since then he had led a debauched and intemperate life till 4 years ago, when he was attacked with dyspepsia, for which he had recourse to old school treatment. He had derived so much benefit therefrom that he discontinued all medicines for four months previous to the appearance of the haematuria. For 8 days immediately before the attack of this disease he had to keep up nights and to take his meals at

late hours for a Puja-festival in his village, about 10 miles north-east of Calcutta. During this period he noticed increase in the quantity of his urine, and 4 or 5 days after his arrival at Calcutta he began to pass bloody urine, for which he placed himself under the treatment of a well-known old school physician for a week without any benefit.

At the time of his admission he had no other complaint than the bloody urine and the consequent feeling of weakness with slight pain in the bladder. The quantity of urine was normal, mixed with coagulated blood. He had given to him *Canth. 6*, *Nux v. 6*, *Puls. 6*, *Terebinth 4*, *Arn. 6 and Arn. 2* in succession, without any effect. On the 19th *Carbo v. 12* was given, and the blood disappeared after two doses. The patient improved daily under the medicine which was continued for a month. We see the patient almost every day, and we are glad to say that up to date he has had no relapse.

Remarks

This is a very interesting case, in-as-much as the most approved medicines failed to produce any effect on the disease, whereas a medicine which has never yet, so far as we have been able to gather, been mentioned as having been used in it, succeeded in checking and removing it in the most

prompt manner and the shortest possible time. The pathogenesis of Carbo veg. simply gives:—"Dark red urine, as if it was mixed with blood. Reddish turbid urine." No mention is made of clots of blood with the urine. We were led to its selection in the present case, by our previous experience of the efficacy of the drug in hæmorrhage from the rectum with coagula.

A Case of Strangulated Hernia

Babu————, aged about 70, is subject to right inguinal hernia for upwards of ten years, in consequence of which he occasionally wears a truss. For some days previous to, and on the 14th of this month, he was exerting himself considerably in levelling a certain piece of ground. At about 2 P.M., he suddenly felt a pain as of the threatening protrusion of his hernia. Immediately it began to descend in spite of his efforts to keep it back. The descent was slow so long as he kept his hand pressing against it. The moment he took his hand off it, which he had to do in order to take his baby in his arms, the gut came down, and would not go back. It descended into the scrotum forming a pretty big tumor. All efforts in putting it back having failed, I was sent for at 3 P.M. I found the constriction at the

neck very great, and the patient was in great agony. He was in the sitting posture, with his hands pressing against the hernia. On being asked to lie down in order that I might attempt the taxis, he said he could not do so without risk of the gut descending more and more. The descent into the scrotum was, he said, due to his having laid himself down, as on previous occasions. I attempted the taxis while he was in the sitting posture. I tried for over ten minutes, but could do nothing. I requested him, therefore, to lie down for a minute. He did so, but the hernia far from being reducible, actually did come out a little more. I could not, under such circumstances, insist upon the lying posture, so I asked him to sit up. He said that since the descent of the hernia the passage of flatus has altogether stopped, though he feels there is considerable urgency to it. I gave him a dose of *Lyco. 200*. He had vomited once before taking the medicine, but in a quarter of an hour after its administration he again vomited, and vomited three times. In less than half an hour he passed a stool, and in a little over an hour, the gut went back into the abdominal cavity. After this he had a shivering fit which lasted a few minutes, and was followed by a sound sleep of over five hours.

Remarks

In this case there could be no doubt that the credit of the reduction of the hernia was due to Lycopodium. Whether the repeated vomitings after its administration was due to it or not, it is not possible to say, as the patient had vomited once before. But the stool was evidently the effect of the drug, and the subsequent return of the gut into the abdominal cavity was but a part of the peristaltic movement thus originated. This is not the only instance in which Homœopathic remedies have succeeded in reducing a hernia after strangulation and after failure of the most careful taxis. In one case I had succeeded with a high attenuation of Nux vomica.

A Case of Ulcerating Epithelioma over the left heel cured by Hydrastis

Babu K. C. B., aged 24, by profession a teacher, came to the Out-Door Dispensary on the 31st March 1879 for treatment of an ulcer on the left heel.

Patient stated that while walking in his class he accidentally struck his left heel against a bench which caused some pain in the part at the time. In the evening he observed a slight swelling of the heel. The pain disappeared in about two days, but the swelling continued, and gradually began to increase. At the end of about 5 months the swelling, which was soft and fluctuating, projected about ½ in. from the heel. A medical man suppos-

ing it was an abscess advised him to puncture it himself with a needle, which he did; but instead of any pus only blood flowed rather profusely. About a week after this another medical man, making the same mistake, incised it. The consequence was a much greater flow of blood which had to be stopped by ice, pressure and styptics. After this he went to the Medical College Hospital and was admitted in the ward of the first Surgeon. The tumor was pronounced to be a nævus, and treated with astringent lotions, and hypodermic injections of tannic acid. As a result of this treatment the tumor first became hard, and then began to slough. Tired of being tortured in the hospital, he placed himself under the treatment of a Homœopathic practitioner. The benefit derived was slight and not permanent. He therefore again had recourse to the treatment of the Surgeon who had treated him in the College Hospital, who this time paid him visits at his house. Strong nitric acid was applied to check the excessive proliferation of the granulating surface. The tendency to bleeding increased, tannic acid injection was again resorted to, which was followed, as before, by sloughing. Then chloride of zinc paste was applied and kept on for three days, which caused more suffering and

more sloughing. The diseased part was examined microscopically and found to be epitheliomatous. All thought of cure was now given up, and amputation above the ankle was advised as the only chance of saving life. Thus frightened the patient fled with his life from hospital where he had latterly gone again.

When he came to us we found the whole of the left heel involved in ulceration. The ulcer was of an oval shape measuring 3″×4″. The surface of the ulcer was covered with soft, spongy proliferating granulations, which were very thick and gave the whole a protuberant appearance. The granulations were not quite painful, but they had a great tendency to bleed, indeed the slightest movement would cause profuse bleeding. The edge of the ulcer, where the diseased and the healthy parts met, was very painful and tender. The vessels at edge and of the surrounding parts were considerably enlarged. The whole part for some distance around was very hot. The sufferings of the patient were worse at noon and from 10 P.M. to morning. Has been getting fever since 3 days with chilliness, burning of the eyes, but very little thirst. Tendency to mucous stools. A sensation of burning within the body which caused a desire for cooling things.

Treatment—For the tendency of profuse bleeding we gave him *Ham. 6*, which was continued till the 20th April. The tendency to bleeding was considerably diminished, but there was not much improvement in the ulcer itself. The discharge continued as before, there was no sign of commencement of healing.

On the 21st April we gave him *Hydras. 3*, and continued it for three days, but finding no improvement we changed the dilution to the 2nd, which we continued for three days with no better result. We kept him without medicine to the 9th May. On the 10th *Hydras. 5* was given. In the course of a day or two, the discharge became less, and from this time forth improvement was steady, the healing advancing from the circumference. By the 5th October, the ulcer had completely healed.

The only local application used was warm ghee or clarified cow's butter. The patient was kept throughout the treatment entirely on vegetable diet, fish and meat having been strictly forbidden.

We see the patient now and again. He is hale and hearty. The cicatrix over the heel is firm and rather hard, being more corneous than skinny.

A Case of Malarious Fever in a Child, with Urination during chill, benefited by Cedron

Surendra, aged 4, has been suffering off and on since he was 6 months old from malarious fever, spleen very much enlarged, extending in front to within an inch of the umbilicus, and downwards about 2 inches above the crest of the ileum. Very pale and anæmic. Last attack of fever has commenced since 23rd June. Fever is of the remittent type, aggravation from noon. Motions loose, yellow, 3 or 4 in 24 hours.

29th June—Fever came on a little after noon with slight chills followed by burning heat, and sleep during the first part of the heat. *Aco. 6*, 1 dose. Fever left with perspiration by evening.

30th—No medicine. Fever came on as usual half an hour after noon, lasted the whole night and continued till late in the morning.

1st July—The father of the child reported that both yesterday and day before the child used to pass urine during chill in a half drowsy state. *Cedron 6*, one dose at 11-30 A.M. Fever came on at 2 P.M., later than usual by an hour and half, was of less intensity, but lasted the whole night. Maximum temperature 103°. Did not pass any urine during chill or any other stage of the fever.

2nd—*Cedron 6*, one dose at 7 A.M., and again

at 2 P.M. Fever came on at 4-30 P.M. Max. Temp. 101°.

3rd—*Cedron 6*, one dose at 7 A.M. No. fever.

4th—No medicine. No fever.

5th—No medicine. No fever.

A Case of Amaurosis

Gopal, aged 28, came to the Out-Door Dispensary on the 23rd June 1879.

He is by profession a blacksmith and was suffering from amaurosis of the left eye. The left pupil was widely dilated and he complained of indistinct vision as if he saw through a film. *Carbo v. 30.*

On the 5th July he reported that his sight in the affected eye to be much better than before. The left pupil was smaller than before but not of the same size yet as the right. Cont. Med.

On the 16th August he said that his dimness has almost disappeared and whatever was left did not prevent him from working. The pupils were now equal.

For the little indistinctness of vision that was left after this, he took medicine up to the 17th of October, after which he had no trouble whatever with his sight.

Remarks

In this case Carbo veg. was selected because the patient was by profession a blacksmith, and the indistinctness of vision was supposed to have been produced by the excessive heat to which the eyes were exposed, out of deference to a tradition, how originated we cannot say, but which we have verified often, that Carbo veg. acts remedially against the effects of heat, whether of fire or of the sun.

A Case of Facial Paralysis

Adya Nath Biswas, aged 45, came to the Out-Door Dispensary on the 5th of July 1879, for treatment, having been attacked with facial paralysis of the left side.

Previous history—About 10 days before, one afternoon he had felt a biting and throbbing pain in the occipital region and nape of the neck of the left side. The next morning when he went to wash his mouth he noticed that he could not gargle properly. The same evening one of his friends remarked that the outer angle of his mouth was hanging down a little.

Present symptoms—He hād pain in the left side of the occipital region and nape of the neck and also on the left temporal region. He could not blow properly, and air escaped from the angle

of the mouth on the left side. The angle on the right side hung down a little. The left eye can be closed well. The sensibility of the left cheek was also diminished. *Rhus tox. 6.*

He was continuing the medicine with but little improvement till the 16th.

On the 17th he reported that he had fever. *Aco. 3.*

On the 21st he was seen to be much better. He could blow with his mouth much better than he could do before. Cont. *Aco. 3.*

On the 12th August he was seen to have no more trace of paralysis in his face.

Remarks

Had it not been for the fever which came in the course of treatment, we would probably never have selected Aconite, and we would have had to grope long for the proper remedy. We have treated several cases of facial paralysis, all apparently having been the result of cold, but we have never succeeded in effecting their cures by one remedy for all, though the symptoms were scarcely different.

A Case of Acute Dysentery

Rami, a Hindu female, aged 15, came under treatment at the Out-Door Dispensary on the 18th of February 1881.

She was suffering from dysentery for the last three days and had to go to stool several times, about 40 or 50, in 24 hours. There was no blood with the stools, which were scanty and consisted entirely of mucus. There was considerable pain (griping and tenesmus) during stool. *Ipec. 6, T.D.*

On the 20th there was no improvement either in the number of stools or in the pain. A round worm was passed with a stool. *Cina 6.*

21st—The number of stools and the pain were just the same. *Kurchicine 10 grs.* to be divided into 6 doses, of which she is to have three doses daily.

After taking *Kurchicine* she was much better. The number of stools and the pain considerably diminished, and a large number of round worms, about 15 or 20 were expelled.

Kurchicine was continued in the same dose up to the 26th instant, by which date the pain had ceased altogether, and there was but slight mucus with the stools.

On the 2nd March she reported that there was still slight mucus with the stools; our stock of *Kurchicine* having gone out we had to give *Ipecac.* again, and this completed the cure within a short time.

Remarks

Kurchicine is the active principle of the plant called Kutaja in Sanskrit, and known by the botanical name of Wrightia antidysenterica. The bark of the plant, in the form of decoction, is extensively used by our Kavirajs, native physicians, in dysentery, especially when it is chronic. A fragmentary proving of the drug (tincture of the bark) will be found in the Calcutta Journal of Medicine for May, 1873, from which it will be seen that it is capable of producing at least the preliminary symptoms of dysentery. The alkaloid Kurchicine has been discovered by our friend, Babu Ram Chandra Dutta, Assistant to the Professor of Chemistry, Calcutta Medical College, and Laboratory Assistant to the Indian Association for the Cultivation of Science. It is very likely to prove a valuable drug in dysentery and intermittent fevers. In the case reported here, it did excellent service. The reader will not have failed to notice its anthelmintic properties.

A Case of Abscess in the Abdominal Parietes

Patient, a child aged 4 years and 9 months. On the 23rd June 1883, a swelling was noticed in the left lumber region on a level with umbilicus; it was painful and prevented him from walking and even from standing erect. Fever made its appearance on the 27th and daily increasing, an Assistant Surgeon was called on the 30th. This gentleman promised to cure the patient in 3 days. He gave no medicine, but applied *Bell.* liniment

and over it a poultice. By the 2nd July the swelling and pain and fever all increased; another practitioner was called in, who rightly suspected the swelling to be an abscess and ordered Quinine mixture internally, and Belladonna plaster externally. On the 5th July this last gentleman called again, and finding no abatement of the fever nor of the swelling, gave up all hopes of resolution, and adopted measures for encouraging suppuration. On the 6th a third practitioner was called in. This gentleman suspected suppuration of the spleen; he applied a large Belladonna plaster over the swelling, and gave fever mixture during fever, and quinine mixture during remission. He called again on the 8th and continued what he had ordered on the 6th.

I was sent for on the 10th. I found the child suffering from intense fever and a painful swelling on the left side of the abdomen. The swelling extended from the left floating ribs to the pubes, the whole region between these parts being hard, red and exceedingly tender. The spleen could not be felt owing to the tenderness. I gave *Merc. s. 6*, three times a day. Diet, plain sago.

12th July—Fever less; but swelling no better. Con. medicine and diet.

14th—Fever still less. Pain less; the swelling seems less red and somewhat reduced in size. Cont. medicine. To have Chapatis (hand-made bread) from to-morrow.

16th—Much better; fever considerably less. Swelling going down and much less painful. To have medicine only twice a day. Diet same.

19th—Very much better. Patient quite cheerful. To have medicine only once a day. Diet same.

22nd—No more fever. Swelling much reduced in size, though the hardness still continues. Child quite cheerful. No medicine for two days.

25th—Child improving rapidly. No more fever, hardness in the swelling less. No medicine. Diet same.

29th—Child can stand supported. No medicine. Same diet (chapatis) for sometime yet.

I saw the child again on the 29th of this month (August) and found him all right. In the sitting posture a slight depression in the abdominal parietes was observed about 2 inches to the left of the umbilicus. This nearly disappeared when he stood up. When the part was pressed a small irregular knotty swelling was felt rather deep below the skin, but it was not painful. Is this a lymphatic gland, and did the inflammation origi-

nate in it and spread to the surrounding tissues? The effect of Mercurius in causing resolution of an inflammation that threatened suppuration and invaded such an extensive area of the abdominal parietes was marvellous. There cannot be the slightest question that it saved the child from the knife and the consequences of a huge abscess. The administration of *Hepar sulphuris*, as was advised by a Homœopathic practitioner, would in all probability have helped the suppurative process and entailed more suffering.

I would draw particular attention to one point in the treatment of this case, and that is the withholding of rice till the inflammation had wholly subsided. A long experience had convinced me that rice-diet is generally very injurious in inflammatory disorders, especially when the inflammation threatens or assumes a suppurative character.

A Case of Remittent Fever

Birendra Kisore, aged 10, son of a medical friend, was attacked with fever on the 18th June, after an unusually long walk of about 6 miles and exposure to sun and rain. On the 19th had epistaxis to which he is occasionally subject. His

father gave him *Aco. 1*, one dose in the afternoon, and another after evening. On the 20th in addition to the fever he complained of great painfulness of the limbs. A dose of *Rhus tox. 30* was given. On the 21st the pain was less, and no medicine was given. On the 22nd the child complained of headache and palpitation of the heart. The eyes were blood-shot. The temp. was not taken, but the fever was high, A dose of *Bell. 6* was given at 9 P.M.

23rd June—Saw him in the afternoon. Heard that he had a stool, not solid, in the morning, blackish and tenacious. As there was not much fever, gave him no medicine.

24th Morning—Fever slight. No medicine.

Evening 6 P.M.—Heat much increased; sleepy; solitary crepitations in the left lung; painfulness of the whole body. *Bryo. 6.*

25th, 7-40 P.M.—Temp. at 10-40 A.M. was 102.8°, pulse 104, respiration 48. From 1 to 4 P.M. temp. was 103°. Just now temp. is 104°, pulse 104, respiration 48. Complains of much pain in the ears. Stopped *Bryo.* Ordered *Merc. s. 6.*

26th, 6-30 A.M.—Temp. 100.4°. To have one dose of *Merc.* At 11-15 A.M. temp. was 104°, pulse 104, respiration 48. At 1 P.M. temp. fell to

101.8°, but at 4 P.M. it was 102°, at 7 P.M. 103°; at 9 P.M. it rose to 104° at which it remained till 2 in the morning.

27th, 7 A.M.—Temp. was 101.4°. At 11 A.M. temp. was 102.2°, pulse 104, respiration 48. No medicine. At 1 P.M. temp. was 102.8°; at 4-45 P.M it was 102°, and the forehead, neck and chest were then perspiring. At 7 P.M. temp. was 103°, pulse 100, respiration 44.

28th, 7 A.M.—Temp. was 99.8°. It rose to 102° at 1 P.M., declined to 100° at 4 P.M. but rose again to 102°, when the pulse was 86, and respiration 44. At 9 P.M. temp. was 103.6°. No medicine.

29th, 7 A.M.—Temp. 103.8°, pulse 104, still I gave no medicine. The temp. gradually declined to 100° at 5-30 P.M. when the pulse was 76, respiration 36. On minute inquiry I learned that the chill in the beginning of the fever commenced in the chest whence it spread to the rest of the body, that the urine is passed more frequently and more copiously at night than in the day, that the patient loses breath when talking, and that the pain in the ears was continuing. There are two medicines covering the chill symptom, *Cicuta* and *Spigelia*. I preferred *Spig.* because it covered the other symptoms and also because the

fever has been all along commencing from early morning.

30th, 7 A.M.—Temp. 98.4°, pulse 88, respiration 32, *Spigelia 6*, one dose. At 11 A.M. when temp. was 98°, he had another dose of the medicine. The temp. rose to 101° at 5 P.M. and remained at this point till 7 P.M. when the pulse was 80 and respiration 44. I was now told that there was a persistent sweetish taste in the mouth ever since the 24th. I ordered *Sulph, 30* to be given when the temp. would get below 100°.

1st July, 7 A.M.—At 11 last night when the temp. had come down to 99.4°, a dose of *Sulph. 30* was given. The temp. now is 98°, pulse 84, respiration 48, but no more sweetish taste. At 10-30 A.M. the temp. was abnormal, pulse 64, respiration 36, skin quite cool. No medicine. At 4 P.M. temp. became normal, but afterwards rose to 101° at 9 P.M.

2nd July, 7 A.M.—Temp. was 96°, at 9—97°; at 10-30—97°; pulse 60, respiration 28. At 8-30 A. M. he had a good copious natural stool, after 8 days, the last stool having been passed on the 23rd of last month. From this time forward the boy steadily improved, the temperature continuing subnormal till the 4th when I gave him rice.

Remarks

In this case Bryonia, though clearly indicated by the painfulness of the body and the state of the left lung, did no good. Mercurius removed the lung-symptom, but the fever, which at first seemed to show a tendency to decrease, increased afterwards, and did not come down permanently till Spigelia was administered. I should here mention that the peculiarity of the commencement of the chill as to locality whence it spreads to the rest of the body, often affords valuable help in the selection of the right remedy in intermittent fevers. Sulphur, selected by the peculiarity in the taste which was persisting for sometime, completed the cure. This case furnishes a good proof that pathology has not yet advanced sufficiently far to help, without symptomatic indications, in the selection of the appropriate remedy.

A Case of Sciatic Neuritis

This was a good case, and the patient has furnished us with the following clear account of it:—

"On Friday the 5th August last, I felt a little pain in my left knee-joint. I took it to be an ordinary pain from cold or constipation of the bowels. On the following day the pain increased a little, I applied hot water fomentation to the part and wrapped it round with a piece of flannel. This gave me no relief. On the next day the

pain went on increasing, I could not walk easily. I repeated the fomentation, but it did me no good. On the following day it made me restless. I could not walk, I was obliged to confine myself to bed, and in the lying posture I felt comfortable. I had recourse to a Native Kabiraj's treatment; he prescribed mash oil and old ghee mixed with fowl egg and rock salt to be rubbed over the part affected. I continued the process for a week but got no relief, on the contrary the pain became so violent and acute, that it made me restless and even in the lying posture I could not get relief. I had then to seek for other medical aid, and placed myself under the treatment of two Allopathic doctors, who treated me for 11 days. They first prescribed castor oil, hot water fomentation, and liniments to be rubbed on the part affected. I applied the same for a week but it did me no good. Then they directed me to apply a mustard plaster to the part affected, but no relief ensured. The pain gradually increased and spread from knee-joint up to the waist and down to the ankle; it was so tormenting that life became burdensome to me. I found no rest on any side even in the lying posture. Both external and internal applications having failed, they had recourse to morphia and atropine

injections under the skin of the buttock; the relief was temporary and did not last long.

"In utter hopelessness and despondency I had recourse to your treatment in which I had very little, or in fact, no faith before. You were pleased to prescribe on the 23rd August last *Rhus tox. 6*, but it gave me no relief. On the same evening you changed the medicine and gave *Colocy. 6;* gave some relief, but it did not last long. The same medicine was continued the next day, but in fact it did make no change for the better.

"On the 25th August you gave me *Aco. 6*, it had no effect.

"On the 26th in the evening, when the pain was at its highest pitch you were pleased to prescribe *Sulph. 12.* The moment a dose was taken in, it worked like miracle. I felt as if the hell-fire that was burning within me was extinguished at once by a heavy shower."

Remarks

To the above statement we have to add the following to complete the description of the case: Previous to the attack the patient had exposed himself much to the sun and rain, having to superintend the building of his house, often in the sitting posture with the thigh bent upon the leg. The pain commenced in the popliteal region; which became painful on

pressure especially in the middle. The pain in the course of a few days, while under Allopathic treatment, spread along the course of the sciatic nerve at first downwards to the ankle and then upwards to the point of its exit at the buttock. The nerve was painful along its whole course to the ankle, but more particularly at the popliteal region where it is superficial. The pain was continuous day and night, but used to be worse in the evening, depriving him of sleep till midnight or even beyond. Notwithstanding all this suffering there was no fever. No history of syphilis.

Sulphur was prescribed, because the pain was aggravated in the sitting posture, or more properly when the patient sat on the tuberosities of the ischia. It had to be continued for some days, for it was found that discontinuance of it would bring back the pain, though in a very mild degree.

A Case of Sloughing Whitlow

Babu L. V. M., aged 38, first noticed pain in the last phalanx (external border) of the right index finger about the 15th October 1884. In a day or two the pain became more and more acute, and the part became red and swollen.

A day or two after the commencement of the inflammation he took *Bell. 3* and *Sil. 6* successively, and applied ice and cold water, but finding no relief he came to Dr. Sircar on the 20th inst. He was advised to take *Arn. 3* internally,

and to apply a lotion of its mother tincture, attributing the inflammation to the process of fitting corks into phials which the patient, being a Homœopathic druggist, was in the habit of doing.

There was some relief of his sufferings on the first day after taking Arnica, but the pain subsequently became as bad as before. On the 24th he was seen again by Dr. Sircar, who prescribed *Sil. 30*, and the medicine was continued for two or three days without any effect.

Thinking suppuration to be inevitable, patient took of his own accord *Hep. sulphur. 3*, and applied an ointment of Nim (Azadirachta Indica), which had once given him good result in a similar case, but it failed him in his own. The inflammation became worse, and to get relief he had the inflamed part incised, or rather punctured, by a friend. After the operation the pain doubly increased, the part became more inflamed and the wound assumed a gangrenous character. He came again to Dr. Sircar on the 7th or 8th November. He was advised to take *Led. 3* internally, and to apply *Calendula lotion* externally. This at once put a stop to the threatened gangrene, and reduced the inflammation in the course

of nearly a week. The slough not showing any tendency to detach itself, *Lach. 30* was prescribed. and the *Calendula lotion* was made a little stronger than before. In about 2 or 3 days the slough came away and the ulcer healed up rapidly. He was quite well by the end of November.

A Case of Colic

Khetter Mohun Dutt, aged 30, an inhabitant of Boral, a village south of Calcutta, came to the Out-Door Dispensary on the 26th of June 1883. He was suffering from a burning and colicky pain in the right hypochondriac region for the last four months. The pain used to come on in irregular paroxysms. He could not lie either on the right side or on the back. There was also slight pain on pressure in that region. *Diosc. 4* was prescribed.

On the 7th July he reported that he had no more paroxysms of pain, and that he could lie on the right side and on the back without feeling any inconvenience. In a few days he was all right.

A Case of Facial Paralysis

Hriday Malakar, aged 32, was presented himself for treatment, at the Out-Door Dispensary, on the 30th July 1883.

Previous history—The patient was suffering from rheumatism, consequent on an attack of chancre contracted four years before. For the last few days he had swelling of the gums and intense aching pain in the left upper and lower incisors. To relieve this pain he was advised by some one to hold a piece of red hot iron between his affected teeth. Following this advice, he had the facial paralysis of the left side, but the pain in the teeth entirely disappeared.

Present symptoms—The paralysis occupied the whole of the left side of the face together with the left half of the tongue. He had this paralysis for the last 12 days. He had lost all taste in the paralysed portion of the tongue and there was a sensation of coldness in that part. There was constant lachrymation of the left eye with inability to close it perfectly. The left nostril had lost all sense of smell. The left angle of the mouth allowed all water to come out if he tried to gargle and he could not blow properly on account of his inability to retain the wind in his mouth. *Aco. 6* was prescribed.

On the 2nd of August, no progress for the better being reported *Bell. 6* was given.

7th August—Much better, almost well.

The medicine was continued for another week, during which period he was perfectly cured.

A Case of Syphilitic Irido-Keratitis

M., aged 20, an inhabitant of Chandernagore, was first seen on the 9th of July 1883.

The patient had an attack of syphilis three years before. He was now suffering from irido-keratitis of the right eye for the last 11 days. A dense patch of opacity on the upper part of the cornea was distinctly visible and the zonular inflammation was well marked. Lachrymation, photophobia, gritty sensation and supra-orbital pain of the affected eye were also present. The eye-sight was almost absent, he could not distinguish objects placed before him; the only power of vision he had was to mark the difference between light and darkness. He had also loss of appetite and constipation. *Hep. s. 6* was given.

The medicine was continued up to the 27th of July, with the effect of reducing the zonular inflammation and therewith the disappearance of

lachrymation, photophobia, gritty sensation, supra-orbital pain, &c. But the nebula in the cornea still continued to interfere with his vision.

28th July—*Hep. s. 30* was given.

On the 28th of August, he was seen to be doing well. The dense patch had almost disappeared. The last medicine was continued for a few days more, with complete restoration of his eye-sight.

A Case of Loss of Memory

J. L.—an East Indian, aged 47, was admitted into the Out-Door Dispensary on the 15th June 1885, for loss of memory and headache for the last 6 months. He said that he was always forgetful and does not remember words which were said to him half an hour before. He was in the habit of drinking for a long time, and had left off that habit only for the last six months. He thought that this forgetfulness and headache might be due to his former irregularities. The headache was of a dull nature, used to come now and then, and had no particular periodicity. Bowels regular. *Nux v. 6* was prescribed.

On the 18th he reported himself to be no better, *Nux v. 6* continued.

21st—Finding no change *Anac. 6* was prescribed.

24th—He reported that he was feeling much better. The headache has disappeared, and he could now remember the words he had heard better than before.

On the 30th June, he complained of slight heat; believing this to be due to medicinal aggravation, the medicine was discontinued.

3rd July—He said that he was feeling well. *Anac. 12* was prescribed.

6th July—He reported that he was doing very well and supposed that he had now his memory as sharp as he had before the sudden attack of forgetfulness. All medicine was discontinued.

A Case of Sudden Disappearance of Vision while writing

D.————, aged 42, resident of Meteaburuj, and by profession a clerk, was admitted into the Out-Door Dispensary on the 6th of July 1885.

He was suffering from sudden disappearance of vision while writing for about 20 days. The loss of sight would come at any time between 9 A.M. to 3 P.M., and last only about half an hour after application of cold water to the head, but an

hour or an hour and a half if no measures were taken to relieve it. This distressing symptom would never come on while reading, nor during the night even when writing. He had also vertigo while walking, whose sudden appearance compelled him to sit down for a while. Frequent micturition and loss of sexual desire were the other complaints from which he also suffered during this period. *Crotalus 6* was prescribed.

On the 6th, he reported that he was considerably better and had no loss of vision during that period. The same medicine was continued.

11th—His servant came and reported that his master was doing well, and had told him to have that medicine repeated.

The same medicine was continued for another 3 days, which relieved him of all his sufferings.

A Case of Dysentery

Abhoy Charan Ghosh, aged 46, was admitted into the Out-Door Dispensary on the 15th of May, 1884.

He was suffering from dysentery for 1 month. Griping, tenesmus, and straining during stool, and passing a few drops of blood after each stool, were the accompanying symptoms. After taking a

powder prescribed by an old school physician he vomited bile and passed bilious stools mixed with blood. The stools became more frequent than before *Nux. v. 6* was prescribed.

On the 18th he reported that the pain in the bowels was much less, but the number of stools was almost the same. *Canth. 6.*

19th—No more pain in the abdomen. The number of stools as well as the blood and mucus became less. *Canth. 6* was continued.

21st—He had improved much, still there was some blood with the stools. The same medicine was continued, and he was advised to take Gandhal (pæderia fœtida) soup for diet.

23rd—He reported that there was no more mucus and blood with the stools, and had no other complaints except his weakness. Medicine was discontinued.

On the 27th and 31st, reports were received that he was doing very well.

A Case of Urinary Calculi

Judan Ghosh, a milkman of Shetpur near Baraset, presented himself for treatment at the Out-Door Dispensary on the 11th Nov., 1884.

He was passing at first white sediment with

his urine which was clearly visible after being deposited. This sediment was gradually replaced by small concretions which gave him trouble during micturition. Though he had no decided obstruction still the urine was passed in a thin stream, and by great effort he succeeded in passing out these concretions. *Lyco. 30* was prescribed.

14th—No decided improvement was reported. The same medicine was continued.

19th—He said that he had not passed any more gravel after the 16th.

From the commencement of taking the medicine every morning he used to pass small gravels till the 16th, on the morning of which day he passed a pretty large one about the size of a pea, elongated in shape, and since then he has been doing well.

The same medicine was continued up to the 21st of November, relieving the patient of all his urinary troubles.

A Case of Hæmaturia

Bhola Nath Sadhukhan, aged 45 years, came to the Out-Door Dispensary on the 7th March, 1885. He had the first attack of hæmaturia about 20 years ago. About 10 years before he had a

relapse for the first time, and in August 1884 for the second time; this second relapse had lasted about a month. He got rid of the previous attacks without taking any medicine. He was suffering from the last attack for the last 12 days. He passed blood 5 or 6 times during 24 hours. It was more in the day time than in the night. There was no history of gonorrhœa or syphilis. *Carbo v. 12* was prescribed.

10th March—Some improvement being reported, the same medicine was continued.

13th—Doing very well. *Carbo. v.* was continued.

16th—About three fourths of his complaint have disappeared. *Carbo. v. 30.*

A few days after, report of his perfect recovery was received.

A Case of Mitral Regurgitation

Nani Madhab Pal, aged 36, was admitted into the Out-Door Dispensary on the 4th May, 1885.

The patient had had malarious fever for a long time. After the fever had been cured he was attacked with rheumatism, since which the affec-

tion of the heart has come on. He has been suffering from the heart disease for about 5 years and has been treated by Kavirajs and old school physicians but to no effect. He had gonorrhœa also long before the attack of rheumatism.

Symptoms on admission—He complained of a pain and palpitation in the præcordial region with sudden attack of vertigo and fainting.

On ausculation a distinct bruit was heard loudest at the apex with the first sound of the heart. He was also suffering from seminal debility, sleep disturbed by dreams, and costiveness. *Spig. 6* was prescribed.

8th—On auscultation the bruit was heard to be less distinct than before. *Spig. 6* was continued.

12th—He said that his palpitation was much better. *Spig. 6* was continued.

On the 15th further progress was reported and the same medicine was continued.

19th—The heart sounds were almost normal, the pain in the chest was also much less, but his costiveness was continuing. *Nux. v. 6* was prescribed.

22nd—He reported that he had no more complaints. Medicine was discontinued.

A Case of Cancrum Oris cured by Lachesis

Reported by Babu Jadunath Mukherjee

Panna Lal, aged six years, had suffered from worms in July 1885, for which he was advised to take *Cina 30*, morning and evening; finding no benefit from the medicine within 3 or 4 days he was taken to an Allopath who prescribed a dose of santonine and followed it up with a dose of castor oil on the following morning; this brought on a free motion with discharge of a large number of lumbrici. Soon after this he had a strong attack of fever which lasted for more than three months and is still continuing. He was brought to me at this stage of the disease and kept under my treatment for a fortnight or so, during which I gave him *Calc. c. 12.* The medicine did him much good, inasmuch as he was without fever for more than a fortnight. For some irregularity or other the child had a relapse after this, and the parents got tired of keeping him under Homœopathic treatment any longer, and he was put under a Kaviraj who could do nothing to improve matters. So from the Kaviraj he went again to the hands of an Allopath, and then to Kaviraj again, according to the whim and fancy of the parents. This alternation of treatment for a period of 3 months or more made

him worse still, and he was at last brought to Dr. Sircar. This was on the 25th of February 1886.

Dr. Sircar noted the following symptoms on his first visit: patient pale and emaciated, with a sallow look; fever of a remittent character, the temperature ranging between 100° to 104°; there were two distinct accessions in 24 hours; spleen and liver both enlarged; right cheek swollen, and inflamed, with a circumscribed sloughing spot in the centre (about half a rupee in size); right eye almost closed; jerking pulse, a tearful countenance, and afraid of being touched by any body in the face. Ordered *Bell. 6*, 2 doses.

26th—Sloughing extended rapidly over the inflamed surface, fever as bad as before; constant desire to be fanned; ordered *Carbo v. 12*, two doses after consultation with Dr. Sircar.

27th—The slough seems still on the increase; patient very talkative during height of fever, *Lach. 6.*

28th—No further extension of slough, fever also less. Cont. medicine.

29th—There is very little discharge from the sloughing spot, slough not loose yet to be removed. Ordered *Calendula* dressing, and repeated medicine.

1st March—Child feeling better in every

way, slough still sticking to the surrounding healthy border of the cheek. Cont. medicine and external application of *Calendula.*

2nd—Distinct line of demarcation all round the slough, which is loosening from the lower border. Repeated medicine.

3rd—A large portion of the slough, which was hanging, loose, was removed. Cont. medicine.

4th—Another portion of slough was found loose and removed; healthy granulations at the edges of the open wound, child improving fast. Cont. medicine.

5th—Child getting on nicely, fever almost nil, a small slough still adhering. Cont. medicine.

6th—From this day up to 12th instant the child found improving steadily, sloughs had all separated, leaving a healthy granulating surface. Cont. medicine.

13th—Doing well, no fever, appetite sharp, desire for eggs which were allowed. Omit medicine.

15th—Had a slight attack of looseness of the bowels probably from taking eggs. Eggs disallowed. No medicine.

18th—No more slough, the edges of the perforated spot are healthy, although the gap is not filling up yet. Ordered strapping of the wound with adhesive plaster. No medicine.

20th—Wound contracting and the gap filling up. No medicine.

25th—Patient doing well; ordered milk and chapatis with moog soup.

Remarks

In this case Belladonna, which I have found to be very frequently useful in high fevers with double accessions, did no good whatever. The rapid extension of the sloughing, indicative of low vitality, with constant desire to be fanned, induced us to give Carbo veg.; but it too failed in arresting the disease. The loquacity during the height of the febrile paroxysm and the severity of the local destructive process, giving rise to a septicæmic condition in a constitution previously debilitated by malaria and bad treatment, led us to think of Lachesis, and we were happy to observe its beneficial effects from the very day it was exhibited. We used it for fifteen days with uninterrupted improvement, and we had the satisfaction of seeing the child saved by it from the very jaws of death.

A Case of Cholera

Reported by Babu Amrita Lal Sircar. L.M.S

L.—, a Hindu female, aged about 80 years, came to Calcutta on the morning of the 20th April 1894. She was hale and hearty when she came down and took her usual meal during the day. From early morning of next day, *i.e.*, the

21st inst., she began to pass loose stools. When I saw the patient at about 6 P.M., I found that she was very weak and had about 15 loose stools, but no vomiting. The pulse was strong and bounding. Taking the history of the case I learnt that she had taken fried paddy and milk two or three days continually before she came to Calcutta. I then ordered a dose of *Camphor water*. Two hours after I was called in, and upon enquiry I found that since the exhibition of *Camphor water* she had 5 loose motions, the stools were ejected with great force and spurting, and were also hot in character. The pulse at this time was observed to be intermittent. I was then told that she was an opium-eater. I ordered her a dose of *Crot. t. 6*, and her usual dose of opium half an hour after the exhibition of the medicine. For about an hour and a half the patient had no stools; but again from about 11 P.M., she began to purge.

At about 1.30 A.M., on the 22nd inst., I visited the patient. She was found to be very weak, her pulse was slow and intermittent, and she had great thirst. The colour of the stools was exactly like water, and there was no solid food materials in them. I consulted my father, Dr. Sircar, at this late hour, and asked him if I could not give her a dose of *Verat. 6*. He gave me

permission to do so but with an observation which I shall never forget in my life, inasmuch as it taught me how very cautious we should be even to give an infinitesimal dose of medicine to a patient. The observation was—"you may give her a dose but I fear it may bring on vomiting" as the patient has had no vomiting up to that time. However, without any further consideration one dose of *Verat. 6* was given at 1-30 A.M., and an hour and a half afterwards the patient vomited and had a watery stool as if to fulfil the prophecy of my father. I went to see her at about 3-15 A.M. and saw the vomited matter and the stool. Instead of being frightened at this I was rather glad, for the vomited matter contained seeds of undigested patoles and other undigested food materials which I believe relieved the stomach from further irritation. I did not do anything for the patient but simply watched her till 4-30 A.M. She was very thirsty at this time and cramps began to appear in the fingers and toes. I gave her little water to drink and relieved her cramps by stretching. From 1-30 to 5 A.M., she had no more stools or vomiting. Early in the morning, at about 6-30 A.M., she had two or three stools. She was fully prostrated at this time, her finger tips were bluish, her pulse intermittent and weak,

thirst remaining the same, and cramps continuing. A dose of *Carbo v. 12* was ordered by my father, and within two hours after the exhibition of the medicine the finger tips were found to be of natural hue. Three stools were passed from morning till 11 A.M., when another dose of the medicine was repeated. The cramps ceased, and she was lively when I saw her at 2.-30 P.M. Sago water was prescribed for her food. At 11 P.M., I saw her again and I came to know that from 11 A.M. to 11 P.M., she had one thin stool with yellowish tinge. She passed the night well. There was one peculiarity in the case, and that was she had no urine for four days. On the morning of the 23rd inst., she felt comfortable, and all medicines were stopped. She had three semi-liquid stools of yellow colour. Passed water on the 24th inst., and was nearly all right. Soft rice was ordered for her diet.

A Case of Renal Colic, relieved by Berberis vulgaris 2x

A young lady of 16, in the eighth month of pregnancy, was attacked with severe pain in the left kidney on the morning of the 1st August last,

and was free from it in an hour and a half, without anything being done for it. It, however, made its appearance every day, but not at any stated time, and used to last from an hour and a half to two hours. A Homœopathic friend, in view of her delicate condition, could not venture to give her any medicine internally, but simply had given her *Puls. 30* to inhale. This, however, was without effect.

I saw her at about 6 P.M., of the 7th inst., the 7th day of her illness. About a couple of hours before my visit she had begun to have the pain which, instead of leaving her as usual, was getting more and more excruciating. On inquiry I learned that the pain is ushered in by frequent urging to urinate with very scanty discharge, the scantier the discharge, the greater the severity of the pain. The pain runs down along the left ureter to the bladder. During the pain there used to be both vomiting and stool, and the pain would cease only when the discharge of urine was copious. At first the pain used to disappear all at once; but for the last two days its cessation was gradual.

On inquiring into the history of the case, I learned that she had the pain once about 2 years ago, that it had then lasted about 4 days and that

she was ordered by her physician to take lithia water which she did for 12 days, that is, for eight days after the pain had left her. So the present was her second attack.

I gave her *Berb. 2x*, one drop for a dose, to be repeated every 2 hours for three or four doses, if necessary. I learned on the following day that she had to repeat the medicine only once, after which she fell asleep, and has not had the pain since.

A Case of Acute Rheumatism after taking decomposed Shrimps

Reported by Dr. Amrita Lal Sircar, L.M.S.

Sheik Golam Ibrahim, Mahomedan, aged 40, of Calcutta, our press-man, suffered from acute inflammation of both the ankle-joints. The patient states that on Thursday the 6th of September he took some cooked shrimps with his evening meal, which were not quite fresh but slightly decomposed. At night when he was in bed, he noticed that the ankle-joints began to itch and also several petechial patches were found near and about them. The left ankle-joint became painful and swollen. This of course he did not mind much at this time. The next day he came to his work as usual, after having bathed

and taken rice with the same shrimps which had been cooked the night before.

When he came to work, he showed us his legs which we found to be in the condition described above. We advised him to stop work and await the result. Within two hours the swelling perceptibly increased and became so painful, that the patient felt difficulty to stand. As his business required him to be long in the standing posture he was obliged to take leave for rest. Assuming that the disease was due to taking decomposed animal food, Dr. Sircar prescribed *Ars. 12.* This, however, did him no good. The swelling began to increase, the pain increased in proportion, and moreover, fever and heaviness of the head supervened. *Lach. 6* was then prescribed, and at 4 P.M., the first dose was exhibited. Very soon the patient felt a little relief. The pain was slightly better but the swelling remained almost the same, and at about 6 P.M., he went home with great difficulty. At his lodging he took another dose at 8 P.M. This dose gave him much relief, the pain and swelling were much reduced, but the fever remained almost the whole night. The next morning, that is, on Saturday morning, Dr. Sircar called at his place, and seeing that the progress of the case was

satisfactory, ordered him to continue the same medicine. The medicine acted like a charm, and on Sunday morning the patient was so well as to be able to walk, without help of any body, to our house which is a mile from his place. The petechial patches had subsided on the morning of Saturday. The swelling went down on Sunday and he was perfectly recovered so as to attend his office on Monday.

Cases of Gingivitis with Inflammation of Bone

Reported by Dr. Amrita Lal Sircar, L.M.S.

Case 1. Prof. N.—Hindu, Brahmin, aged 54, was suffering from severe pain and swelling of the left upper gum involving the jaw-bone. The patient could not sleep at all on account of pain. He came to Dr. Sircar early in the morning of November 23rd, and he mentioned that he had indulged in pomegranate and apple and pulp of palm-nut for some four or five days. Dr. Sircar prescribed *Ars. 30*; the patient reported next day that no sooner he took a dose of the medicine than he felt relief, and at night when he went to bed he was almost all right, the pain and the swelling having gone down as if by magic. Next morning there was not the slightest pain or swelling of the part.

Case 2. S.—a medical man, aged 60, had severe inflammation of gum of the lower jaw on the left side, in the middle of October last. The inflammation involved bone and culminated in suppuration, and the pain of the whole of the left side of the jaw was so great that though averse to operation, he decided upon having the part lanced. But in the hope of averting the operation, he took a dose of *Silicea 30*, with which drug he himself had caused dispersion of gumboils in innumerable cases. The medicine was taken in the evening, and the pain and swelling increased to such a fearful extent that he had not a wink of sleep in the first part of the night. He had some sleep in the latter part of the night, and he awoke in the morning, with considerable subsidence of the pain and swelling; and he was well in a few days, though as the result of the action of *Silicea*, he had itching eruption, all over the body, from which he is still suffering. About fifteen days after, he had similar and perhaps severer inflammation of the gum of the upper jaw of the same side. For fear of aggravating his itching eruptions he could not think of *Silicea*, and he kept himself without medicine, though suffering severely for some days. One day the suffering was so great that he was driven to take

a grain of opium. This did not improve matters in the least. On the contrary his bowels became somewhat distended, and the pain increased so much that he writhed in agony till two o'clock after midnight, when he thought of counteracting the effects of opium by *Nux vomica*, but before taking it he referred to the Materia Medica and found the following symptom exactly corresponding with his: "Swelling of the gums of the size of a finger, with throbbing pain as in an abscess." He took one dose of the 6th and fell asleep in half an hour. He awoke nearly well in the morning. One more dose had nearly completed the cure, when he had the folly of taking a dose of the 3rd which brought back the symptoms for a short time, but he was well again in a day or two.

A complicated case of fever consisting of the cold stage alone; final recovery after a single dose of Aranea diadema

I was called to see Babu M. N. Dev, aged 24, at 11, Nandaram Sen's Lane, Sobha-Bazar, Calcutta, on the 9th instant (Dec.) when I gathered the following history:

The patient was suffering for two and a half years from what was looked upon as Angina

Pectoris. The symptoms were: prickings in the heart, which used to rapidly increase in intensity, followed by violent palpitations, coldness of the extremities, unconsciousness, and convulsions. These used to be relieved by inhalations of nitrite of amyl, without which they did not show any tendency to abate. For the first six months the fits used to come on daily, sometimes twice a day. Sometimes the fits would occur during sleep. Besides nitrite of amyl inhalations during the fits, the doctors (old school) prescribed nitroglycerine, nitrite of soda, arsenic and several other medicines in various combinations, for internal use. After six months, the fits used to come on every week for eight months, and after this period, for the last four months the fits used to come on occasionally from four times to once a month.

On the 18th Nov. last, while suffering from catarrh for four days, he bathed in the river in the forenoon to get rid of his cold sooner as he hoped, but began to be worse from the afternoon of that day, and got fever in the night. This fever used to come on every forenoon with chilliness, sometimes shivering, attended with coldness of the extremities. The temperature never rose high, but the attendant symptoms were very

severe; restlessness, headache, nausea, loquacity, &c. The doctors who attended him thought that these were due to his heart, though there were no direct symptoms referable to that organ, and gave him Am. brom., Nitro-glycerine, Quinine, Arsenic, Belladonna, Spt. Chloroform, &c. All the symptoms increased, and in addition retching and vomiting supervened, and became most distressing. For the relief of these symptoms which, from their continuance and severity, were threatening the very life of the patient, mustard plasters were applied to the epigastrium, castor oil purge and soap-water enemata were administered, and Morphia, Hydrocyanic acid, and several other medicines were freely given. But all in vain.

The symptoms becoming alarming, the patient was placed under a Kaviraj, that is, a practitioner of the old Hindu system of Medicine; but the retching and vomiting became so aggravated under his treatment that as a last resort Homœopathy was thought of. A neighbouring lay Homœopathic practitioner, Babu Sam Lal Bose, a very intelligent, modest young man, was sent for in the morning of the 9th December. He prescribed in succession *Nux v. 30*, *Cina 30*, *Ipec. 6.* Finding no good from them he asked me to see the case this very morning. The retching and vomiting

were incessant and violent, and even a teaspoonful of water would be thrown up immediately. From my previous experience of the beneficial effects of *Eupat. perf.* in such conditions, I prescribed a dose on the 6th Dec. The first dose, though immediately rejected, seemed to do some good. It prolonged the intervals between the vomitings, and this encouraged the patient to take another dose. But no sooner was this done, than the vomiting came on with increased violence. I called again in the evening, and found the condition of the patient to be really pitiable. He had not a moment's respite from the incessant torture of retching and vomiting. On inquiry I learned that the vomited stuff had a compound taste of sour, bitter and saltish, sometimes it was one or the other. The only medicines which corresponded to this were *Sulph.* and *Puls.* Thirstlessness decided in favour of the latter. A dose was given in my presence; it was thrown up immediately. But singularly enough, the medicine, which could only have just come in contact with the mucous membrane of the mouth, œsophagus and stomach, had the effect of stopping the retching and vomiting at once.

10th Dec.—I called in the evening. I learned that after the dose of *Puls.* he had no more vom-

ting, and that he had passed a restful night. At 1 A.M., this morning he had the return of his original pains in the heart, for which Babu Samlal had given a dose of *Ars. 30*, with the effect of relieving the heart pains at once, but of bringing back at the same time the retching and the vomiting which had been so effectually kept in check by the dose of *Puls.* given last night. The retching and vomiting not showing any signs of abatement, a dose of *Puls. 30* was given at 3 P.M., after which he had slept for 2½ hours. Has been bad again with these distressing symptoms since 5-30 P.M. On making further minute inquiries it appeared that the fever comes regularly at about 11 A.M. with chilliness and shivering, that the heat that follows is almost nothing compared to the severity of the symptoms, ranging between subnormal 96° to normal or a little above normal, and that the retching and vomiting, though present day and night, are particularly bad in the afternoon. There was no perspiration at all, notwithstanding the incessant character and intensity of the vomitings. It seemed as if the failure of the perspiration aggravated the retching and the vomiting, and this reminded me of the symptom which Dr. H. C. Allen has noted under *Cactus* in his admirable *Therapeutics of Intermittent Fever, viz.*, "violent

vomiting when perspiration fails." I could not find any authority for this singular symptom, but as some of the cardiac symptoms of the drug corresponded with the symptoms from which the patient had been suffering for two and a half years, and as the fever appeared with clock-work regularity at 11 A.M. I administered a dose of *Cact. 3x.* The medicine was retained, and the vomiting ceased at once. But the patient had not, however, that rest in the night which he had after *Pulsatilla.*

11th—Though the patient had no sleep in the night, he was free from retching and vomiting. A dose of *Cact. 3x* was repeated this morning. The fever, however, came on all the same at 11 A.M., with restlessness, cold feet, headache, &c., but without any retching and vomiting. No more medicine was given the whole of this day.

12th—Fever came on as usual at 11 A.M. I did not attend this day, but I learnt that the patient after the onset of the fever was very restless and had suddenly become insensible, and that inhalations of Nitrite of Amyl had to be had recourse to in order to restore him to consciousness. Babu Samlal gave him a dose of *Ars. 30,* afterwards, which is said to have relieved him considerably of the heart pains without bringing back the retching and vomiting, and he passed a

peaceful night. Babu Samlal came to me on the evening of the 13th, and taking all symptoms into considerations I suggested *Aranea diadema 6x*, to be given in the morning, at least a couple of hours before the expected attack.

14th—A dose of *Aranea*, as suggested, was administered in the morning. From this day no more attack and no more attendant troubles. In the course of a few days, the patient was well and strong enough to come and see me at my house, with Babu Samlal.

Remarks

This case is full of interest. It shows how the relief of symptoms is effected by drugs in proportion to the degree of their Homœopathicity. For the single symptom "vomiting immediately after drinking," which was the chief and the greater trouble of the patient, Eupatorium perfoliatum, previously found beneficial in numbers of cases with the same symptoms, was prescribed, but proved worse than useless on a repetition. Pulsatilla, which was selected for the characters of the vomited matter and for another symptom. *viz:* thirstlessness, though immediately rejected, kept the vomiting in check for a considerable time till its influence was counteracted by Arsenicum, and on a repetition proved useful for a much shorter time only, so that we have to look about for another remedy. This we found in Cactus grandiflora, whose influence upon the vomiting was of a permanent character. But the removal of this symptom—though it afforded a world of relief to the patient, indeed, may be said to have saved

him from death which could not have been long delayed if the vomiting had remained unchecked for a day or two longer—was not followed by the removal of the whole disease from which the patient was suffering. After the removal of the retching and vomiting there remained symptoms which constituted an intermittent fever with one, the cold stage alone, which persisted and could only be removed by a drug which presented its similimum. Could Aranea diadema have removed the whole disease if administered in the beginning? Nothing short of a parallel case treated with the drug from the beginning can answer this question.

A Case of Mitral Regurgitation

(Reported by Dr. Amrita Lal Sircar, L.M.S.)

B—, married Hindu lady, aged 23, nonparous —an inhabitant of Katdai near Jahanabad, in the district of Hooghly. She is of dark complexion, of middling size, and neither too thin nor too fat. She stated that she was comparatively healthy and strong till she became a victim of the fell disease from which she was now suffering, the symptoms of which were as follows: She was unable to work hard and to walk fast. She felt a sort of palpitation near the cardiac region. She used to spit blood at times. There was bleeding from the nose, and also swelling of the abdomen as

well as of the hands and legs. For these symptoms she had been under the treatment of native Kavirajs and Allopathic physicians for about two years. The bleeding from the nose was stopped by Kaviraji treatment, but, all other symptoms remained as they were. When at last she heard that there was no hope of her recovery, she came to the Out-Door Dispensary of Dr. Sircar on March 12, 1893.

The following were the symptoms then observed:

The liver was enlarged. The abdomen distended with serous effusion, the face and the eye-lids were puffy, menses scanty, palpitation of the heart, spitting of blood at intervals of ten or twelve days. A murmur was heard at the apex with the second sound, which was conducted posteriorly under the left scapula. The heart was enlarged and the apex thrill was left at the sixth interspace.

On March, 12 *Spig. 6* was prescribed, and continued till the 6th of April. The patient felt much relief, the palpitations being much less, but the puffiness of the hands, face and legs remained the same. The medicine was then stopped for about a week, after which *Spig. 6* was again given and continued for three days, after which she had

no medicine till the morning of the 19th, when she reported that she was almost the same. *Spig. 6* was again prescribed and continued till the 30th, when she reported herself better.

On the 1st May she had slight fever which gave way to *Ars. 12.* But this caused a little aggravation of the swelling and as there was no thirst *Apis 6* was prescribed, and continued till the 8th of June. Some benefit was derived, but this becoming stationary, *Apis 10* was substituted for *Apis 6*, and was continued till the 19th of June, with the result that the swelling of the limbs and the puffiness of the face went down a great deal, but the palpitation of the heart was almost in the same condition. *Spig. 6* was again given on the 29th June and continued till the 10th of August. She felt herself much better in every respect, except that the menses continued scanty and watery. Hence on the 11th Aug. *Puls. 6* was given which was changed to 30th on the 14th and was continued till the 22nd.

From the 22nd Aug. 1893 to the 25th of February 1894 she was kept under observation without medicine, but no alteration was made in the diet which consisted only of chapatis, mughdal and milk, rice being altogether prohibited. The patient improved steadily, the heart sounds

became much like normal and the swelling of the hands and feet and the puffiness of the face all disappeared.

On the 27th Feb. 1894, the mother of the patient reported that she was suffering from prolonged menses for sixteen days; the discharge being profuse, red and hot, *Bell. 6* was ordered, two doses daily. In about a week she was all right. We kept her under our observation till the 15th of April, 1894, when she went to her native village in restored health.

A Case of Colic, cured by Bovista

Babu U. N. Das, aged 26, came to me on the 1st May last, for an intermittent colic pain in the abdomen which was described by him as very severe and distressing. The pain first made its appearance on the 26th April. For about 15 days previous to this first appearance of the pain the patient had given up taking Chapatis (unleavened, hand-made wheaten bread) which he used to take since December last, for his evening meal in place of rice. He went back to rice, thinking that during the excessive heat of the season, it would prove a less heating food than wheaten bread. The first effect of this change was

the diminution of appetite, which gradually became less and less, and in fifteen days it came to be associated with the pain in the abdomen, for the relief of which the patient sought my help.

On the first day, that is, on the 26th April, the pain was first felt in the morning; it passed off after the morning meal. It recurred in the afternoon at 3 P.M.; but was of lesser intensity and duration, lasting for an hour or so, and going off after eating something. The pain recurred every day with increased intensity twice as on the 1st day, for 4 or 5 day. Afterwards the pain used to come on after evening also, going off after supper. The pain was of a griping, twisting character. It used to start from below the umbilicus and diffuse itself up above to the epigastrium. It was not relieved by bending double or by pressure, but only by eating something. There was some constipation, and the urine was scanty and reddish in the morning, free and natural at other times. There was no thirst, no heart-burn.

When the patient first came to me on 1st May, I simply regulated his diet. He came to me again on the 2nd inst., reporting no improvement; I still gave him no medicine. On the the 3rd the pain not getting better, on the contrary, being very distressing, and the patient insisting upon

medicine, I gave him *Nux v. 6* in the evening. The next morning, the patient reporting some amelioration, the medicine was continued on that and the following day. On the 5th the pain increased, and it appeared to me as if it was an aggravation of *Nux v.* I therefore gave *Camphor.* On the 6th some improvement being reported, *Camphor* was continued. The pain, however, became very bad on the 7th and I was obliged to look into the Materia Medica. I found under *Bovista* the following symptoms: "Twisting pain in the abdomen; cutting pain in the fore part of the abdomen, in the morning, relieved after eating; cutting in the abdomen, extending towards the stomach." I gave *Bovista 3x.* This had the effect of relieving the pain at once. In two days he was quite well, and continues so.

Remarks

This is a case which shows how symptoms alone, notwithstanding our inability to refer them to their true seat, can help in the selection of the appropriate remedy. It was not possible from the symptoms elicited from the patient to determine the exact seat of the pain, as to whether it was the stomach or the intestines, and if the latter which part. Hence such a case could not be treated, if we had to depend upon strict pathological Materia Medica or a Materia Medica which takes note of only the pathological lesions produced by drugs. Even if we had a perfect pathological Materia

Medica, we could not dispense with symptoms. For several drugs may affect the same organs or the same parts of one or more organs. But their differentiation can only be effected by the difference of symptoms which develop under their action; the order of their appearance and the conditions of their aggravation and amelioration furnishing the differentiating characters.

A Case of Meningitis with threatened Apoplexy

(Reported by Babu Baroda Prasad Das)

G. S., aged about 54 years, complexion fair, trunk corpulent with rather slender extremities, neck short and thick, was taken ill on the 1st January 1895. At 1 A.M., he complained of intense headache of a pricking character, an indefinite, uneasy sensation in his abdomen and sleeplessness. There was a good deal of eructations; also great anguish of mind.

While at Jaunbazar (in Calcutta) he felt his first discomfort. This was a sensation of heat which was so very excessive that he had to put off his shirts and even to be fanned. Finding no relief and his anxiety having increased, he caused a carriage to be brought to convey him to his house at Kidderpur about 3 miles off. On his way he vomited once, which consisted of his

morning meal. The vomiting continued during the night at various intervals; it consisted only of mucus and a little watery substance. The first thing I enquired into was about his food. He had taken Polao (a rich greasy food) on the 29th of Dec. last, and on the 30th and 31st he had taken curry made of spoiled Bhetki fish. I gave him *Puls. 6*, after which he fell into a slumber which lasted for about an hour. He awoke with no abatement of his sufferings. *Puls.* was repeated. Finding no effect I gave *Carbo v. 12* with as unhappy result. 7-45 A.M. *Bell. 6.* At 8 A.M. vomited; about 5 minutes after this there was a severe attack of convulsion in my presence. It was more confined to the left side. The left arm was out-stretched and the hand clenched; the left eye spasmodically closed; the right eye was injected and rolled from side to side. The movements of the lower extremities could not be watched as they were covered. The fit lasted for about 2 or 3 minutes, immediately after which he fell into a deep snoring sleep. During convulsion I resorted to inhalation of camphor and dashed cold water on the face. Consciousness returned after about 20 minutes.

11 A.M.—Temp. 100.4°, pulse 96, full and bounding, patient semi-unconscious. Fear of death

having been predominant from the beginning I gave him *Acon. 6*, after which he was visited by Dr. Sircar. It having been elicited from the history that he had prolonged exposure to the sun three days before as well as on the very day of his illness, Dr. Sircar suggested *Glon. 6*, which he directed to be given if *Acon.* failed. After repeating another dose of *Acon.*, gave *Glon.* at 1-30 P.M. At 4 P.M. found him very sleepy; the vision appeared to be more affected than the hearing; could be easily roused, but could not recognize persons, though they were near him; complained always of intense headache. I consulted Dr. Sircar at his place in the evening. He ordered *Nux v. 6*, which was given at 9-45 P.M. At 8 P.M. before *Nux v.* was given, had one stool, at 10 P.M. temp. 101.4°.

2nd January, 7-40 A.M.—Temp. 101°, pulse 88, tongue moist on the sides; but there was a broad, dry brown stripe in the middle extending from the tip to the root. There was delirium during sleep last night. He woke frequently only to complain of his head, drank large quantities of water at a time. At 2 P.M. temp. 100-8°; 4.40 P.M. 106.6°. Complains of great discomfort and a sensation of heavy weight in the stomach. Consulted Dr. Sircar. He suggested *Bry. 6*, two

doses of which were given, the 2nd, four hours after the first.

3rd Jan., 7 A.M.—Temp. 100.3°, pulse 84. At 8 A.M. one stool, had slept well during last night. Headache much better. Repeated *Bry. 6*, of which only one dose was given during the day.

4th Jan., 7-45 A.M.—Temp. 98°, pulse 78, tongue cleaner, feels better; medicine discontinued.

He was perfectly well up to the 10th of January. But on the 11th the headache returned with increased force, for which he had to pass a sleepless night; appetite poor. There was, however, neither rise of temp. nor acceleration of pulse. On examining his nostrils I found a swelling on the inner side of the right ala of the nose, which bulged out so much as almost to touch the septum. I punctured it with a needle, a few drops of blood came out followed by immediate relief. The effect, however, was temporary. I repeated the operation on the 12th and 16th with like result. There was retching at certain hours of the morning and a good deal of eructations during the height of the headache. *Ipec. 6* and *Bell. 6* were successively tried, but to no purpose. At last it came to my notice that the aggravation of all the symptoms always took place

at about 4 P.M. I gave *Lyco. 6*, and it had the desired effect. The first dose postponed the attack several hours, and the pain when it returned was very much less than before. There was return of mild attacks at irregular intervals from the 19th to the 24th. *Lyco. 30* completed the cure.

Remarks

The fact of the patient having exposed himself to the Sun, the premonitory symptoms, the attack of convulsion followed by snoring, almost stertorous sleep, led us at the time to apprehend an attack of apoplexy, which was averted by Acon. and Glon. The persistence of intense headache, after the urgent symptoms were over, evidently pointed to the meninges as the seat of mischief, and Bry. at once checked the inflammation and brought the patient round in an unexpectedly short time. After a pause the headache assumed quite a different character, from being inflammatory it become neuralgic, due no doubt to gastric irritation, as was evidenced by the persistence of eructations which continued so late as the 14th of Jan. The selection of Lycopodium according to the time of aggravation was justified by the event.

Two Cases of Diarrhœa, Cured by Nat. sulph.

Case 1—Mr. W. R., aged 63, was taken ill with diarrhœa from the morning of the 13th August last, which came on after a pretty heavy dinner which he had indulged in on the previous

day, notwithstanding that he was suffering from loss of appetite, costiveness, pains and aches in the chest, palpitations, &c., for some time. I was asked to treat him on the morning of the 19th. The stools would commence towards morning and stop after mid-day. They were thin, greyish, passed with noisy flatus, and about four or five in number. They were not very copious. There was continual rumbling of the abodmen. The patient had no appetite, felt feverish, languid and depressed. He described his palpitations as fearful. Occasionally he would get a stool or two at night but never in the afternoon.

The morning diarrhœa and the noisy flatus passed with the stool led me to prescribe *Natrum sulph.* I gave the 6th decimal dilution, one drop for a dose, twice daily. He began to improve from the very first dose. He was nearly well in three days, and quite well in six days.

Case 2—Dr.....subject to colic and diarrhœa, was taken ill with his old complaint on the 20th August. He could not trace it to any dietetic irregularity, unless the slight turbidity of the drinking water owing to the rainy season be taken as such. The diarrhœa came on in the afternoon, and the colic, which was of a twisting character and which was present day and night,

was particularly bad after each stool. From about 4 P.M. to about 8 P.M., there were four or five stools each of which was liquid, yellowish, profuse, gushing, with much spluttering, followed by aggravation of colic which became more and more unbearable. In his previous attacks, which were characterized by stools of the same character, and occurring always in the afternoon, he had tried various Homœopathic remedies with no benefit. He therefore took, out of sheer despair and in expectation of immediate relief, 15 drops of laudanum. This, however, did not give him the relief he had expected, and he took 10 more drops after an hour. This had the effect of stopping the stools, and as a necessary consequence, of mitigating the colic. He woke in the morning to find that his colic had not altogether disappeared. It troubled him the whole day, and became aggravated again, but not so much as on the previous day, after a stool in the afternoon.

In this way he suffered till the 28th. He took no medicine on the 21st, 22nd and 23rd. On the morning of the 24th, having regard to the time of the aggravation of both the diarrhœa and the colic, from about 4 to about 9 P.M., he took a dose of *Lyco. 30*, with some benefit, the number of stools and the intensity of colic being less. This

encouraged him to take a dose in the morning of the 25th, but he became worse. He took a dose of *Thuja 6* on the 26th with no benefit.

On the 29th the diarrhœaic stools commenced in the morning, in fact, for the first stool he had to leave his bed early in haste. The stools were of the same character, liquid, profuse, coming out in gushes, passed with loud flatus causing spluttering. There was insecurity of the sphincter ani so far that occasionally fæces would escape during the passage of flatus and of urine. There was considerable tympanites with pinching and twisting colic. The success of the 1st case narrated above led him to take *Nat. sulph. 6.* One dose was enough to remove all the symptoms. He took a second dose on the following day, and he was all right. The pain in the left upper molars, from which he had been suffering for some time, disappeared with the diarrhœa and the colic.

Remarks

These two cases are very instructive. They illustrate the efficacy of Natrum sulph. in morning diarrhœa. Guided by their pathogenesis Dr. Bell has, in his excellent Homœopathic Therapeutics of Diarrhœa, &c., differentiated this drug from Sulphur, by the remark that the morning stool of the former differs from that of the latter in occurring later and

after rising. The clinical evidence of the second case shows that the distinction is not invariable. So far as the present pathogenetic record goes, the diarrhœaic stools of Nat. s. are yellowish. The first case shows that Nat. s. can cure where the stools are greyish and not yellowish. Again, Nat. s. is credited with the symptom—relief of colic after stool, whereas the second case shows that there may be aggravation instead of relief of colic after stools, so that the former symptom would be no contra-indication for the use of the drug.

These cases forcibly point to the necessity of subjecting the existing materia medica to thorough reproving.

A Case of Night-Blindness, cured by Nux vomica

In April last, when I was at Baidyanath Dham, Babulal, a servant of mine complained of night blindness. The blindness used to set in as soon as the sun used to set, and would continue till day-dawn when he could see again. There was no pain in the eye, nor any visible change in it. There was no other complaint. I could not trace it to any cause, except that after his morning work he used to go for his village, about a couple of miles from where I was living, at about noon, and come back to his duty a couple of hours after, so that he had to

expose himself to the heat and glare of a powerful sun.

We have a reputed remedy by which I was myself cured when I had the disease in my boyhood, and by which I have cured several similar cases. This is the liver of the goat, which is directed to be eaten after being fried in ghee (clarified butter). A couple of days' use of this pleasant remedy or rather food has been enough to cure the disease. I have succeeded with it after failure with treatment by drugs. I was, therefore, anxious, before giving the patient any drug to try this plan of treatment. But unfortunately I could not procure the liver of the goat. I waited three days, and still the thing could not be had. Then thinking that the remedy cures the disease by acting upon the liver, I thought of *Nux vomica*, and gave him pilules moistened with the 6th dilution. The improvement reported on the following day was not satisfactory. I thought this was due to the small size of the dose, and I, therefore, gave him drop doses of the same dilution. The improvement was rapid and remarkable, and in a couple of days he was all right. There was a slight relapse in June next, and the same remedy, in the same dilution and dose, was efficacious as before.

A Mild Case of Epilepsy cured by Calcarea Carb

J—, aged 13 years, suffering from epileptic fits from the latter end of July last, came under my treatment on the 19th Sept. 1894.

Previous history—The boy had resided for sometime at Chandpur, a sea-side watering place on the Midnapur coast of the Bay of Bengal. Here he used to take sea baths, and he used to bathe also in a dirty tank. The tank water after boiling was used for drinking purposes as well. A few days after his return from Chandpur, eruptions like boils, appeared on his thighs and arms. The parts used to itch and subsequently became hard and red. A medical practitioner gave some lotion for application to the parts. After its application the eruptions disappeared for a short time, but appeared again attended with fever. One of them formed an abscess and burst; but the eruptions continued to appear off and on. After a few days the skin began to fall off from both the hands in scales. He began to have headache at the same time. The skin of the feet also began to fall off. It was about this time that the fits made their appearance and were of a very mild form. There was no convulsion; there was only stretching of the hands and feet before and after a fit. The

eruptions disappeared after a few doses of some Homœopathic medicine but the headache increased.

Present symptoms—The fits come on usually during the day time and rarely at night. Only twice during two months he had fits during sleep. Before the commencement of the fit he has a sensation of laziness with yawning (গা ভাঙ্গা ও হাই তোলা). During the fit there is only slight groaning, but consciousness remains, so that he can answer question asked at the time. The fits end with jerks of the head towards one side or the other. In the beginning he used to ask those near him to press his temples, but now he would not allow any one to touch his head, as it was unpleasant to him. He grinds his teeth during sleep and has involuntary startings.

20th September 1894—*Bell. 30.*

22nd—The fits were not less. One peculiarity that was observed was, that the boy was all right so long as he was out of his house, in the open air, either driving or walking about. *Puls. 30.*

25th—Fever since yesterday evening. Has cough and a pustule in the left lower lid near the inner canthus. He had taken some plantain custard yesterday. *Hep. sulph. 6*

26th—No Fever. Fits more frequent during sleep. *Sil. 12.*

27th—No marked improvement. *Calc. c. 30.*

28th—From the day of the administration of the medicine the child began to improve, and a few days after information was received that he was doing well. The subsequent report, after a month, was that the child was cured.

A Case of Neuralgic Toothache cured with Plantago maj.

Babu Lal Mohan Sanyal, of Doctor's Lane, Taltalla, Calcutta, aged 62, came to me in the afternoon of the 21st inst. for relief of a toothache from which he said he was suffering for 15 days. The seat of the pain was in the root of the last molar of the left side of the lower jaw; but the whole left side of the head suffered sympathetically. There was throbbing pain within the left ear which would get worse from the slightest touch. There was aggravation of the toothache and of all the other pains whenever cold or hot water was taken into the mouth. He has had all sorts of medicine, internal and external, without the slightest benefit. Hot fomentations externally would cause only temporary relief. There was

no swelling of the gum around the affected tooth. The pain was thus in the nerve of its root. He could not attribute it to any cause, but on inquiry I found he had indulged in all sorts of cooling things in this hot weather, including the infusion of the raw mango which is very acid.

I gave him *Plantago major 2x*, 4 doses. The first dose gave him so much relief, that he likened it to the quenching of a fire by water. The remaining three doses completed the cure, and he is now quite well, astonished at the magic action of Homœopathic medicines. In another case some years ago *Plantago* acted so instantaneously that the patient said that he felt relieved before the medicine had reached the stomach. Toothache has brought in many a convert to Homœopathy.

A Case of Cholera

I was called to see Srimati————, a married lady, aged 63, at about seven in the morning of the 21st February last. I found her pulseless, with cold extremities, sunken eyes, and tormented with thirst.

The history was—She was seized with vomiting and purging at about 2 A.M. She had about 8 watery stools between 2 and 3 A.M.,

attended with much pain in the bowels, the quantity passed each time varied from 16 to 24 ounces. Within that time she had vomited 10 times, the vomited matter consisted at first of undigested food which tasted sour, and afterwards of watery fluid with flakes of mucus, without any taste whatever. The pulse disappeared and the extremities became icy cold from 3 A.M. and the vomiting ceased about that time. From 3 to 6 A.M. the patient had about 13 stools, the quantity being somewhat smaller, from 8 to 10 ounces each time, watery and containing flakes of mucus. There were slight cramps in the extremities and the thirst gradually increased in intensity.

Between 4 and 6 A.M., the patient had taken 4 doses of a mixture each containing Tinct. Strophanthus m i, Nitro-glycerine (1 in 100) m i, and Peppermint water 4 drachms; and two powders, each containing Hydrg. c. Creta gr. ½ and sugar of milk gr. ii.

When I saw her at 7 A.M., she was passing stools pretty frequently though slightly less so than before, and the quantity each time was also less. The character of the stools was peculiar, they were pinkish as if mixed with blood. As the stools were attended with much pain in the intestines I gave her *Ver. alb. 30.*

By 12 noon she had passed 10 stools of the same character, became more thirsty and began to be restless, tossing her limbs about, the extremities continuing icy cold, there was no sign of pulse at the wrist, but there was no cramp and no vomiting. I gave her *Carbo v. 12.*

From 12 noon to 6 P.M., she passed 8 stools of the same character, and the collapse became worse. On learning that she was in the habit of taking opium, about 3 grains at 5 P.M. daily, I ordered half the quantity to be given to her with about one-eighth of a minim of peppermint oil. After the opium the stools were less frequent, being 6 only in 12 hours from 6 P.M. to 6 A.M. But there was no other improvement. Pulselessness, icy cold extremities, and pains in abdomen, continuing as before. In addition there was more restlessness, hiccough which was severe at times, tongue dry and bluish though no thirst, epigastrium tympanitic, cold, clammy sweat on forehead, suppressed urine.

22nd Feb.—Passed a stool at 6 A.M., of reddish colour and containing mucous flakes as before, in quantity only about an ounce. Gave *Arsenic 30.* She passed 4 more stools up to 2-15 P.M., of the same character, one of which was copious, being 8 ounces. But there was this

improvement noticed to-day. She began to vomit bilious stuff, greenish and bitter, quantity varying from 2 to 4 drachms. Up to noon she had 6 such vomitings. She had no thirst, but would ask for water to relieve the hiccough which was very frequent. The extremities were still cold, there was still no pulse. The same quantity of opium was again given to-day at 6 P.M.

23rd—No stool the whole day. No urine. Pulseless. Still complains of pain in the abdomen. Some tympanites. Severe hiccough. Gave some globules moistened with *Tinct. Camph.* At 5 P.M. there seemed to be a return of the pulse at the wrist. Opium was again given to-day, but an hour later, that is, at 7 P.M. There was no sleep at night, and delirium set in from 3 o'clock after midnight.

24th—Pulse distinctly perceptible, 120. Temp. 97°. Low muttering delirium with stupor, from which she could be roused, and then she would answer questions sensibly. Picking of the bed clothes. *Bell. 3x* in the morning. No stool, but passed urine freely at 1-30 P.M. Hiccough less, Opium only 1 gr. was given at 6 P.M., slept a little at night. There being still no stool, and the bowels being tympanitic, a dose of *Nux v. 6* was given late at night.

25th—No stool. Pulse stronger, 110. Temp. 98°. Passed urine freely once at 8 A.M. but continued delirious and became careless of her clothes, showing symptoms of loss of her usual modesty. Gave a dose of *Hyoscy. 6.* Urine again free at 1-30 P.M. but delirium no less. Stopped her habitual crude opium. Became restless after evening as from want of opium. Gave *Opium 3x*, 2 drops at 9 P.M. to be repeated after 4 hours, if not stool would follow. After the second dose, passed stool at 3 A.M. and slept better.

26th—Less delirious. Passed urine and stool at 8 A.M. No hiccough. Pulse 100. Tongue moist. Opium stopped. Diet, milk.

27th—Pulse 100, temp. 98°. Passed urine and stool twice. Became very restless at night complaining of gnawing in the whole body, just as opium eaters deprived of their opium complain. Half a grain of opium was given at 1 A.M. and in half an hour she became quiet and slept soundly.

28th—Passed two stools, colour yellow, mixed with slime and blood. No delirium. Diet, Barley water and Gandhal soup. Opium 1½ gr. at 6 P.M. Slept well at night.

29th—Passed 5 loose stools. Diet—Barley water and Gandhal soup. Opium gr. 12.

1st March—Passed 3 loose stools. Diet, well-boiled rice and fish-broth. Opium gr. 12.

2nd—Passed one natural stool. Is all right. Diet, soft rice and fish-broth. Opium gr. 12.

Remarks

The chief points of interest in this case are:—

(1) that it was a case of cholera in an opium eater;

(2) that notwithstanding the collapse, the habitual opium had to be given, though of course, in reduced dose;

(3) that the reputed remedies for choleraic evacuations and collapse did not seem to do appreciable good;

(4) that the reaction seemed to come on gradually and spontaneously, or perhaps the Camphor given in very minute doses had something to do in bringing it about;

(3) that constipation setting in, the crude opium, which was evidently aggravating it, had to be stopped, that Opium in dilution succeeded in bringing on stool after Nux vomica had failed;

(6) lastly, that the habitual opium had to be resumed.

What was the pink colour of the stools due to? It is a pity I had no opportunity of examining the stools microscopically to ascertain the point. I suspect the colour was due not to blood but to some micro-organism, probably the micrococcus prodigiosms. The stool of the 28th Feb. really contained blood.

A Case of Severe Diarrhœa cured by Conium

Ram Dayal, my personal servant, aged 21, was attacked with diarrhœa from 10 P.M. of the 18th inst. (May, 1896). He had passed several stools by 4 o'clock in the morning, when his illness came to my notice from the groans he was uttering on account of the severe abdominal pains he was suffering from. On inquiring into the cause he told me that he has begun to have stools since 10 o'clock in the evening. The stools have gradually become more and more watery and profuse and almost involuntary up to 5 A.M. He has had about eight stools, during the last three of which he had passed no urine. While being removed to another house he passed two copious watery stools in the course of half an hour. There was no urine with these stools. There was no vomiting, no cramps of the extremities; but the gripings and pinchings in the intestines were very severe. The pulse was exceedingly weak, just perceptible at the wrist, countenance sunken, voice very feeble but not hoarse, skin cold, not clammy.

Having, in the recent epidemic of cholera in Calcutta, and also in this place, Baidyanath Dham, where I have come for a change, found

Sulphur given in the beginning to act most beneficially in cases where the stools commence about midnight and are felt hot by the patient, I was going to administer this medicine to the patient almost as a matter of routine. But I was immediately reminded of the unscientific character of my procedure, and I, therefore, asked the patient if the stools that he was passing were felt by him to be hot. "No," he at once replied, and after a little reflection, said, "on the contrary they are cold." This made me desist from giving the *Sulphur* that I had in my hand. I had no recollection of any drug that has produced stools, which are felt cold by the patient. I began to consult my repertories, and chiefly the Cypher Repertory. My search was fruitless as regards the particular symptom which was the object of that search. But I stumbled upon one symptom which helped me. This was cold flatulence produced by *Conium*. Of course there was a vast difference between cold flatulence and cold stool. But still the former indicated the temperature of the parts through which the wind passed, and thinking that cold stool might indicate a similar condition I gave a few globules of *Conium 6x* to my patient.

I had to go out for a couple of hours, and

on my return, was glad to learn the medicine had taken most marvellous effect. There was only one stool after its administration, much less in quantity, and there was urine with it. He looked better, and the pulse had also improved. He passed three or four stools only in the course of the day, each less in quantity than the preceding, and more and more consistent, and with each urine was passed. He made a most satisfactory recovery, without any more medicine.

Remarks

There was for some time an epidemic of cholera prevailing in the village where we were, and also in the neighbouring villages. How this case would have terminated if not promptly treated, or properly treated, it is more than one can say. The probability is, that if treated with the routine Camphor, Veratrum, &c., the disease would have assumed the characters of genuine cholera, and might have ended fatally, at least not so satisfactorily as it did. My persuasion is that, when not strictly appropriate, Homœpathic medicines do produce pathogenetic effects and produce the very morbid conditions for which they are truly Homœopathic, but which not really existing are brought about by them in patients whose constitutions have been rendered sensitive by disease. In the treatment of all diseases, and of cholera in particular, routine practice is most disastrous. I look upon the recent unfavourable results of the Homœopathic treatment of cholera in Calcutta and elsewhere, as due

to this cause. Every case requires the strictest individualization, or bungling and failure must be the result. Every epidemic, if scrutinizingly studied, would be found to differ in some essential characters from previous epidemics. This is the reason why in one epidemic Camphor, in another Arsenic, in a third Veratrum, in a fourth Sulphur, &c., is found to succeed, and no other. It is absolutely necessary that the character of an epidemic, the genus epidemicus, as it is called, should be studied with care, in order that the work of prescribing may be both accurate and comparatively light. Of course it must be remembered that this should not dispense with the study of each individual case in order to determine its own peculiarities, but the genus epidemicus having been ascertained, such study would be easier than it could otherwise be.

Cases of Cholera

Case 1—Hem Chandra Datta, aged 16, was attacked with diarrhœa in the morning of the 3rd June. The diarrhœa assumed the choleraic form in the afternoon. Was treated by an old school practitioner till 1 o'clock after midnight, when collapse setting in, a Homœopathic practitioner was called in, who gave him *Ver. alb. 6* and *Cup. acet. 6* in alternation every half an hour. The report is, the vomiting stopped at 4 A.M., and the cramps became less.

I saw him in the morning (at 7 A.M.) of June 4th. The pulse was barely perceptible at the wrist. Was complaining of severe cramps at the side of the chest and a peculiar sensation at the middle of the sternum which he said made his breathing difficult and uneasy. I learnt from the attending Homœopathic practitioner, Babu Kunja Lall Mullick, a graduate of the Campbell Medical School, who was treating him, that he had given him a short time before *Secale 3x*, which he thought has somewhat reduced the cramps.

On inquiring of the patient I learnt that the stools he has been passing were all along hot. This symptom, with the fact that the diarrhœa had begun in the early morning, induced me to order a dose of *Sulph. 12x*. After this the choleraic symptoms became considerably modified. The stools from rice-water became yellowish, though still watery. The body became warm and the pulse perceptible at the wrist. The cramps ceased altogether.

5th June, 7 A.M.—Sour vomiting. Stool yellowish. Burning sensation all over body. Abdomen painful to touch. No urine. *Ars. 30.*

8 P.M.—Patient restless and delirious; delirum of a furious character; eyes red. *Stram. 6x.*

One dose was given at 10 P.M., another at 2 A.M. After the second dose patient slept quietly for 4 hours.

6th June, morning—Has passed several yellowish stools with a few drops of urine with each stool. Patient continues low. *Stram. 6x* at 8 A.M. Slept quietly for 4 hours up to noon. The sleep was so deep, that the patient's father thought we had given him a sleeping draught.

7th—Several stools with a few drops of urine at each stool.

At 3 P.M., made water about a poah (8 ounces). Patient low and drowsy. *Opium 6*, one dose. Slept well for 4 hours in the night.

8th—Stool and urine as yesterday, that is, frequent and scanty. Patient complains of great weakness and burning sensation all over the body; desires cold drinks, such as lemonade, cocoanut, milk, &c., *Ac. phos. 6x*, one dose at 7 P.M. another at 11 P.M. Diet, milk and barley. Slept well at night.

9th—Patient remarkably better. Complained of hunger for the first time and asked for food. Diet, boiled rice and fish-broth. After this, stools became healthy and urine free. No medicine.

10th—In the afternoon there was slight rise

of temperature which was 99.4°; diet, milk only. No medicine.

11th—Eruptions (miliary) appeared all over the body. Temp. at 4-30 P.M. 99.4°. As the old school doctor had given Calomel, I ordered *Sulph. 30*, one dose.

12th—Eruptions the same. Temp. at 4-30 P.M. 99°—less than yesterday. One more dose of *Sulph. 30*. Diet, wheaten hand-made bread.

13th—No more rise of temp. But eruptions just the same. *Puls. 6*, two doses.

14th—Eruptions better. Cont. *Puls. 6*.

He was all right in the course of a few days.

Remarks

In this, as in many similar cases, in which the stools are hot and commence early in the morning, the beneficial effects of Sulphur in changing the aspect of the disease were well seen. But it could not complete the cure, though in many other cases a single dose proves curative. Arsenic was evidently useless, as it very often has been in the present epidemic. Stramonium, though it wonderfully controlled the furious delirium, had to be supplemented by Opium in order to overcome the drowsiness, which continued in spite of the free secretion of urine. The extreme prostration, which threatened to terminate life, in spite of improvement in the other symptoms, was successfully combated by Phosphoric acid.

Case 2—Upendra Nath Datta, age 24, in the same house with the patient mentioned above, and in fact a relation of his, was attacked with the disease on the 31st May. He began to have loose stools at noon, which became rice-water at 5 P.M.

I was consulted about him on the same day that I visited the other patient, namely, on the 4th June. He was being attended by the same Homœopathic practitioner, Babu Kunja Lall Mullick. From him I got the following report of the previous days' progress of the case and its treatment:—

31st May, 8 P.M.—Stools rice-water like, copious; body cold, perspiring copiously. Thirst unappeasing. Stomach rejects everything, even iced water. Pulse not perceptible at the wrist. Eyes sunk in the sockets. Voice husky. Cramps in the lower extremities. *Ver. alb. 6* and *Cup. acet. 6* in alternation.

1st June, 8 A.M—Deep collapse. *Aco. 1x*, 2 doses at intervals of 4 hours. Urine continues suppressed. Intense thirst. Burning sensation all over body. *Ars. 30*, one dose at 2 P.M., and another at 6 P.M.

7 P.M.—Pulse perceptible at the wrist. Body slightly warm. Urine still suppressed. *Canth. 6*,

one dose, at 9 P.M., and a second at 1 A.M.

2nd—Stool yellowish, being passed every hour, and about an ounce each time. Eyes congested, no urine yet. Pulse perceptible. *Bell. 30* every 4 hours, two doses only to be given. Plenty of cold water to drink, and cold water to be applied to the head. 3 A.M.—Urine about one chittack (2 ounces) was passed.

3rd, morning—Stool thicker, but no more urine. *Sulph. 6*, one dose at 8 A.M. Patient was drowsy the whole day, eyes red, respiration hurried. *Canth. 30*, one dose at 6 P.M., another at 9 P.M. 11 A.M.—Patient delirious. *Hyosc. 6*, 2 doses at intervals of 4 hours.

4th, morning—Stool the same, eyes deeply congested. Urine still suppressed. Patient unconscious, but very restless, wishes to sit up, and talking nonsense.

I was consulted at about 8 A.M. and suggested *Agar. mus. 6*. Two doses were given at intervals of 4 hours. 6 P.M.—Pulse full and bounding. Very restless and furious, screams loudly. *Stram. 6*, one dose at 10 P.M., and another at 2 A.M. After the second dose patient slept quietly for 4 hours.

5th, 7 A.M.—Abdomen slightly distended. I ordered a few globules saturated with *Tincture of Camphor* to be given occasionally.

Evening—Patient again delirious, eyes congested, sordes on the teeth, urine suppressed, difficulty of breathing, taking at intervals of about 5 minutes a deep and long breath. *Apis 6*, one dose at 10 P.M. Urine, an hour after the dose of *Apis* about 1 poah (8 ounces), again at 3 A.M. the same quantity. Slept quietly.

6th—No stool, but urine three times, about ½ poah (4 ounces) each time. Patient continues very low, drowsy, not answering when called. *Opium 6*, one dose.

7th—No stool, urine 5 times. Not so low, drowsines less. Diet milk and barley.

Evening—Temperature rose to 100°. Again very low; tip of tongue dry. *Opium 6*, one dose.

8th—No stool, bed sores over the sacrum. Urine free. *Nux v. 6*, one drop. Diet, milk and barley.

Evening—Temp. rose to 100°. Patient continues very weak. Eyes same as before.

9th—No stool for 90 hours. Urging to stool, but ineffectual. Feels very uneasy on account of costiveness; says he must have stool, or he would not be well. Ordered Glycerine 1 drachm to be injected through the anus. One healthy and formed stool almost immediately. Another similar stool 3 hours after.

10th—No stool. Urine free. Temp. at 5 P.M. 99.4°. Ulceration of both corneæ at the lower margins. No medicine. Diet, milk and vegetable soup.

11th—Just the same. *Puls. 6*, one dose. Had one healthy stool after it.

12th—Ulceration of corneæ increasing. *Sil 12*, two doses every 6 hours.

13th—Patient left for his native village in the morning.

We have since heard of his complete recovery.

Remarks

In this case the urine, which appeared to have been brought about by Belladonna, became again suppressed. Agaricus, notwithstanding some symptoms which pointed to it, failed to produce any effect. Stramonium did succeed in controlling the delirium, but failing to act upon the kidneys, the improvement was not permanent. Apis well succeeded in stimulating the kidneys to action after the failure of several remedies, such as Canth., Bell., Hyosc., Stram., but notwithstanding the free secretion of urine, the drowsiness deepened and had to be removed by Opium. For the obstinate constipation we had to inject Glycerine which acted well upon the rectum and produced healthy stools.

A Case of Sloughing of the dorsum of the Tongue

A Hindu lady, aged 55, was placed under my treatment for sloughing of the whole of the dorsal surface of the tongue, on the 14th June last. I was told that the disease commenced only ten days ago as a white spot in the middle of the tongue. The slough was whitish in appearance, thick, and firmly adherent. There was not much fœtor. The submaxillary glands were swollen and inflamed. There was in the beginning considerable swelling of the tongue and lips, but it was much less now. The gums were painful, but not swollen or ulcerated. She had suffered similarly about 15 years ago, and was cured under my treatment, but I have entirely forgotten the medicines I had given then. I now prescribed *Acid nitric 6x*, one drop for a dose, twice daily. Diet, milk.

17th—Visited her in the morning. Found the slough separating, and the glands less swollen and painful. Continued medicine and diet.

1st July—Visited. The slough has completely separated. Patient better in every respect. Cont. medicine and diet.

19th—Found the ulcer nearly healed. The surface of the tongue still very raw. *Sil. 12.*

She was quite well in the course of a few days.

Remarks

There was no history of syphilis, and I could not trace how the extensive sloughing did originate. There must have been some irregularity of diet, or more probably some excess of lime in the prepared betel which the natives of India are in the habit of chewing, especially after meals. But I could get not clue as to what was the real cause from either the patient or her attendants. The effect of Nitric acid was almost magical.

A Case of Dysentery

Indubhusan, a male Hindu child, aged 13 months, was suffering for 2 months from dysentery after an attack of what was supposed to be measles. The stools were 7 to 8 in 24 hours, slimy, yellowish green, and bloody, passed with much urging and noisy flatus. I gave him (July 2, when I first visited him) *Argentum nitricum 6x*, 1 globule twice a day. On the 4th, report was brought to me that the number of stools was less, being 4 to 5 in 24 hours and the child's appetite seems to have increased, as he takes his milk with greater eagerness. The medicine was repeated.

I visited him again on the 10th at 11 A.M.

I found him sleeping. I could feel the liver which was slightly enlarged. The stools were still of the same character, and 5 in number during day and night. I omitted *Arg. n.*, and gave some globules of Nihilum (Placebo).

12th—Report was brought to me to the effect that the number of stools had increased, being now 6 instead of 5 in 24 hours. They were more in day than in the night, frothy, and more diarrhœaic than dysenteric, and still passed with flatus. *Ipec. 6x*, globules.

14th—No better. Stools of the same character. *Acalypha 3x*, globules. On the 20th report was that he was much better. Gave some Nihilum globules. I heard no more of him, from which I conclude he must have recovered, otherwise the father, who had great faith in me, would certainly have come to me.

A Case of peculiar sequela of Influenza

Jotindra Mohan Chatterjee, a resident of Bhowanipur, aged 18, came to me on the morning of the 23rd inst. (Aug.) for a troublesome complaint from which he was suffering for three years after an attack of Influenza. The complaint

was a constant sensation of a lump in the throat with as constant a tendency to hawk and clear the throat. The result of the hawking was the expectoration of clots of blackish mucus. *Acalypha 3x*, 1 drop, twice a day, cured him in a few days.

Remarks

These cases well illustrate the remedial virtues of Acalypha indica which we could only avail ourselves of in the light of its recent provings. It has certainly other pathogenetic and consequently curative powers, especially over the female reproductive organs, as seen in the cases in which it was empirically used by Dr. Marc. Jousset. But these require to be developed by further provings especially in the female subject. Are there none to follow the examples of Babus Gopal Chandra Dutt and Joykissen Ghosal?

A Case of Measles with Pneumonia

(*Reported by Prasanna Lal Kumar, L.M.S.*)

A Hindu lad, aged four years and three months, had fever for 10 or 12 days. As a brother and cousin of his, living in the same house with him, had measles at that time, he was not given any medicine in anticipation that he also might get measles. After 10 or 12 days the fever grew stronger and the measles not having appeared as was expected, he was given 1 gr. of

Quin. sulph. during intermission. The temperature rose up to 104° on that night. The next day (29th October) he was again given Quin. sulph. in 1 gr. doses once in the afternoon and again at about 8 P.M. During the night the temperature remained normal, but it commenced to rise from the morning of the 30th instant. At 5 P.M. the temp. was 105.5°. On auscultation moist crepitations were heard at the base of the right lung, but there was no dullness present. Some cooings also could be heard here and there over both the lungs. He was given the following mixture:

Ammon. carb. gr. i
Liqr. Ammon citratis ʒ ss
Spt. aether. nitrosi m v
Vin. Ipecac. miiss
Syr. Simp. m xv
Aqua ad ʒ ii

Mix for one dose, a dose to be taken every three hours. Three doses of this mixture were given.

31st October, 6-30 A.M.—Temp. came down to 101.5°. At about 9 A.M. Dr. Sircar was called in. The temp. was then 99°; no stool for two days. He prescribed *Nux v. 30*, four globules of which were given at once. At 10 A.M., had one scanty stool. 1-30 P.M.—Temp. 101.4°. 2-30

P.M.—Had another hard scanty stool. Temp. at 7-30 P.M. 103.2°, at 8-30 P.M. 104.2°, at 10 P.M. 104°.

1st November, 6-30 A.M.—Temp. 102°. Measles appeared all over the body. Condition of the lungs was the same as yesterday. No medicine was given. Temp. at 1 P.M. 104°, at 4-30 P.M. 103.8°, pulse 140, respiration 75 per minute. The dilator nasi muscles were acting violently during respiration. The face was quite flushed. Dr. Sircar still gave no medicine. Temp. at 8 P.M. 103.8°, at 10 P.M., same. During the night the child was delirious and had one scanty soft stool.

2nd, 6-30 A.M.—Temp. 102°, at 8-30 A.M. 101.4°. Moist crepitations could be heard all over the back of the right lung and also over the front below the mammary line downwards. It was distinctly duller than the left lung. Moist crepitations could also be heard over the back of the left lung down the lower angle of the scapula. The face was cyanosed. Respiration short and abdominal in character, 75 per minute; pulse 150. 2 globules of *Phos. 6x* were given. 11 A.M.—temp. 102°, resp. 70; 2-30. P.M.—temp. 102.2°, resp. 50, pulse 144. Appears to be somewhat lively. 4 P.M.—temp. 103.2°, resp. 60. At 7 P.M.

temp. 102.2°, at 8-30 P.M. 102.4°, at 10 P.M. 101.8°, 2 globules of *Phos. 6x.*

3rd, 1 A.M.—Temp. 101.2°, resp. 40, 6-30 A.M.—temp. 100°, 2 globules of *Phos. 6x.* 9 A.M. —temp. 100°. No crepitation could be heard over the left lung. The right lung on percussion more resonant and the number of crepitations fewer. 10 A.M.—temp. 100.4°; resp. 40 1 P.M. —temp. 99.4°. Appears much better; could sit up and play. Temp. at 4-30 P.M. 99.2°, at 8 P.M. temp. 99°.

4th, 6-30 A.M.—Temp. 97°. The right lung almost perfectly clear, no more crepitations. Sibilant and sonorous rhonchi could be heard here and there over both the lungs. The cough was dry and distressing. No medicine.

5th, 6-30 A.M.—Temp. 98°. Cough dry. 2 globules of *Ipec. 6x.* 7 P.M.—temp. 98°. 2 globules were again given.

6th—The cough easier. Since the first inst. the patient has had no stool, to-day he passed a copious healthy stool.

The patient steadily improved and is now (Nov. 20) all right.

Remarks

There was evidently some peculiarity in the constitution of the child which prevented the eruption of the measles from

coming out. The quinine given had, probably, the effect of heightening that peculiarity. The Nux vomica antidoted this effect of quinine, and thus facilitated the breaking out of the eruption. The action of Phosphorus in controlling the pneumonia, which had threatened to be serious, was evident and remarkable.

A Case of Malarious Fever with Continued Nausea

Mrs. R ————, aged 49, resident of Entally, Calcutta, came to me on the 17th April for treatment of a fever from which she has been suffering for 10 days. The fever comes on twice in twenty-four hours, once after noon and again after midnight. The symptoms were chilliness followed by heat. The fever subsides without sweat. The most distressing symptom both during the fever and during the apyrexia was nausea. There was no vomiting except what she would induce by titillating the throat in the hope of relieving the nausea. I gave her *Ipec. 6x.*

19th April, 1898—Called in the morning, and said the nausea was just a little better, but the fever was coming on as before, twice a day. The tongue was coated thickly white, *Ant. c. 6.*

21st—Called in the morning. Said the fever has left her, but the nausea was worse. The taste

in the mouth was sweetish. Thinking that the fever having been subdued by the Antimonium crudum, the increased nausea was probably an aggravation produced by the drug, gave her no medicine.

23rd—She came to me as usual in the morning. She is free from fever, but the nausea is no better, if not worse. Notwithstanding freedom from fever, this symptom, which was preventing her from taking food, was daily reducing her strength. *Sulph. 30.*

26th—I was sent for in the evening to see her at her house as she was so weak that she was unable herself to come, as she was hitherto doing. Found her lying in bed with extreme prostration. In addition to the nausea she complained of a coppery taste in the mouth. *Rhus. t. 6x.*

28th—Report was brought in the morning that she was no better. Thinking that worms might be the cause of the persistent nausea, though there were no other symptoms of worms, I gave her *Cina 6x.*

30th—Nausea only a shade less, but still considerable to be very annoying and distressing. *Ipec. 30.*

18th May—Called at my house in the morning, and said she had discontinued medicine

in the hope that she would gradually get over the nausea; but though she has been free from fever since the 19th of last month when she had the *Ant. c.*, the symptom was persisting with a devilish pertinacity. By a most searching questioning I was enabled to elicit a symptom which was present from the beginning but which she did not think it necessary to mention, or perhaps had concealed for shame. The symptom was abolute aversion to smoking of which she was particularly fond. This at once led me to select *Pulsatilla* because the drug not only covered the "Intolerable nausea without vomiting," but also the "extreme loathing to tobacco-smoking" to which she was not only accustomed, but very much addicted. I gave her the 6th decimal dilution, with instructions to take only one dose, and then report. This one dose had the desired effect. There was no more nausea after that. The disgust for food vanished, her appetite returned, and she made a rapid recovery.

Remarks

This case well illustrates the necessity, so earnestly enjoined by Hahnemann, of making a most scrutinizing inquiry into the symptoms of a patient, in order to find out an analogue in the Materia Medica. The difficulty of such inquiry, especially in the case of females, must be experienced by

every practitioner. But the difficulty must be faced in the interests of the patients themselves. Had the characteristic symptom regarding tobacco-smoking not been discovered, it is doubtful if the true Homœopathic remedy could have been found out. Would unaided Nature have succeeded in bringing about a recovery? She was without medicine for eighteen days and yet she was not only not better, but getting worse and worse. The probability is, she would never have recovered without the medicine that was selected for her.

A Case of Paralysis of Muscles of the Neck cured by Lycopodium

A Hindu male child, aged 4, was brought to me on the 10th September for Nasal Voice. The child was suffering from this symptom for about a month since his recovery from a bad attack of fever. On examination the uvula was found to be rather long and relaxed. On inquiry I learned that drinks, not solid food, return by the nose. The patient was lean and emaciated, but was free from fever and had no other organic disease. An old school doctor had diagnosed ulceration of the floor of the posterior nares and had feared perforation of the soft palate. He was placed under a Homœopathic practitioner, who treated him with *Caust. 6* for a fortnight but without any benefit. I gave him some globules saturated with

Merc. sol. 6, two to be taken for a dose twice a day.

The child was brought to me on the 24th, that is after six days' use of *Mercurius sol.* There was complete disappearance of one symptom, "return of drinks by the nose", but the nasal voice was not a whit better. I gave him *Aurum met. 10x*, globules, to be used in the same way as the first medicine.

18th—The child was brought, as usual, in the morning. The voice was much improved, the nasal twang being less; but a new and most alarming symptom had developed itself—the patient could not keep his head erect. There was evident paralysis of muscles of the neck, more of the right side, as the head fell more towards the left side. Thinking this might be due to *Aurum*, I discontinued the medicine, and gave some Nihilum globules. The child was brought on the following day, the 29th. Nasal voice quite gone, but paralysis of muscles of the neck rather worse. Gave *Lycop. 30* in *globules.*

1st Oct.—Was glad to see that the child could keep his head erect pretty well. The medicine was repeated, and in the course of a few days, the grave symptom of paralysis of the neck disappeared.

Remarks

This case affords a beautiful verification of a pathogenetic symptom of Lycopodium, which is thus recorded in the *Chronic Diseases:* "A sort of paralysis of the cervical muscles, the head sank down forwards more and more, as if it would fall off." In our case the tendency of the head was to fall more to the left, than to any other side; and yet Lycopodium removed the symptom, showing that the drug does produce paralysis of the muscles of the neck, and it is immaterial on which side the paralysis may be predominant. This symptom of Lycopodium was furnished by Hahnemann, and however obtained, whether with the 30th dilution on a healthy subject, or simply as a removed clinical symptom, there can be no question that it is a genuine symptom. This shows how unwise it is to reject all the symptoms of the Chronic Diseases which have been furnished by its author.

A Case of Dyspepsia after the Continual use of Purgatives

Patient, a Hindu, aged 38, came to me on the morning of the 15th Feb. 1897, for the following symptoms: Vomiting of mucus, not of the ingesta, immediately after eating; twisting in the intestines; hot flatulence; pains along the sciatic nerves; vertigo. The history was that he had suffered from malarious fever for 7 or 8 years, for which he used to take purgatives very

frequently. After recovery from the fever he has been suffering from the above symptoms for 5 years, and has derived no benefit from any treatment. The symptoms pointed to *Aconite*, and though it was a chronic case I gave him *Aco. 6x in globules*, 3 or 4 to be taken twice a day.

25th—He came to report that the vomiting has ceased, but the other symptoms were no better. Gave *Aco. 30 in globules*, to be used in the same way.

5th March—Reported improvement in the other symptoms also. Continued *Aco. 30.*

29th—Better in every respect, except that the sciatic pains and vertigo were still lingering. Continued the medicine with which he went home some eighty miles from Calcutta, and did not return, which he would have done if he had not been cured.

A Case of Cholera

27th Feb. 1897—Was called in the afternoon to see a case of cholera at Kulpighat, 67 Strand. The patient, a Hindu, aged 24, is a native of Mukundpur, near Diamond Harbour, where he was suffering from indigestion for some time. He came to Calcutta—in the morning of Friday, the

25th inst. He took papaya fruit in the afternoon, and the diarrhœa from which he was suffering developed into cholera by midnight, with both vomiting and purging. Yesterday up to noon was under old school treatment. Since then has been under a Homœopathic practitioner, who having left Calcutta, I was sent for. The symptoms at the time I visited were: thin, almost watery stools, but much less frequent than before; incessant nausea, and vomiting ten to fifteen minutes after drinking water which he was obliged to take often on account of the intense thirst; pulse barely perceptible at the wrist. Thinking this might be an aggravation of the *Arsenic* which he in all probability had received from the Homœopathic practitioner, I gave him *Ipec. 6x in globules*, a few (3 or 4) to be given every hour. Report came to me at 10 P.M. that he was better, the vomiting having become decidedly less. Sent some Nihilum globules.

18th—Report in the morning: Better in every respect, except that he has passed no urine yet. Sent *Canth. 6x in globules*. Evening Report: No urine yet; has passed two worms with stools. Ordered a small bit of camphor to be placed at the orifice of the urethra.

1st March, 9-45 A.M.—Visited. Was glad

to hear the patient has passed urine three times since last night; stools still thin, but fæculent and yellowish; considerable thirst and burning of body. Gave him some Nihilum globules, and ordered Gandhal soup with plain sago. He was well, in a short time, and I had not to visit him any more.

A Case of Empyema

Abdus Sattar, Mahomedan, aged 18, resident of Dhobapara (Mudiali) near Garden Reach, about 5 miles from Calcutta, was brought to me in the morning of Tuesday, the 27th September last. He was suffering from fever of the remittent type for the last 34 days, with aggravation in the afternoon. There was much emaciation and considerable dyspnœa. On examination the whole of the left side of the chest was dull on percussion. There was just a slight respiratory murmur at the apex of the left lung. The intercostal spaces were as it were filled up and almost bulging as if from fluid pressure from within. There was much cough but no rales in the right lung. Heart beats exaggerated and visible. Considerable bulging of the precordial region. Can lie only on the left side: slightly jaundiced tint of the conjunctiva and of the

skin, but no enlargement of the liver. Tongue slightly furred.

I diagnosed the case to be one of pleuritis of the left side with effusion filling up the whole of the pleural cavity, causing shrinking of the whole of the left lung, and probably also pericarditis with effusion. I gave *Bryo. 2x.*

29th Sept.—Report was that the patient was better, fever and cough and dyspnœa were less. Continued *Bryo. 2x.*

30th—Report was brought in the morning that the cough was worse, but in other respects much the same. Thinking the increase of cough was due to an aggravation of *Bryo. 2x*, gave *Bryo. 4x.*

2nd Oct.—Report of strong fever yesterday. Sent. *Aco. 2x.*

4th—Fever less but cough worse. *Bryo. 6x.*

8th—Patient brought in the morning. A swelling, about the size of a small orange with distinct fluctuation, was observed about 3 inches below left nipple. The dullness of left side was the same as before. Fever was less but cough no better. The swelling appeared to me to indicate pus and not watery fluid as I had at first thought. I prescribed *Sulph. 30* in the hope of causing absorption of the fluid whatever it was,

and also to allay the cough which was very troublesome.

13th—Report came that the patient was better as respects the cough, otherwise much the same. Continued *Sulph. 30.*

14th—Patient's father reported that the swelling had increased and become more fluctuating. As my own health did not permit me to visit the patient at his house, and as I thought it too risky to bring him over to mine, I asked the father to have the swelling explored by a medical friend of mine who resides in his neighbourhood, and to make a small incision if there be pus.

17th—Report was that the swelling was explored and incised yesterday, as I had directed, with the result that about 4 pounds of pus had come out. Stopped medicine.

19th—Report that the discharge through the opening made is pure pus, and about ½ lb. daily. Patient feeling better. No medicine.

26th—Patient brought to me in the morning. Found pus freely discharging in considerable quantity through the opening. Patient was better in every other respect; fever and cough were less, and breathing easier. But respiration was not fully established. To check the suppurative process, I gave *Sil. 12x* which was continued

till the 4th November, after which the improvement being stationary, I changed the dilution to the 30th centesimal which was continued till the 10th. But no further improvement following I again stopped all medicines.

18th Nov.—Report was that the patient was almost the same, the slight fever hanging on still. Gave *Sulph. 30.* From this day improvement became rapid. The discharge ceased and the opening through which it was flowing healed up in a day or two. The fever and the cough disappeared in about a week. The appetite increased and there was great cry for more food than was allowed.

16th Dec.—Patient brought this morning. I was glad to find him nearly all right, the fistulous opening quite healed, the respiration fully established in the upper and partially in the lower part of the affected lung, though still frequent, being 28 in a minute, the swelling over the precordial region quite gone. Continued *Sulph.*, and ordered a bath to be given to-morrow.

21st—Patient brought. Found him better still. Stopped medicine.

Remarks

It is difficult to say whether this was a case of suppurative pleuritis from the beginning, or of simple pleuritis with

serous effusion taking on degenerative suppurative changes in the course of old school treatment. When the patient was brought to me thirty-four days after the commencement of illness, there was nothing to lead me to infer that there was pus in the pleural cavity. Taking the fluid which had filled the whole of the left side of the chest to be ordinary serous effusion,and having regard for the jaundice and the symptom that the patient could lie only on the affected side I prescribed Bryonia. It did some, but not much, good in the beginning. I had to use Acconite for the strong fever which had come on while the patient was taking Bryonia. Under Aconite though the intensity of the fever abated, the cough became more troublesome, and I had to use Bryonia again, but this time in a higher dilution. Though the medicine was used for four days, the morbid process that was going on in the pleura went on unchecked and declared its true character by the matter within pushing itself out through the intercostal spaces, evidently the fifth and sixth, and forming a fluctuating swelling. The fact of Bryonia failing to cause absorption of the effusion shows that it was purulent and not serous at the time the patient was first brought to me, whatever it might have been in the beginning.

It the diagnosis of empyema had been positively made at once, could we have used any medicine that could cause the absorption of so large a quantity as upwards of four pounds of pus? My experience with Hepar, Silicea and Mercurius in such cases in the past does not return an affirmative answer to the question, and it is doubtful if anything else, than what was done, could have been done that would have hastened the progress of the case, which it must be admitted, was satisfactory. It is remarkable that Sulphur should have

played so important a part in expediting the recovery. This shows that probably there was some constitutional taint which this price of anti-psorics corrected. I must not omit to mention that I had to put the patient on a very restricted diet. I forbade all juicy and acid things. I kept him chiefly on milk and allowed him wheaten bread (chapatis) only when the fever had considerably abated

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A Case of Inguinal Hernia

Babu N. K. Aged about 63 years, is subject to hernial protrusion in the right inguinal region. The protrusion does not advance much beyond Poupart's ligament.

On the 17th August last at about 11 A.M., he had an attack of this kind. The immediate cause appears to have been straining during defæcation. The tumour was hard and very tender to touch. The patient remained quiet in his bed, the bowels moved once or twice; at about 5 P.M. very gentle taxis was applied to reduce the hernia without any success. As there was no urgent symptom he was no further molested but was ordered to remain quiet in his bed and to apply ice over the tumour, Ice was applied with an ice bag for about an hour but it did no good. The patient remained in this state

during the whole night and had very little sleep. In the morning of the 18th I was consulted. I prescribed *Nux v. 30.* One dose was given at 7 A.M. and another at 11 A.M. In the meantime the patient had one or two stools, and felt easy enough to take a bath and a meal of rice. The hernia went back completely at about 3 P.M. as it used to do before under the same medicine.

A Case of fits of Convulsion after a fall, benefited by Alumina

January 5, 1899. A child, 4 years old, was brought to my clinic in the morning, with the following history: Had a fall 21 days ago. He fell flat on his back. As he fell, a pile of wood fell on the middle of his body, that is, on his abdomen. The pile was not heavy enough to do any external injury. But the child became unconscious. Half an hour after the fall he began to have convulsions which lasted for 6 hours. The intensity of the convulsions would abate by the application of ice to the head. The eyes were upturned while the convulsions lasted. The child was better and free from convulsion for 15 days. On the 16th day, after he had played in the sun for sometime, he began to

have a fit of convulsion which lasted 4 hours, and was attended with vomiting, the vomited matters coming out even through the nose. On the following day, the 17th day after the fall, there was another fit of convulsion attended with vomiting. The child was better for 2 days after which he had a fit of convulsion again, but there was no vomiting this time, instead of which there was violent diarrhœaic motion just before this fit, or rather just as the fit commenced. The stools since passed are not diarrhœaic but hard and covered with whitish slime. Since the fall the child has become very timid and fearful. Prescribed *Alumina 6.*

Jan. 10—Child was brought in the morning. He was better, has had no more fit. Repeated the medicine.

Feb. 2—Report by the father. No more fit, but had fever from the 17th to the 21st January which was cured by *Bell. 6.* There is some timidity still. Gave some unmedicated globules with instructions to bring the child again if necessary. The child was well for two months, and a relapse took place after some irregularity. His father having fallen ill at this time he was not brought to me, but was placed under a Kaviraj.

Remarks

Alumina was selected in this case for the mental symptom (timidity) and for the convulsion, and it certainly did good, keeping the patient free from convulsions for two months, and which in all probability would not have returned had it not been for some "irregularity", the nature of which I could not ascertain. I have not yet met with a case of convulsion, in our literature, in which Alumina had been used.

A Case of Renal Colic, cured by Lycopodium

Babu H. P. M., aged 46, resident of Calcutta, by occupation a clerk, came to me in the morning of the 1st October 1899, with the following complaint. He has been suffering for two months from a pain which runs down from the region of the left kidney to the left testicle. He suffers also from great windiness, passing flatus upwards and downwards constantly. His general prostration is very great. All these symptoms are gradually increasing, and the renal pain is occasionally very severe. Gave him *Lycopodium 16x.*

4th October—Called in the morning and reported that the pain from the kidney down to the testicle is nearly gone, and that the flatulence has become less, though still he has to eructate much. Continued *Lycopodium.*

8th—Called in the morning as usual. Pain entirely gone, does not feel the windiness, though he has to eructate but much less frequently. Prostration is also dicidedly less. Continued medicine.

17th—Presented himself as usual with all the symptoms nearly gone.

22nd—Cured.

Remarks

There are two points of interest in this case. First, the renal colic was left-sided, and yet Lycopodium effected a cure. The general belief amongst Homœopathic practitioners is that Lycopodium is more suited for right-sided affections. Dr. Nash says—"Lycopodium affects the right most, or at least the troubles begin on the right side..... Any complaint that begins on right and goes to left makes me think of Lycopodium." Accordingly, we find Lilienthal recommending it for renal colic when pain extends down (right) ureter to the bladder. In our case the pain extended from the left kidney to the left testicle. It is true that 'the sides of the body' of subject is of more account than some imagine, and that "drugs have an affinity for particular parts, organs and even sides of the body." But we must study the whole pathogenesis of a drug and not make hasty generalizations from a few instances, and we must also see that we take note of side with reference to particular symptoms.

The second point of interest is that the 16th decimal dilution of Lycopodium that was prescribed was made from a mother tincture which I had myself prepared from the

pollen with strong rectified spirit. The phial, in which the pollen and the spirit were mixed in the proportion of one to five, was every day, two or three times, strongly shaken for over two months, at the end of which the clear supernatant liquid was drawn off, and found to be saturated with the odd of the pollen, as evidenced by the milkiness produced when dropped on water. Dr. Hughes says—"It seems probable that the medicinal virtues of Lycopodium reside in this peculiar oleaginous matter with which its sporules are filled; and hence the comparative inertness of all preparations of the drug which do not involve complete fracture or solution of the investing envelope. No tincture but an ethereal one is found to effect solution." But here we had a strong spirituous solution of the drug which did hold the oleaginous matter, and gave effective therapeutic result. Possibly the frequent violent shaking for over two months may have helped the solution. This should serve as a hint to pharmaceutists in preparing dilutions of Lycopodium. There does not appear to be any necessity for triturations which are always a troublesome affair.

A Case of Stiffness of the neck, cured by Dulcamara

On the 5th of this month (Dec.) I was asked to prescribe for an old lady of nearly eighty suffering for four days from a most painful stiffness of the posterior muscles of the neck with most excruciating pains from the slightest

movement. On inquiry I found that this was brought on by a bath in very cold water. There was a constant pain in the part which was described as of a throbbing character, but the pains that would come on from movement, however slight, to one side or the other, or forward or backward, were so torturing that the patient had to sit upright like a board without being able to rest her head upon a pillow, and thus had to pass two nights without a wink of sleep.

There was a temptation to try *Bryonia* from the aggravation from movement and from symptoms in its pathogenesis similar to those of the patient; but having regard to the cause I gave *Dulcamara 6x*, and the result was remarkable. The medicine was given at 9 in the evening, and the patient within half an hour fell asleep almost freed from pain, lying in a horizontal position with her head on a pillow. She rose in the morning with pain nearly gone. The medicine was continued for 4 days. The recovery was perfect. Would *Bryonia*, had it been prescribed for the similarity of symptoms, have succeeded in effecting such a cure?

A Case of Diarrhœa, cured by Gummi Gutti

A cook maid, T————, began to have purging and vomiting on the 14th July, 1902. The stools and vomiting were of such a character as to threaten to develop into cholera, and consequently *Tincture of Camphor*, a few drops in water, was administered. The threatened cholera was averted but the diarrhœa with occasional vomiting continued more or less, and by the 11th August became troublesome. The stools were liquid, frequent; flatulence was a marked symptom, giving rise to rumbling and tympanitic distension partially relieved by stool. These symptoms and the fact that her occupation necessitated frequent exposure to heat from the oven, induced me to give her *Carbo veg. 30*, which she took for 3 days till the 13th, after which she felt somewhat better and I did not hear of her case till the 17th December next, when I learnt that she had fever on the 2nd, since when her diarrhœa has become worse. The symptoms now were: stools frequent, watery, and undigested, coming out with a gush, and preceded by pinching in abdomen, chiefly in epigastrium and hypogastrium, the urging being sudden after the pinching; gurgling as of fluid in the intestines; vomiting; great debility, *Gummi*

Gutti 6x, a few doses (globules), in three days effected a complete recovery.

A Case of Psoriasis in a Parrot with Discolouration and Dropping Off of Feathers, cured by Arsenic

A beautiful parrot of the Chandana variety was caught about a year ago. It was apparently in full health. Its feathers were bright green with red streaks on the middle of the upper surface of the wings. It was put in a cage. After about a couple of months' confinement, it was noticed that feathers were dropping off, first from the breast, then from the wings and from the tail. Most of the downy feathers of the breast became white before dropping off. In the course of three or four months, the bird had lost so much of the feathers, of the wings and of the tail that it was unable to fly; so during the day it was let out of the cage and allowed to walk about, and after nightfall was put in its cage again. Notwithstanding this freedom given to it, the disease did not show any sign of improvement. The ladies from time to time gave the bird baths of turmeric water which according to them is a powerful

insecticide. But these baths were of no use. In the course of ten months from the commencement, the bird lost nearly three-fourths of its feathery covering. Singularly enough it did not lose appetite. It could eat well, and in fact it was rather greedy.

In the beginning of May last I thought of trying some medicine and *Arsenic* was the first medicine that came to my mind. I could not, however, make the poor thing take the drug. I put some globules of the 30th in its milk, but seeing that I had put something in the milk it would not take it. I tried to put the globules in the milk without allowing it to see what I was doing. But somehow or other it became suspicious about its milk and refused to take it from the day I had mixed medicine with it. At last about the middle of May I thought of mixing with the gram soaked in water with which we used to feed it, a little sugar of milk with about half a drop of *Arsenic 30.* He ate the gram. The dropping of feathers ceased in about four or five days. In about a week the downy feathers of the breast which had become white began to turn green. In a fortnight, feathers appeared in the wings and the tail and began to enlarge to their natural dimensions.

In the course of a month the bird had nearly regained its full and beautiful plumage. It became quite a pet with me and I had expected that it would for some years to come remain a monument of the great genius which had discovered the true science of healing which was to be a blessing not only for mankind but for the animal world as well. But alas! on the 18th June, a feast day in my house, the ladies forgot to put the bird in its cage, and at midnight it was caught by a cat and made a meal of, to the grief of the whole family and specially of myself.

Remarks

This was truly a remarkable case. It not only demonstrated that Homœopathy was applicable to the lower animals, thus pointing to the similarity of structure and function throughout the animal world, but it showed also how sometimes high dilutions act beneficially, and even one dose sufficing to effect the cure of a long existing disease. When administered the 30th Arsenic, I did not expect any improvement, at least in so short a time, and I would have repeated the medicine if no improvement had followed in the course of a week. But improvement being perceptible in the course of four days I waited to see if the improvement that had begun would continue. It not only continued, but became more and more and so much so that I gave up all thought of repeating the medicine. Would repetition have been useless or even

injurious? It certainly could not have accelerated the cure which was so rapid without it. This case teaches the value of patience on the part of the physician.

We have experience of the efficacy of our dilutions, and of the Hahnemannian 30ths, in the horse, the dog, the sheep, the cow, etc. We do not think they have been tried on the elephant, the rhinoceros, the camel, the leopard, etc. It would be interesting to see if the high dilutions would act in these animals. Trials alone can decide, and these will come in time.

আমাদের প্রকাশিত বাংলা পুস্তকাবলী

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